C6 | THE WAR ON DRUGS: FROM LAW ENFORCEMENT TO PUBLIC HEALTH

"*I believe that drugs have destroyed many lives, but wrong government policies have destroyed many more"*. Kofi Annan, speech to the World Health Assembly, 19 May 2015

Since the mid-twentieth century global drug policy has been dominated by strict prohibition, with the use of punitive law enforcement to try and reduce the illicit drug trade. This approach, which has come to be known as 'war on drugs', is not working. Not only has it failed to achieve its goals, it has also fuelled poverty, undermined health and failed some of the poorest and most marginalized communities worldwide.

Just like trade policy, tax avoidance and climate change, current global drug policies clearly undermine public health, yet campaigners on poverty and global justice, and to a lesser extent the health community, have remained largely silent on drug policy. Despite this, a growing recognition of the failure of the war on drugs and a move towards adopting a public health approach are gathering pace around the world.

Image C6.1 A Rally & Concert to End the War on Drugs, MacArthur Park, Los Angeles, 3 November 2011 (Nikki David / Neon Tommy; License: CC BY-SA 2.0, https://creativecommons.org/licenses/by-sa/2.0/)

Drug policies – public health impacts

The war on drugs impacts health – in particular that of the poor and marginalized – in a number of ways. These include the following:

Direct health impacts By driving drug use underground and into criminal markets, strict prohibition means there are no controls on drug strength and purity, and criminal sanctions for the possession of drugs and drug paraphernalia mean that drug injection is frequently done with unsterile equipment in unsafe conditions. This increases the rates of overdose and infectious disease among people who use drugs (Keefer and Norman, 2010).

Enforcement activities such as aerial drug crop spraying, most prevalent with the chemical herbicide glyphosate (Guyton et al., 2015, pp. 490–91), which the WHO declared a likely carcinogen in 2015, have been identified as causing damage to eyes and skin, as well as miscarriages (Count the Costs, n.d.). Although Colombia suspended the dangerous practice of aerial spraying with glyphosate in 2015 (the last country in the Americas to do so), South Africa continues to spray harmful herbicides from the air on inaccessible areas of cannabis cultivation, endangering the health of some of the most marginalized communities in the country (De Greef, 2016).

Restricted access to medicines In a speech to the World Health Assembly on 19 May 2015, Kofi Annan said that "Under current drug control policies, African access to essential medication for pain management is highly restricted". Stringent implementation of the international drug control treaties restricts access to essential (mainly pain) medicines for the populations of entire countries. This is because unduly restrictive regulations aiming to combat the non-medical, illicit market have resulted in highly restricted access to controlled drugs for essential medical purposes.

Five and a half billion people, or 80 per cent of the world's population, living in countries largely in the Global South, have limited or no access to essential medicines such as morphine for pain relief (Hallam, 2014). Ninety per cent of the world's AIDS patients and 50 per cent of global cancer patients living in low- and middle-income countries, have access to only 6 per cent of the morphine used for pain management globally (West African Commission on Drugs, 2014).

A 2010 Human Rights Watch report found that hundreds of thousands of children in Kenya suffer from AIDS, cancer and other chronic or fatal illnesses that cause severe and debilitating pain, which could be easily alleviated by opioid medicines. Many of them were suffering in unnecessary pain due to the widespread unavailability of these medicines as a result of strict legal and regulatory barriers, despite the medicines being classified as essential by the WHO (Box C6.1) and the Kenyan government (Human Rights Watch, 2010).

Box C6.1: Inaccessibility of essential opioid medicines in India

Access to controlled essential medicines, such as morphine and other opioids for pain relief, became severely limited in India as a consequence of the 1985 Narcotic Drugs and Psychotropic Substances (NDPS) Act. The NDPS Act introduced highly cumbersome licensing procedures to obtain opioids and significant penal penalties for very minor infringements, leading to fear of penalization among pharmacists and medical professionals for even minor clerical errors. This has contributed to a widespread aversion to stocking or prescribing these drugs (Rajagopal, 2007, pp. 615–22).

Different norms exist across state-level legislations and policies on licensing, the maximum days' supply of opioids allowed in a single prescription (varying between six and thirty days), dispensing procedures for pharmacies and allowances for emergency prescriptions and corrections (Cleary et al., 2013). A 2014 amendment to the 1985 NDPS Act was intended to address the impact of these regulatory barriers and improve access to opioids for medical purposes. However, these legislative changes have not yet been properly implemented across the majority of Indian states, and many of the barriers to access, as well as the culture of fear stemming from the 1985 Act, still continue to limit access to controlled essential medicines across large regions of India. The availability of essential opioid analgesics in India is among the lowest in the world; according to data from the WHO and the International Narcotic Control Board (INCB), India was ranked 117 out of 144 for the availability of morphine in 2014 (Pain and Policy Studies Group, 2015).

The continuing disparity in the availability of essential opioid analgesics across the states and between urban and rural areas in India means that in many cases patients and their families must travel hundreds of kilometres to these medicines. Interviews conducted in New Delhi, Gujarat and Punjab in 2017 (Health Poverty Action, forthcoming) give first-hand accounts of advanced stage cancer patients and their family members being forced to travel very long distances every month, in some cases across multiple states, to access essential opioid pain relief medicines, with the travel alone costing 40–80 per cent of the family's monthly income and in several causing families to incur debts (this does not even account for the additional costs of purchasing the medicine itself). As one cancer patient interviewed in Ahmedabad, Gujarat, said:

"I have travelled 450 kilometres from my town called Bhilwara in the state of Rajasthan to come here because morphine is not [readily] available there…I have had pain before also, but I started to have pain so strong I could not bear it since March. It is very difficult for me to

come here and also for my family to accompany me. It takes 10 hours to travel from my town to here and costs 800 rupees per person. As my family is accompanying, for four of us it costs 3,200 rupees per month to come by train. Our family's income in total however is only 5,000 rupees a month. We cannot pay for the travel costs from our income, so we have had to take loans with interest from other people in our town".

In a number of cases people have been forced to quit work to care for their family members, including to undertake these long journeys with them or on their behalf to collect medicines. Children are forced to give up school to take up wage labour to fill the gap in the family's income or pay off their debts. In some cases families making these journeys were also regularly forced to leave young children at home without anyone to take care of them. A 37-year-old female patient with stage 4 cancer, also interviewed in Gujarat, said:

"I travel to receive treatment for my disease and now also to ask for the prescription for morphine from a village that is 450 kilometres away from here…My husband is a labourer in construction works, but he quit his job to take care of me, so we had to take a loan. I have three children aged 16, 12 and 10, and the two oldest stopped going to school to go to work as labourers so that the family is able to pay back the loans".

Ketamine, an anaesthetic drug suitable for use in major surgeries performed in resource-poor settings without oxygen or electricity, is also in potential danger of being placed under the same restrictions internationally (International Committee of the Red Cross, 2015). Some anecdotal reports indicate that recent national restrictions in India are having an impact on its availability in health facilities in rural areas.

Restricted access to health services The criminalization of people who use drugs and the social stigma attached to drug use act as strong barriers to accessing medical care and other support services. Women who use drugs face particularly strong stigma, especially pregnant women who are often denied prenatal care and opioid substitution therapy, putting their life and that of their baby in jeopardy (Kensy, 2012; United Nations Office on Drugs and Crime, 2014). Social stigma also constrains state expenditure on narcotic substance abuse treatment services.

Some countries are also unwilling to fund or develop HIV/AIDS treatments for people who use drugs. Among people who inject drugs, less than 4 per cent of those living with HIV globally have access to antiretroviral treatment, which plays a key role in reducing HIV transmission (Harm Reduction International, 2012; Montaner et al., pp. 531–36). Harm reduction services, which provide

access to sterile injecting equipment through needle and syringe programmes, are essential in reducing HIV transmission and prevalence (Global Commission on Drug Policy, 2012). Where harm reduction services have been established early on – such as in the UK, Switzerland and the Netherlands – this has curbed HIV epidemics among people who use drugs, whereas countries that continually refuse to implement these life-saving programmes – such as Russia – face elevated HIV prevalence among people who inject drugs (Global Commission on Drug Policy, 2011).

Diverting attention and resources from essential services Many governments are engaged in a constant civil war with drug cartels, a war they are ill-equipped to win. The costs of waging this war, both financial and in terms of dominating space on the political agenda, leave little room for state services and social improvements. Enforcing anti-drug policies costs at least US$ 100 billion a year globally, rivalling the US$ 130 billion worldwide aid budget (Count the Costs, 2012). Reforming drug policies could release substantial funds at both the national and international levels for basic services such as education and health. To take one example, the Overseas Development Institute (ODI) estimates that the additional financing needed to meet the Sustainable Development Goal of universal healthcare is US$ 37 billion a year.[1] Conversely, the annual estimated resource needed for harm reduction globally is just US$ 2.3 billion (Cook et al., 2014).

It is also important to remember that the US$ 100 billion spend on enforcement is only a part of the overall cost of the war on drugs. The extent of the damage inflicted by current drug policies on poor and vulnerable communities is impossible to calculate.

Escalating violence Between 2006 and 2009 at the height of the country's war on drugs, Mexico mobilized 45,000 military troops to combat drug trafficking gangs and increased its federal police force from 9,000 to 26,000 officers (Keefer and Norman, 2010). The Mexican government has estimated that from December 2006 to December 2010, the first four years following the launch of a major offensive against drug cartels, there were 34,612 violent deaths directly related to the war on drugs (Tuckman, 2011). Similarly, in February 2003 Thailand's war on drugs resulted in the extrajudicial killing of approximately 2,800 people, the arbitrary arrest of thousands and the use of extreme violence by the police (Human Rights Watch, 2004).

In recent years, the media in Ghana, Liberia and Sierra Leone has documented incidents of people using drugs being killed or injured by police officers during raids (International Drug Policy Consortium, 2017). More recently, we have seen the shocking extrajudicial killings of over 7,000 people in the Philippines as a result of the approach of President Duterte who ran on an anti-drugs platform (Human Rights Watch, 2017). In March 2016 prior to

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his election, Duterte had declared, "When I become president, I will order the police to find those people [dealing or using drugs] and kill them. The funeral parlours will be packed."

Undermining democratic governance and state services The power and influence of drug cartels severely weakens states. The corruption this fuels has a devastating impact on attempts to address poverty. It means that officials make decisions in the interests of those bribing them, and exclude ordinary citizens from having a say in holding their governments accountable. The culture of fear and corruption can make it almost impossible for citizens to exert democratic influence, access their rights or hold their officials to account for the quality and reach of essential services.

Increasing poverty and undermining local food production Prohibition has had a severe impact on small-scale farmers who grow drug-linked crops. In the opium growing areas of Southeast Asia and Afghanistan, and the coca growing areas of Latin America, forced drug crop eradication campaigns have led to the destruction of the only means of subsistence for these marginalized farmers and their families, further exacerbating their poverty and vulnerability. In many areas it has created a vicious cycle where illicit crop producers become increasingly dependent on cultivating drug-linked crops to counter the impoverishing effects of eradication (Transnational Institute, 2014).

This approach can also result in the contamination of water supplies and destruction of nearby food crops as a result of aerial spraying. A lack of sequencing in alternative development programmes, which places conditional crop eradication before the establishment of alternative livelihoods, also creates food insecurity and in some cases has led to humanitarian crises requiring emergency food aid (Jelsma and Kramer, 2008).

A turning tide

It is almost always the health of the poorest and most marginalized that bears the brunt of the war on drugs: whether small-scale farmers in Asia and Latin America whose sources of income are destroyed, non-violent drug offenders who make up a large share of people in the criminal justice system in Africa, or people – largely in the Global South – who have limited or no access to essential pain relief medicines (International Drug Policy Consortium, 2017).

Taking a public health approach to drug policy would mean that people who use drugs are no longer targeted for human rights abuses; they could access the health and support services they need. Thus a key barrier to accessing essential medicines currently faced by people across the world would be removed.

Further, if the money spent on enforcing failing drugs laws were to be freed up and spent on public services, it could enormously enhance the quality and reach of state services aimed at improving health.

The recognition of the failure of the war on drugs is growing. A number of countries in both the North and South are already pioneering alternative policies that emphasize harm reduction, public health and human rights. These range from de-penalization or decriminalization (reducing or eliminating penalties for low-level drug offences like possession and use, while trafficking remains illegal) as in the Netherlands and the creation of a market where some drugs are legal but strictly regulated, as with prescription medications, to health and education programmes to help reduce the potential harm drugs can do to people and communities.

An approach in which offences like drug possession or use are reduced from criminal to civil violations, is increasingly being pursued with regard to certain drugs, for example in Jamaica, Belize, Puerto Rico (Metaal and Ten Velde, 2014). In their report on drug decriminalization, Rosmarin and Eastwood (2013) note that around 25 countries have removed criminal penalties on personal possession of some or all drugs. Among others, Colombia, Chile, Mexico, Paraguay, Peru, Spain and Uruguay have decriminalized the possession of small amounts of certain drugs for personal use.

Portugal is perhaps the most cited example of decriminalization, having decriminalized the possession of all drugs in 2001. This was combined with an extensive public health programme aimed at people who use drugs. In spite of the initial fears, decriminalization did not lead to significant increases in drug use and the country has seen a decrease in HIV infections and drug-related deaths, although this has been attributed as much to the shift to a health-centred approach to drugs and its wider health and social policy changes as to its drug policy reforms (Transform, 2014).

The Organization of American States (2013) released a sweeping review of drug policies in the Americas, including a 'Scenarios Report', the first multilateral agency report to seriously consider drug policy reform and legal regulation. The governments of Mexico, Colombia and Guatemala openly called for a genuine discussion on reforming the United Nations' drug policies, which resulted in the 2016 UN General Assembly Special Session on Drugs. They have been joined by the World Health Organization and UNAIDS, both of which have called for the decriminalization of drug use (Bridge, 2014a, 2014b).

Perhaps the most widely discussed approach is the creation of a legal, regulated market for some drugs. Uruguay is now adopting this approach to cannabis, as are the US states of California, Colorado, Washington, Oregon, Alaska, Maine, Massachusetts, Nevada and the District of Colombia, which have all legalized cannabis for recreational use. A recent study from the Colorado Department of Revenue indicates that the presence of a legal market for cannabis has not led to a significant increase in the number of new users; most of the demand is coming from visitors to the state and from people who previously bought cannabis illegally (Light et al., n.d.). Canada will be next to take this approach; its new Cannabis Act plans to

legalize and regulate cannabis and the act is anticipated to come into force by July 2018.

What next?

Paul Hunt (2008), special rapporteur on the Right to Health has observed, "I have no doubt that it is now time to develop a human rights based approach to drug policy." It is clear that the recognition that the current drug policy is causing immense suffering and is denying poor and marginalized people their right to health, is swiftly gathering pace.

The debate is often polarized between two extremes – prohibition on the one hand and free market legalisation on the other – and neither of these simplistic positions provides a viable solution to what is a complex public health problem. In reality, the choice is not limited to these two extremes. There is a third set of policy options, which is to use a combination of regulation and legal controls. This is the area that should now be explored.

Drug use should not be a criminal problem requiring law enforcement solutions. It is a public health problem requiring public health solutions. There is no one-size-fits-all approach to drug policy, as the failure of the war on drugs has demonstrated. Policies should be developed to fit the needs, and involve the active participation, of those who are most affected: impoverished drug crop cultivators, people who use drugs, and poor and marginalized communities who rely on non-violent involvement in the trade to meet their basic needs.

We urgently need research into new approaches and public health solutions, including an evidence-based assessment of all policy options. This must be approached innovatively and with a completely open mind, actively encouraging creative new approaches and trialling new policy options.

Note

This estimate covers childhood illnesses, immunization, maternal health, family planning, TB, malaria, HIV/AIDS and health system strengthening, but has some limitations (such as the omission of non-communicable diseases) that are discussed further in Greenhill and Ali (2013).

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