Mexican Law Review
New Series
VOLUME VI
Number 2

DRUG USE AND THE RIGHT TO HEALTH: AN ANALYSIS OF INTERNATIONAL LAW AND THE MEXICAN CASE

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Abstract. *This article is an analysis of international and Mexican law regarding the prohibition of drug use and the right to health. It argues that the decriminalization of personal drug use in domestic legislation is not prohibited by the 1961 Single Convention on Narcotic Drugs and the 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. Therefore, a health-oriented system to resolve the problem of drug use is not optional for the binding States, but an obligation according to the normative content of the right to health under international law. Therefore, given that Mexico has ratified the International Covenant on Economic, Social, and Cultural Rights (ICESCR) and the right to health has constitutional status, the criminalization of drug use or drug possession for personal use is a violation of the Mexican Federal Constitution and the ICESCR.*

Key Words: *Drug use, criminalization of drug abuse, drug dependence, human rights, international law, right to health.*

Resumen. *El presente artículo es un análisis sobre la prohibición del consumo de drogas y el derecho a la salud tanto en el derecho internacional como en el nacional. El argumento principal es que la ausencia de criminalización del consumo personal de drogas en la legislación nacional no está prohibido por la Convención Única de 1961 sobre Estupefacientes y la Convención contra el Tráfico Ilícito de Estupefacientes y Sustancias Psicotrópicas de 1988 y, por ende, un sistema orientado a la prevención y rehabilitación para resolver el problema del consumo y adicción a las drogas no es opcional, sino obligatorio a la luz del contenido internacional del derecho a la salud. En ese sentido, y dado que México es parte de las referidas convenciones y se otorga estatus constitucional a los derechos humanos, como el derecho a la salud reconocido en el Pacto Internacional de Derechos Económicos, Sociales y Culturales, se considera que la sanción penal del consumo o de la estricta posesión de drogas para el consumo es una violación directa a la Constitución Federal y al mencionado tratado internacional.*

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Palabras clave: *Consumo de drogas, criminalización del consumo, adicción, dependencia, derechos humanos, derecho internacional, derecho a la salud.*

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I. Introduction

In the past five decades, drug control has become a major concern in Mexico and the rest of the world.[1] In 1961, the members of the United Nations adopted the Single Convention on Narcotic Drugs (1961 Single Convention) with the intention to prevent non-medical use of narcotic and psychotropic drugs.[2] The idea behind the convention was to establish international rules to inhibit the supply of drugs and, thus, reduce the risks of drug use and protect the health of the population.[3]

Before and after the 1961 Single Convention, almost all countries have decided to criminalize both the supply and the demand of drugs. With some recent exceptions, such as the Netherlands and Spain, most nations punish any kind of production, possession, purchase and cultivation of drugs.[4] Nation-States believe the criminalization approach is enough to deter drug production and drug use. The main targets are the behaviors themselves and

[1] International Narcotics Control Board [INCB], *Report of the International Narcotics Control Board 2008*, Chapter I, U.N. Doc. E/INCB/2008/1, U.N. Sales No. E.09.XI.1, available at http://www.incb.org/pdf/annual-report/2008/en/AR2008_Chapter_I.pdf.

[2] Single Convention on Narcotic Drugs, 1961, March 25, 1961, U.N.T.S available at http://www.incb.org/pdf/e/conv/convention_1961_en.pdf. This convention was amended by the 1972 Protocol amending the Single Convention on Narcotic Drugs.

[3] *Id.*

[4] Liana Sun Wyler, Congressional Research Service, International Drug Control Policy (2011), available at http://fpc.state.gov/documents/organization/107223.pdf.

not the causes and/or effects of the drug problem. In contrast, many studies have argued that this criminalization approach has been inefficient and is not the best way to solve the problems of drug trafficking and drug use, especially with behavior related to the possession and purchase of drugs solely for personal use.[5]

With regard only to drug use, these studies note that the worldwide demand of narcotics and others substances has increased rather than decreased over the last two decades.[6] According to the United Nations Office on Drugs and Crime (UNODC), an international agency established in 1997 to monitor issues regarding drug abuse, crime prevention, and criminal justice,[7] between 155 to 250 million people in the world consumed illicit substances at least once in 2008.[8] Within this group, 10% to 15% of the consumers are "problem drug users"[9] (16 to 38 million), and only 12% to 30% of them received treatment in the past year.[10] Similarly, in 2002, 5% of the Mexican population between the ages of 12 and 65 admitted to having used drugs at least once in their life, and the percentage increased to 5.7 in 2008.[11] Of this group, 13% of the consumers move to consuetudinary use and 1.9% to substance dependence.[12] Only 16.9% of the drug users entered into treatment and/or rehabilitation.[13]

In this sense, academics[14] and the UNODC[15] have stated that individuals who purchase and use drugs for their own consumption (addicts or not) suf-

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[5] *See* U. N. Office on Drugs and Crime [UNODC], *Discussion paper: From coercion to cohesion. Treating Drug Dependence through Health Care, Not Punishment* (2010), available at http://www.unodc.org/docs/treatment/ Coercion_Ebook.pdf.

[6] *Id.* at 2.

[7] About UNODC, unodc.org (April 5, 3:54 PM), http://www.unodc.org/unodc/en/about-unodc/index.html?ref=menutop.

[8] U. N. Office on Drugs and Crime [UNODC], *World Drug Report 2010,* U.N. Sales No. E.10.XI.13 (2010), available at http://www.unodc.org/documents/wdr/WDR_2010/World_Drug_Report_2010_lo-res.pdf.

[9] *Id.* at 12.

[10] *Id.*

[11] Consejo Nacional contra las Adicciones [National Council against Addictions], *Encuesta Nacional de Adicciones 2008 [National Inquiry of Addictions 2008]*, *41*, available at http://www.conadic.salud.gob.mx/pdfs/ena08/ENA08_NACIONAL.pdf. The National Inquiry of Addictions 2011 does not include the same data; however, it concluded that the population between 12 and 65 years old which admitted to have consumed any drug in the last year (2010-2011) is 1.8%, when in 2008 was 1.6%. *See* Consejo Nacional contra las Adicciones [National Council against Addictions], *National Inquiry of Addictions 2011, at* 41, available at http://www.conadic.salud.gob.mx/pdfs/ENA_2011_ DROGAS_ILICITAS_.pdf.

[12] *Id.* at 49.

[13] *Id.*

[14] *See* Redonna K. Chandler et al., *Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety*, 301(2) JAMA 183, 184 (2009).

[15] UNODC, *Discussion Paper: From Coercion to Cohesion, supra* note 5, at 2.

fer extreme negative externalities resulting from the criminalization system.[16] Consumers are socially discriminated against and, in most cases, they do not receive any kind of physical or mental treatment or rehabilitation.[17] For these reasons, some academics and the UNODC suggest that: *a)* a health-oriented system to reduce the supply and demand of drugs is more efficient than a sanction-oriented approach;[18] and *b)* this health-oriented system is allowed under international law.[19] In other words, they conclude that prevention, education and physical and mental treatment are the most effective ways to reduce illegal drug use and, more importantly, that the decriminalization of personal drug use is not prohibited by the 1961 Single Convention and the 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988 Convention), known as the drug conventions.[20]

The objective of this article is to support the health-oriented approach from a different perspective. This article argues that a health-oriented approach to the problem of drug consumption is not only optional, but an obligation under international law and, especially, under the normative content of the right to health, established in the International Covenant on Economic, Social and Cultural Rights (ICESCR). Given that Mexico has ratified the above-mentioned drug conventions and the ICESCR, this article holds that the criminalization of the consumption or possession of drugs for personal use is a violation of the right to health in Mexico.[21]

In order to justify these conclusions, this article is divided into four sections. Part II discusses whether under international law there is a mandatory obligation for States to criminalize the consumption or possession of drugs for personal use. This section is divided into two parts: the first is a brief introduction to the drug control system and conventions, and the second is a discussion of whether international drug control conventions obligate States to criminalize drug use. Part III explains the normative content of the right to health and analyzes whether this right includes protection against the criminalization of drug consumption or possession for personal use. Finally, based on the arguments expounded in the other sections, Part IV is a practical examination of Mexican legislation on drug use and the right to health.

It should be noted that the reasoning in this essay does not exclude the fact that the criminalization of drug consumption or possession for personal use may also violate other fundamental and human rights related to the right to

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[16] *Id.*

[17] *Id.* at 2-3.

[18] *Id.*

[19] *Id.* at 1.

[20] United Nations Convention against Illicit in Narcotic and Psychotropic Substances, December, 20, 1988, U.N.T.S., available at http://www.unodc.org/pdf/convention_1988_en.pdf.

[21] According to the first paragraph of Article 1 of the Mexican Federal Constitution, every person enjoys the human rights recognized by the Constitution and all the international treaties ratified by the Mexican State.

health, such as freedom of choice, human dignity, privacy, education, non-discrimination, and equality. This article intentionally avoids reference to and a normative analysis of other human rights, with the specific intention of focusing on the relationship between the 1961 Single Convention, the 1988 Convention, and the viability of a health-oriented system.

II. Drug Control and International Law

1. *Drug Control and UN Conventions*

Drug control is established in three international conventions: the 1961 Single Convention, as amended by the 1972 Protocol, the 1971 Convention on Psychotropic Substances (1971 Convention), and the 1988 Convention, which have received almost unanimous international agreement. More than 95% of the United Nations member States have ratified at least one of these treaties.[22] The importance of these drug conventions is that they set the basic legal framework, obligations, tools, and international bodies to monitor and regulate the international drug control system. As established in Article 4 of the 1961 Single Convention, their primary goal is to "limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs."[23]

The main body of this international drug control system is the United Nations Commission on Narcotic Drugs (UNCND), an intergovernmental commission of the Economic and Social Council with fifty-three members.[24] This agency serves as a political branch and is made up of several offices. The most important of these offices is the U.N. Office on Drugs and Crime (UNODC), which provides assistance to governments in strengthening drug control and gives legal expert opinions on the matter. [25] The organization's mission is to "contribute to the achievement of security and justice for all by making the world safer from crime, drugs, and terrorism."[26] Also, the 1961 Single Convention created the International Narcotic Control Board (INCB), an independent committee of thirteen experts to monitor States' compliance to the obligations under this drug control regime.[27]

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[22] The 1961 Convention has 186 State parties; the 1971 Convention has 183 State parties, and the 1988 Convention has 182 State parties. *See* United Nations Treaty Collection, *Database*, treaties.ung.org (April 6, 2012, 3:30 PM), http://treaties.un.org/.

[23] Single Convention on Narcotic Drugs, 1961, *supra* note 2, at article 4.

[24] *Id.* at articles 5, 8. *See* http://www.unodc.org/unodc/en/commissions/CND/02-membership.html.

[25] U. N. Office on Drugs and Crime [UNODC], *UNODC Strategy 2008-2011: Towards Security and Justice for all: Making the World Safer Crime, Drugs, and Terrorism*, 7, available at http://www.unodc.org/documents/about-unodc/UNODC-strategy-July08.pdf.

[26] *Id.*

[27] Single Convention on Narcotic Drugs, 1961, *supra* note 2, at articles 4, 9.

Some civil organizations have argued that drug control conventions and their monitoring authorities lean heavily towards drug prohibitions and law enforcement.[28] For instance, the Beckley Foundation has commented that the treaties are "overwhelmingly prohibitionist in their approach, and, as such, in favor of punishment."[29] Similarly, Human Rights Watch has stated that the conventions "contain weak language on the treatment and prevention of drug use while obliging states to adopt strict law enforcement measures."[30] According to these two organizations, the drug control treaties aim at resolving the drug problem principally by punishing its production and consumption. Although international treaties leave room for States to have the discretional power to decide whether to punish drug possession for personal use, these organizations suggest that the specific obligations and guidelines established in the three conventions are only useful for a system of sanctions and punishment approach system.[31]

Despite the opinion of these organizations, some academics have asserted that drug control convention provisions expressly obligate States to provide adequate treatment facilities for drug addicts and abusers.[32] For them, regardless of the fact that almost all the provisions of the treaties are structured to criminalize both the supply and the demand of drugs, the 1961 Single Convention and the 1988 Convention clearly mandate that the parties shall take the necessary measures to educate, rehabilitate, and reintegrate drug abusers.[33] Also, it should be noted that the INCB itself has stated that drug conventions set minimum standards[34] and establish safeguard clauses for States,[35] with phrases like "subject to its constitutional limitations."[36] For the INCB, each State has broad discretionary powers to incorporate convention provisions into domestic laws, because "there are wide differences between countries and regions in community tolerance or intolerance towards drug-related

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[28] *See* Jonathan Cohen, *Injecting Reason: Human Rights and HIV Prevention for Injecting Drug Users*, 15 (2G) Human Rights Watch 7 (2003) available at http://dspace.cigilibrary.org/jspui/handle/123456789/22415.

[29] Damon Barrett et al., Beckley Foundation Drug Policy Program, Report 13: Recalibrating the Regime: The Need for a Human Rights-Based Approach to International Drug Policy 9 (2008) available at http://www.ihra.net/files/2010/06/16/BarrettRecalibratingTheRegime.pdf.

[30] Cohen, *supra* note 28, at 51.

[31] Saul Takahashi, *Drug Control, Human Rights, and the Right to the Highest Attainable Standard of Health: By No Means Straightforward Issues*, 31 Hum. Rts. Q. 748, 750 (2009).

[32] *See* Richard Davenport-Hines, The Pursuit of Oblivion: A Global History of Narcotics 254 (2001).

[33] *Id.*

[34] International Narcotics Control Board [INCB], *Report of the International Narcotics Control Board 2007*, Chapter I, 1 , U.N. Doc. E/INCB/2007/1, U.N. Sales No. E.08.XI.1 (March 5, 2008), available at http://www.incb.org/pdf/annual-report/2007/en/chapter-01.pdf.

[35] INCB, *Report of the International Narcotics Control Board 2008*, *supra* note 1, at 6.

[36] Single Convention on Narcotic Drugs, 1961, *supra* note 2, at Article 36.

offences and offenders [including drug addicts], and those differences have an impact on the way the conventions are implemented."[37]

Most countries have a prohibitionistic drug regime. For these countries, the best way to deter drug traffic and use is by punishing any stage of the production line, including the producer, the intermediary, and the consumer.[38] The objective is to protect public health[39] by banning the cultivation, manufacture, purchase, sale, distribution, possession, and consumption of several narcotic and psychotropic drugs that may affect the health of individuals and, in consequence, the health and security of society. Public health is "what we, as society, do collectively to assure the conditions for people to be healthy."[40]

On the contrary, with the same intention to preserve public health, other countries have chosen a less repressive legal system, aimed at sanctioning certain behaviors of the drug trafficking process (the purchase and sale of certain narcotics), and oriented at preventing the use of drugs while educating, rehabilitating and reintegrating drug abusers.[41] As UN Special Rapporteur Anand Grover said regarding everyone's right to enjoy the highest attainable standard of physical and mental health:

> …the current international system of drug control has focused on creating a drug free world, almost exclusively through use of laws, enforcement policies and criminal sanctions. Mounting evidence, however, suggests this approach has failed… while drugs may have a pernicious effect on individual lives and society, this excessively punitive regime has not achieved its stated public health goals, and has resulted in countless human rights violations.[42]

The Netherlands is a good example of a non-repressive approach towards drug consumption. The core features of the Dutch system are established in the Opium Act, as amended in 1976 and again in 1995, which is rooted in the general concept of harm reduction. For the Dutch government, the main concerns related to drugs are public health and the correlative minimization

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[37] INCB, *Report of the International Narcotics Control Board 2007*, *supra* note 34, at 1.

[38] *See* Luis Díaz Müller, El imperio de la razón. Drogas, salud y derechos humanos 28 (1994).

[39] *Id.*

[40] Comm. for the Study of the Future of Public Health, Institute of Med., The Future of Public Health (1998); *see* also Tony McMichael & Robert Beaglehole, *The Global Context of Public Health*, *in* Global Public Health 2 (2003) ("Broadly defined, public health is the art and science of preventing disease, promoting population health, and extending life through organized local and global efforts."); Fraser Brockington, World Health 131 (2nd ed. 1968) (defining public health as "[t]he application of scientific and medical knowledge to the protection and improvement of the health of the group").

[41] Díaz Müller, *supra* note 38, at 28.

[42] *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, 2, U.N. Doc. A/65/255 (August 6, 2010).

of risks and hazards of drug use rather than the suppression of all drugs.[43] In other words, as noted in the 1976 parliamentary debate on the Opium Act reforms, the primary elements of Dutch drug policy are: *a)* the central aim is the prevention or alleviation of social and individual risks caused by drug use;[44] *b)* there must be a rational relation between those risks and policy measures;[45] *c)* repressive measures against drug trafficking (other than the trafficking of cannabis) is a priority;[46] and *d)* the government recognizes the inadequacy of criminal law with respect to other aspects (*i.e.*, apart from trafficking) of the drug problem.[47]

Therefore, according to the Opium Act, the possession and use of certain kinds and quantities of drugs is not sanctioned by criminal law.[48] The statute distinguishes between "hard drugs" (heroin, cocaine, amphetamines, and LSD) and "soft drugs" (such as marijuana and hashish).[49] The former are illegal and the law sanctions their possession with intention to sell, the selling, and their importation and exportation while the latter are tolerated by the State to some extent.[50] For example, possession, cultivation, processing, manufacturing, sale, supply, or transporting less than 5 grams of marijuana have been decriminalized in the Netherlands; above that quantity, the sanction will depend of the amount of drug and the specific offense.[51]

2. *International Conventions, Drug Use, and Addictions Treatment: A Criminalized System?*

Drug conventions establish a complex mandatory framework for adherent nations. For instance, the treaties mandate that States take specific actions to stop the production of opium, control the manufacture market of psychotropic drugs, or supervise the trade and distribution of some controlled substances. However, the main international requirement is to criminalize certain behaviors (*i.e.* possession, production, purchase, and cultivation) leading to the supply and demand of drugs.

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[43] Benjamin Dolin, Parliament of Canada, National Drug Policy: The Netherlands 3 (2001) available at http://www.parl.gc.ca/Content/SEN/Committee/371/ille/ library/dolin1-e.htm.

[44] Tim Boekhout van Solinge, *Dutch Drug Policy in a European Context*, 29(3) Journal of Drug Issues 511, 512 (1999), available online at: www.cedro-uva.org/lib/boekhout.dutch.html.

[45] *Id.*

[46] *Id.*

[47] *Id.*

[48] Government of the Netherlands, Drug Policy in the Netherlands, available online at: http://www.government.nl/issues/alcohol-and-drugs/drugs (August 15, 8:35 AM).

[49] *Id.*

[50] *Id.*

[51] *Id.*

Article 3 of the 1988 Convention establishes that States shall adopt the necessary measures to criminalize the following intentional conducts under domestic law:

> 1. (a) (i) The production, manufacture, extraction, preparation, offering, offering for sale, distribution, sale, delivery on any terms whatsoever, brokerage, dispatch in transit, transport, importation or exportation of any narcotic drug or any psychotropic substance contrary to the previsions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention;
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> ...
>
> (iii) The possession or purchase of any narcotic drug or psychotropic substance for the purpose of any of the activities enumerated in (i) above;
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> …
>
> 2. Subject to its constitutional principles and the basic concepts of its legal system, each party shall adopt such measures as may be necessary to establish as a criminal offence under its domestic law, when committed intentionally, the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention;
>
> …

Article 36 (a) of the 1961 Single Convention affirms that subject to its own constitutional limitations, each State:

> [S]hall adopt such measures as will ensure that cultivation, production, manufacture, extraction, preparation, possession, offering, offering for sale, distribution, purchase, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation and exportation of drugs contrary to the provisions of this Convention, and any other action which in the opinion of such Party may be contrary to the provisions of this Convention, shall be punishable offences when committed intentionally, and that serious offenses shall be liable to adequate punishment particularly by imprisonment or other penalties of deprivation of liberty.

For the objective of this article, the first conclusion that can be drawn from these provisions is that drug use itself is not a behavior that is prohibited or sanctioned by the conventions. Drug conventions do not use this concept as a sanctioned behavior. Nevertheless, it is possible to argue that an addict's or non-addict's drug use is implicitly forbidden through the prohibition of possession, purchase, or cultivation of drugs.

In first place, as explained by the INCB, international drug conventions do not accept the existence of a "right" to possess narcotic drugs or psychotropic substances unless they are used for medial or scientific purposes.[52] Therefore, besides medical uses, a person might possess, purchase or cultivate drugs for

[52] *Id.*

only four logical scenarios: to keep the drugs,[53] to donate them,[54] to sell or exchange them, or to consume them. These scenarios depend on the individual's intentions: whether to obtain economic benefits or for personal use. Hence, when legislation prohibits the possession of drugs for personal use, these logical scenarios (including consumption itself) are indirectly criminalized. If a person does not keep, use or donate the drug,[55] what other action can be done? The answer is none. Criminalizing the possession of drugs for personal use is just another way to punish consumption itself.

Along this line of thought, if it is accepted that prohibiting possession of drugs indirectly punishes consumption, it could be argued that drug use is a criminal offense under Article 3.2 of the 1988 Convention. The convention clearly declares that possession of drugs for personal use is contrary to the 1961 Single Convention. Moreover, Article 36 of the 1961 Single Convention prohibits the possession of drugs regardless of their intended purposes. The recognition of this prohibition is important, because the indirect criminalization of drug use affects the legal system in two ways: first, it sets a very high burden on the exercise of a right (the right to control one's body), and, second, it can be considered an indirect punishment of an addiction. Some people consume drugs because they suffer from substance dependence and, in these cases, States must support and rehabilitate the individual, instead of punishing the "medical condition."

Despite this general rule, the conventions establish two exceptions for this possession/consumption prohibition. According to Article 3.2 of the 1988 Convention, each State has power to determine whether constitutional principles and basic legal concepts allow governments to criminalize possession and, indirectly, drug use. It is true that Article 3.2 of the 1988 Convention uses the term "shall" when ordering the criminalization of personal possession of drugs; however, this mandatory provision is subject to a safeguard clause: "subject to its constitutional limitations". In other words, drug possession for personal use is an illegal behavior under international law, but it is not an obligation for States to incorporate it as a criminal offense in their

[53] The term "keep" refers to the logical possibility to retain the drugs with the only intention to hold or preserve them and, in consequence, without use them or sale, exchange, or donate them. The Merriam-Webster Dictionary defines the term as the action to "restrain from departure or removal," "to retain in one's possession or power," and "confine oneself to." *See* Merriam-Webster Dictionary, *Dictionary Online: keep*, available at http://www.merriam-webster.com/dictionary/keep (April 19, 2012 11:25 AM).

[54] The term "donate" refers to the trade of drugs without economic benefits. The Merriam-Webster Dictionary defines the term as the action to make a "free contribution," and "the making of a gift." *See* Merriam-Webster Dictionary, *Dictionary Online: donation*, available at http://www.merriam-webster.com/dictionary/donation (April 19, 2012 11:38 AM).

[55] Donate, sale or exchanges of drugs are not legal action under international law, because involve an economical benefit that is prohibited expressly in the 1961 Single Convention. *See* Single Convention on Narcotic Drugs, 1961, *supra* note 2, at article 36.

domestic systems. Each State has the discretional power to decide whether the prohibition of drug use violates their domestic constitutional principles.

The second exception is established in Articles 3.4(c) and (d) of the 1988 Convention and 36.1(b) of the 1961 Single Convention:

> Article 3.4
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> …
>
> (c) Notwithstanding the preceding subparagraphs, in appropriate cases of a minor nature, the Parties may provide, as alternatives to conviction or punishment, measures such as education, rehabilitation or social reintegration, as well as, when the offender is a drug abuser, treatment and aftercare.
>
> (d) The Parties may provide, either as an alternative to conviction or punishment, or in addition to conviction or punishment of an offense established in accordance with paragraph 2 of this article, measures for the treatment, education, aftercare, rehabilitation or social integration of the offender.
>
> Article 36
>
> …
>
> (b) Notwithstanding the preceding subparagraph, when abusers of drugs have committed such offenses, the parties may provide, either as an alternative to conviction or punishment or in addition to conviction or punishment, that such abusers shall undergo measures of treatment, education, aftercare, rehabilitation and social reintegration in conformity with paragraph 1 of Article 38.

These provisions affirm that States may establish alternative measures for possession and, therefore, drug use in the following circumstances: *a)* an individual commits a minor offense, regardless of the purpose of the behavior; *b)* an individual commits a minor offense and is a drug abuser, regardless of the purpose of the behavior; *c)* an individual possesses, purchases, or cultivates drugs for personal use; and *d)* an individual possesses, purchases, or cultivates drugs for personal use and is a drug abuser. Alternative measures include education, rehabilitation, social integration, treatment and/or aftercare, and they can be implemented by the State as a substitute legal consequence, instead of conviction or criminal punishment, or in addition to these criminal sanctions.

International bodies have said that these provisions are the legal bases for a public health approach to drug control. The UNODC affirms that drug conventions encourage that a health-oriented approach be adopted for both illegal drug consumption and drug dependence rather than solely relying on a sanction-oriented approach: "in the case of nondependent drug users, a health-oriented approach may involve: providing education, reliable information, brief motivational and behavioral counseling, and measures to facilitate social reintegration and reduce isolation and social exclusion. In the case of drug dependent individuals it may also involve more comprehensive

social support and specific pharmacological and psychosocial treatment, and aftercare."[56]

Similarly, the INCB insists that for drug offenses related to possession, purchase, or cultivation for personal use, each State may apply other measures as alternatives to conviction and punishment.[57] The INCB states that drug conventions establish a sharp difference between offences related to drug trafficking and use of illegal drugs, and offences committed by drug abusers or others.[58] As noted by the INCB, treaties acknowledge that to be effective: "a State's response to offences by drug abusers must address both the offences and the abuse of drugs (the underlying cause)."[59]

Summarizing, we can arrive at the following conclusions:

a) Under international law, certain serious behaviors related to the supply and demand of drugs, such as the production, manufacture, cultivation, possession, distribution, purchase, and sale of drugs, are considered criminal offenses when committed intentionally. The sanction is imprisonment or other penalties that deprive a person of his or her freedom.
b) As a general rule, when an individual or a group of individuals possesses, purchases or cultivates drugs solely for personal use, each State shall take measures to criminalize these behaviors.
c) The criminalization of a wide variety of behaviors related to the supply and demand of drugs, regardless of the purpose, is subject to each State's constitutional principles. Hence, each State has the power to decide whether the possession of drugs for personal use is a criminal offence in its own domestic system.
d) Notwithstanding the illegal nature of the behavior, each State may decide to apply measures other than conviction or punishment when the individual commits a minor offense according to domestic law.
e) When the possession, purchase, or cultivation of drugs is for personal use, each State has the power to decide whether to apply measures like the offender's treatment, education, aftercare, rehabilitation, or social integration, or to apply these measures in addition to conviction or punishment.
f) Additional measures may be taken when the offender is a drug abuser, regardless of whether the offender commits the acts for personal use or not.
g) Drug conventions encourage the adoption of a variety of educational and medical measures to prevent drug consumption.

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[56] UNODC, *From Coercion to Cohesion*, *supra* note 5, at 1.

[57] INCB, *Report of the International Narcotics Control Board 2007*, *supra* note 34, at 4.

[58] *Id.*

[59] *Id.*

III. Drug Control and the Right to the Highest Standard of Health

The main conclusion that can be reached from the above section is that each State has the power to decide whether to prohibit the possession and, therefore, the personal consumption of drugs. Despite the fact that under international law drug possession for personal use[60] is a criminal offense, each State is generally free to criminalize this behavior for two reasons: first, because it is subject to constitutional principles and, second, because drug conventions allow States to decide whether the possession of drugs for personal use, regardless of a person's being a drug abuser or not, is an action that deserves criminal sanction. As noted, drug treaties stipulate that in these circumstances, States should apply alternative measures such as treatment, education, aftercare and/or social rehabilitation.

In this sense, if drug consumption is not a mandatory criminal offense in all situations: to what extent are States truly free or have unconditional discretional powers to sanction personal use of drugs in their domestic legislation? The answer is that States have several restrictions to do so, because the physical and mental treatment and the rehabilitation of drug users and addicts is a State obligation under the right to the highest standard of health. In other words, given that drug use in itself is not an absolute criminal offense under drug conventions, international law does not only encourage nations to provide physical and mental support to drug users as a substitute of convictions and punishment, but it establishes that these treatments are mandatory State obligations according to Articles 25.1 of the Universal Declaration of Human Rights (Universal Declaration) and 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).

1. *International Law and the Right to Health*

The right to the highest attainable standard of health or right to health is a fundamental and indispensable human right recognized in a wide variety of international treaties.[61] As the Committee on Economic, Social and Cultural Rights (CESCR) has affirmed, the enjoyment of the highest standard of

[60] Given its objective, this article will only address the exception for personal use and not the other exclusion prohibition related to minor offenses.

[61] The right to health is recognized in several international and regional conventions: Universal Declaration (Article 25.1), International Covenant on Economic, Social and Cultural Rights (Article 12); International Convention on the Elimination of All Forms of Discrimination against Women (Article 12); International Convention on the Elimination of All Forms of Racial Discrimination (Article 5(e)(iv)); Convention on the Rights of the Child (Article 24); European Social Charter (Article 11); African Charter on Human and Peoples' Rights (Article 16); and Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Article 10).

health is an essential element to live a "life in dignity"[62] and is closely related to and dependent upon the fulfillment of other human rights.[63] It should be noted that many scholars have argued that the language of drug treaties provides little guidance as to the specific scope of State obligations under this right.[64] For some academics, the legal scope of the right is ambiguous[65] and its minimum content and core obligations are undefined.[66]

Nevertheless, since its promulgation, the CESCR's General Comment No. 14 asserts that it can no longer be argued that right to health is unduly vague under international law.[67] In this general comment, the CESCR suggested the normative content of Article 12 of the ICESCR and the scope of this right. The following normative elements are the most important:

a) The right to health is not correlative to the right to be healthy.[68] Good health is a factor of the enjoyment of this right, but it is not its entirety. The right to health refers to the enjoyment of a variety of goods, facilities, services, and conditions necessary for its fulfillment.[69]

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[62] U.N. Committee on Economic, Social and Cultural Rights [CESCR], *General Comment No. 14*: *The Right to the Highest Attainable Standard of Health (Article 12)*, 1, E/C.12/200/4 (August 11, 2000) available at http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En.

[63] *Id.* at 2.

[64] David P. Fidler, International Law and Infectious Diseases 14 (1999).

[65] Lawrence Gostin & Jonathan Mann, *Toward the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies*, in Health and Human Rights 54 (Jonathan M. Mann et al. eds., 1999) (noting that the concept of a human right to health "has not been operationally defined"); *id.* at 197 ("[T]he right to health is an international human right because it appears in treaties, but the right is so broad that it lacks coherent meaning and is qualified by the principle of progressive realization."); Virginia Leary, Concretizing the Right to Health: Tobacco Use as a Human Rights Issue, in Rendering Justice to the Vulnerable 161, 162 (Fons Coomans et al. eds., 2000) ("The efforts to clarify the right to health have often been either too theoretical or, alternatively, too detailed and unfocused, resulting in the widespread view that the right to health is an elusive concept and difficult to make operational.").

[66] The essential minimum core content of an economic, social, or cultural right "corresponds with an absolute minimum level of human rights protection, a level of protection which States should always uphold independent of the state of the economy or other disruptive factors in a country." Aart Hendriks, *The Right to Health in National and International Jurisprudence*, 5 Eur. J. Health L. 389, 394 (1998). For a discussion of the appropriateness of having core obligations in light of extremely limited national budgets, *see* Audrey Chapman, *Core Obligations Related to the Right to Health*, in Core Obligations: Building a Framework for Economic, Social, and Cultural Rights 195 (Audrey Chapman & Sage Russell eds., 2002).

[67] *See* But cf. Alicia Ely Yamin, *Not Just a Tragedy: Access to Medications as a Right Under International Law*, 21 B.U. Int'l L.J. 325, 336 (2003) (arguing after the promulgation of General Comment 14, that "it can no longer be argued that the content of the right to health is unduly vague for implementing legislation or enforcement, or that it sets out merely political aspirations").

[68] CESCR, *General Comment No. 14, supra* note 62, at 3.

[69] Office of the United Nations High Commissioner for Human Rights & World

b) The notion of the highest attainable standard of health takes into account both the individual's biological and socio-economic preconditions and a State's available resources.[70]

c) The right to health is related to and dependent on the realization of other human rights as food, housing, work, education, non-discrimination, and privacy.[71] In this sense, the CESCR has said that the right includes "underlying determinant of health", such as safe and potable water, adequate sanitation facilities, trained and professional medical personnel, essential drugs and so on.[72]

d) The right to health implies certain freedoms and entitlements.[73] These freedoms include the right to control one's body and health, and the right to be free from interference, such as non-consensual medical treatment. These entitlements include the "right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health,"[74] the right to the prevention, treatment and control of diseases; to have access to essential medicines; to maternal, child and reproductive health; and to health-related education and information.[75]

e) The exercise and enjoyment of this right need to be available (functioning public health and health-care facilities, goods, services and programs),[76] accessible (health facilities, physically and economically accessible goods and services without any kind of discrimination),[77] and acceptable (all health facilities, goods and services must be adhere to medical ethics and be culturally appropriate).[78] Moreover, facilities, goods and services that respect and fulfill the right to health must have an appropriate level of quality ("scientifically and medical appropriate and of good quality").[79]

Given the normative content of the right to health, the CESCHR affirms that States have general and specific obligations.[80] In general terms, the immediate obligations are to guarantee the right without any kind of discrimina-

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Health Organization, The Right to Health. Fact sheet no. 31, at 5, U.N. Sales No. GE.08-41061 (2008) available at http://www.ohchr.org/Documents/Publications/Factsheet31.pdf.

[70] CESCR, *General Comment No. 14, supra* note 62, at 3.

[71] *Id.* at 2.

[72] *Id.* at 4.

[73] *Id.* at 3.

[74] *Id.*

[75] Office of the United Nations High Commissioner for Human Rights, *supra* note 69, at 3-4.

[76] CESCR, *General Comment No. 14, supra* note 62, at 4.

[77] *Id.*

[78] *Id.* at 5.

[79] *Id.*

[80] *Id.* at 9.

tion and to take the necessary, deliberate, concrete, and targeted steps toward the progressive[81] and full realization of the right to health.[82] These obligations can be divided into actions of respect, protection, and fulfillment.[83]

More specifically, the CESCHR has argued that States have a group of core obligations to ensure the satisfaction of the minimum essential levels of each right set forth in the ICESCR.[84] With regard to the right to health, the CESCHR sets out the following: *a)* to ensure the right of access to health facilities, goods, and services; to the minimum essential food which is nutritionally adequate; and to basic shelter, housing and sanitation, as well as an adequate supply of safe and potable water;[85] *b)* to provide essential drugs, immunizations against major diseases, and education and access to information concerning the main health problems in the community;[86] *c)* to ensure an equal distribution of health facilities, goods, and services;[87] *d)* to provide appropriate training to health personnel,[88] and *e)* to take measures to prevent, treat, and control epidemic and endemic diseases.[89]

The CESCHR also details the content of the State's specific legal obligation to respect, protect, and fulfill the right to health. These are some examples:

a) Respect. States must refrain from denying or limiting equal access of all persons, including prisoners or detainees to the highest level of health.[90] Moreover, States should abstain from enforcing discriminatory public policies, and to refrain from prohibiting or impeding traditional preventive care, healing practices and medicines, and from applying coercive medical treatments.[91]
b) Protect. States must adopt legislation and/or other measures to ensure equal access to health care or treatments provided by third parties.[92]

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[81] Progressive realization does not mean that a State is free to adopt any kind of measures. The Special Rapporteur of the right to health explains that progressive means that the measures taken by a state have to be intended to achieve the full enjoyment and exercise of this right, with the acknowledge of resources availability. *See* U.N. Human Rights Council [HRC], *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt,* 17, A/HRC/4/28 (January 17, 2007) available at http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G07/102/97/PDF/G0710297.pdf.

[82] *Id.*

[83] CESCR, *General Comment No. 14 (2000)*, *supra* note 62, at 9.

[84] *Id.* at 12.

[85] *Id.* at 13.

[86] *Id.*

[87] *Id.*

[88] *Id.*

[89] *Id.*

[90] *Id.* at 10.

[91] *Id.*

[92] *Id.*

c) Fulfill. States must take positive measures to enable and assist individuals and communities to enjoy the right to health. These measures should facilitate (ensure access to), provide (ensure the enjoyment of), and promote the right (take actions to create, maintain, and restore health).[93]

Furthermore, Article 12.2 of the ICESCR provides a non-exhaustive catalogue of examples of State obligations, such as the "reduction of the stillbirth rate and of infant mortality" (Article 12.2(a)); "the improvement of all aspects of environmental and industrial hygiene" (Article 12.2(b)) and, most importantly for this Article, "the prevention, treatment and control of epidemic, endemic, occupational and other diseases" (Article 12.2(c)).[94]

2. *Criminalization, Drug Consumption, and the Right to Health: A Violation of International Law?*

Any person, even if the person uses drugs, is entitled to the right of health. States cannot deny drug users access to health-related facilities, goods, and services. For instance, States must not reject a drug user access to medical treatment (physical and psychiatric) or refuse to provide him or her with essential medicines to help an individual that consumes a certain kind of narcotic. Moreover, States are obligated to establish public policies (administrative or legislative measures) to prevent drug use. The education, treatment, and rehabilitation of drug users are State obligations under the right to health.

Based on these arguments, the relevant questions are why drug users have the right to be treated and rehabilitated by States —as specific legal obligations under international law— and whether it is possible for States to criminalize drug possession for personal use or drug use itself, regardless of the normative content of the right to health.

A. *Drug Users, State Obligations, and the Right to Health*

The concept of drug user is complex. It encompasses at least three kinds of groups:[95] drug users that are not drug abusers or addicts, drug abusers, and drug addicts or people with a "substance dependence". A drug user is an individual who consumes drugs on an irregular or regular basis and does not present the symptoms of an abuser or addict.[96] A drug abuser is a person with a "substance abuse" problem characterized by a regular drug consumption that: *a)* develops a partial physiological tolerance to and dependence on

[93] *Id.* at 11.

[94] *Id.* at 5.

[95] Sana Loue, *The Criminalization of the Addictions*, 24 J. Legal Med. 281, 282 (2003).

[96] *Id.*

the drug; *b)* presents euphoric or similar behavior, and *c)* results in a failure to fulfill his or her most important obligations at work, school, or home and has recurring social or interpersonal difficulties that were triggered or are exacerbated by substance use.[97]

Addiction is a "chronically relapsing [disorder] characterized by compulsive drug taking, an inability to limit the intake of drugs, and the emergence of a withdrawal syndrome during cessation of drug taking (dependence)."[98] The World Health Organization (WHO) has abandoned the term "addiction" and it has defined "dependence" as "a state, a psychic and sometimes also physical [state], resulting from the interaction between a living organism and a drug, characterized by behavioral and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence."[99] This "substance dependence"[100] is characterized by the presence of a combination of at least some of the following elements: *a)* a tolerance to[101] and a withdrawal[102] from drugs; *b)* a use of the substance in increasingly larger amounts or over a longer period of time; *c)* a persistent desire or unsuccessful attempts to reduce the amount or frequency of using the substance; *d)* a significant amount of time dedicated to obtaining, using or recovering from the use of drugs; *e)* the elimination or lessening of social, recreational, or occupational activities due to the use of the substance; and/or *f)* continuing use of the substance despite knowing it is a persistent or recurrent physical or psychological problem.[103]

In sum, the WHO and medical research has classified abuse and dependence (addiction) on drugs as a disease. Consequently, States are obligated to take the appropriate measures to prevent, treat, and control this disease. The legal basis for these obligations is the minimum content of the right to health discussed above and, specifically, Article 12.2(c) of the ICESCR which establishes that States shall take measures for "[t]he prevention, treatment and control of epidemic, endemic, occupational and other diseases". As explained in the previous section, drug conventions encourage States to

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[97] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) 199 (2000).

[98] George F. Koob et al., *Neuroscience of Addiction*, 21 Neurosci. 1 (1998).

[99] Loue, *supra* note 95, at 282.

[100] "A maladaptive pattern of substance use, leading to clinically significant impairment or distress." *See* American Psychiatric Association, *supra* note 97, at 192.

[101] "Tolerance is characterized by a need of increased amounts of the substance to achieve either intoxication or desired effect or by a diminished effect of the substance with the use of the same amount." *Id.* at 192.

[102] "Withdrawal is manifested by a set of symptoms resulting from the cessation of, or reduction in use of, a particular substance or by the use of the same or a closely related substance to avoid these symptoms." *Id.* at 201.

[103] *Id.* at 197-98. *See* Loue, *supra* note 95, at 282.

treat and rehabilitate users (not to punish them) and mandate specific obligations against the abuse of drugs. Article 38 of the 1961 Single Convention affirms that: "[t]he parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-coordinate their efforts to these ends."

Furthermore, this article suggests that States have the following general and specific obligations regarding drug users. First of all, States cannot discriminate and make an overall distinction between people who do not use drugs and those who do. As noted, drug users are entitled to the right to health like everybody else. The fact that an individual consumes an illegal substance is not enough to deny him or her from enjoying and exercising a human right. The CESCHR has stated that the wording "other status" in Article 2.2 of the ICESCHR includes health as prohibited grounds for discrimination.[104] Therefore, States "should ensure that a person's actual or perceived health status [including drug abuser and addicts] is not a barrier to realizing the rights under the Covenant."[105]

However, States can make reasonable distinction between non-users and drug users, for the sole purpose of achieving the highest level of health of the latter group. In other words, given that drug users suffer from a disease (drug abusers and addicts) or are in a position to potentially fall victim to a disease (drug users), a State can take special measures to advance the needs of each specific group and assign certain resources to educate, treat, control, and rehabilitate them. Also, in order to respect and fulfill the right to health, States should refrain from denying the right to health to prisoners or detainees who suffer from substance abuse or addiction, and should incorporate a holistic public health policy to promote saying no to drugs through preventive education. As mentioned above, a health-approach system is more efficient that a sanction-coercive one.

B. *The Criminalization of Drug Use and the Right to Health*

Based on the above arguments, this article argues that the criminalization of drug use itself or the possession of drugs for personal use is a violation of international law and the right to health. Drug users can be classified into two groups: the first one is made up of individuals that produce/cultivate/purchase/possess drugs for commercial purposes and also consume them;

[104] See U.N. Committee on Economic, Social and Cultural Rights [CESCR], *General Comment No. 20: Non-Discrimination in Economic, Social and Cultural Rights (Art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights), 8, E/C.12/GC/20 (July 2, 2009)*, available at http://www2.ohchr.org/english/bodies/cescr/docs/E.C.12.GC.20.doc.

[105] *Id.*

and the second one is a group of individuals that possess/produce/purchase drugs for the sole intention of using them (personal use).

Regarding the first group, as explained in the second section of this essay, drug conventions mandate the criminalization of several actions, such as possession, purchase, cultivation, sale, and importation of drugs, with the objective to avoid illegal drug trafficking. In this sense, under international law, States have a compelling interest in prohibiting, for instance, drug possession. In this case, what is being prohibited is the intention and potential condition of commercializing drugs and not drug use itself; the drug user status is not the criminal offense. Obviously, drug users sanctioned for commercial drug-related activities must be entitled to their exercise of the right to health.

Nevertheless, States cannot criminalize the conduct of the second group of drug users. Under international law, States have discretional power to criminalize personal use. Drug conventions do not impose a mandatory obligation to sanction drug use or possession for personal use; on the contrary, drug treaties subject this prohibition to the constitutional principles of each State (margin of appreciation) and encourage States to take alternative measures. In consequence, criminalizing these conducts can be a straight-forward violation of the obligations to respect and fulfill the right to health (if the State has recognized this human right or at least ratified the ICESCR). In other words, States do not have the absolute obligation to criminalize such actions, but do have the general obligation to provide the highest level of health for all people, including drug users. Therefore, the criminalization of drug use or possession for personal use (an indirect way of sanctioning drug use) is a disproportionate restriction of this human right.

States can argue that they have a compelling interest in restricting or limiting the enjoyment and exercise of the right to health: to avoid drug trafficking. Moreover, States can claim that prohibiting drug possession for personal use would lower the demand for drugs and improve the health of the population. These arguments are misleading. First, because this prohibition imposes a high cost on drug users who, in some cases, suffer from a disease (substance abuse or addiction). States are simply sanctioning a medical condition and not a behavior that is harmful to society.[106] Second, there is a significant amount of evidence which asserts that education, treatment, and rehabilitation is a more effective way to reduce illegal drug use and allay the potential social harm.[107] The restriction of the enjoyment of the right to health by punishing drug users would not survive close scrutiny under Article 4 of the ICESCR. The only possibility for a State to regulate drug use or the posses-

[106] The US Supreme Court, in *Robinson v. California,* 370 U.S. 660 (1962), held that a law which made "status" of narcotic addiction a criminal offense violated the cruel and unusual punishment clause of the Fourteenth Amendment, because the statute is just merely sanctioned an illness which may be contracted innocently or involuntarily.

[107] Chandler et al., *supra* note 14, at 184.

sion of drugs for personal use is through measures other than conviction or punishment, measures that also need to be analyzed under the principle of proportionality.[108]

IV. Mexico and the Criminalization of Drug Use

To apply the reasoning and arguments presented in the previous sections, this segment of the article is a practical analysis of Mexican federal legislation on drug control, which is regulated in several federal and state statutes. This article will only focus on federal laws and, specifically, on the provisions related to drug possession and use because most cases are prosecuted under federal jurisdiction.[109]

The Mexican Constitution safeguards the right to health. Article 4, paragraph one, of the Mexican Constitution states that "every person has the right to health protection." The right is not limited to being healthy; instead, the normative content of the right to health is exactly the same as that defined under international law. Article 1 of the Mexican Constitution establishes that every person enjoys the human rights recognized in the Constitution and international treaties ratified by the State. This means that the Constitution gives constitutional status to a wide variety of human rights[110] and, implicitly, accepts its international normative content.[111] Having said that, this article argues that Mexican legislation violates international law and the normative content of the right to health, because the Federal Criminal Code (FCC) and the Federal Health-Care Law (FHCL) criminalize the possession of drugs for personal use without taking reasonable alternatives into account.

As a general rule in Mexico, federal law prohibits the possession of a wide-ranging diversity of narcotic drugs and psychotropic substances. In other words, Mexico has never granted the general right to possess drugs. Article 195 of the FCC forbids the possession of drugs for commercial activities.[112]

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[108] *See* INCB, *Report of the International Narcotics Control Board 2007*, *supra* note 34, at 5.

[109] Ana Paula Hernández, *La legislación de drogas en México y su impacto en la situación carcelaria y los derechos humanos*, Dissertation-FLACSO (2010).

[110] To see the Mexican Supreme Court opinion about this matter, *see* the Contradicción de Tesis 21/2011-PL and Contradicción de Tesis 293/2011.

[111] Mexico is a party to drug conventions and the ICESCR, which were ratified as follows: the 1961 Single Convention on April 18, 1967; 1971 Convention on February 20, 1995; and the 1971 Convention on April 11, 1990. *See* Treaty Collection, *Database*, treaties.ung.org (April 10, 8:30 PM), available at http://treaties.un.org/.

[112] "Artículo 195. Se impondrá de cinco a quince años de prisión y de cien a trescientos cincuenta días multa, al que posea alguno de los narcóticos señalados en el artículo 193, sin la autorización correspondiente a que se refiere la Ley General de Salud, siempre y cuando esa posesión sea con la finalidad de realizar alguna de las conductas previstas en el artículo 194, ambos de este código." [A penalty from five to fifteen years in prison and a fine between one hundred and three hundred days of minimum wage shall be imposed on the person who

Before the FCC was amended in 2009, Article 195 established that the "Ministerio Público" [Public Prosecutor] shall not present criminal charges against a person who possessed a certain amount of drugs, if that person was a drug addict and the amount of the drugs was proportional to that needed for personal use.

However, in 2009, with the alleged intention to comply with the mentioned drug conventions and international obligations under the right to health, the Federal Congress amended Articles 195 and 199 of the FCC and Articles 13 and 473 to 482 of the FHCL to establish that any drug abuser or addict being prosecuted for drug trafficking or other crimes is entitled to medical treatment and rehabilitation.[113] In this respect, it has changed the entire regime for drugs addicts.

Interestingly, Article 478 of the FCHL establishes that the Public Prosecutor cannot press charges against a person who possesses a certain amount of a drug listed in Article 479 of the FCHL.[114] However, it would be a criminal offense and, therefore, punishable, for a person to have more than the exact quantities of drugs mentioned in said article: for instance, more than 2 grams of opium, 5 grams of marijuana, 50 milligrams of heroin and 500 milligrams of cocaine. Likewise, if the drug is not included on the FCHL list, the person shall be prosecuted under Articles 194 and 195 of the FCC, despite his or her substance dependence.

Regardless, this article considers the FCHL provisions a violation of international laws and the right to health, for two main reasons. First, as explained, a health-care approach is mandatory under international law. When a nation is not internationally bound to criminalize the use or possession of drugs for personal use, but bound by the ICESCR, a State adherent to this convention should prefer a system that focuses on the respect and fulfillment

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possess any of the narcotics described in Article 193, without the authorization established in the Federal Healthcare Law, and as long the individual possesses said drugs for any of the intentions explained in Article 194, both of which are found in this Criminal Code.] *See* Código Penal Federal [C.P.F] [Federal Criminal Code], as amended in August 20, 2009, Diario Oficial de la Federación [D.O.], 14 de Agosto de 1931 (Mex.).

[113] For instance, Article 487 of the Federal Health-Care Law establishes: "El Ministerio Público o la autoridad judicial del conocimiento, tan pronto identifique que una persona relacionada con un procedimiento es farmacodependiente, deberá informar de inmediato y, en su caso, dar intervención a las autoridades sanitarias competentes, para los efectos del tratamiento que corresponda." [The Public Prosecutor or the judicial authority who identified that a person who is being prosecuted is a drug abuser or an addict, shall immediately inform the judge and, in this case, allow the health-care authorities to participate in order to provide the appropriate medical treatment.] *See* Ley General de Salud [L.G.S.] [Federal Health-Care Law], *as amended* in April 24, 2013, Diario Oficial de la Federación [D.O.] 7 de febrero de 1984 (Mex.).

[114] The drugs are opium, marijuana, heroin, cocaine, LSD, MDA, and methamphetamines. *See* Ley General de Salud [L.G.S.] [Federal Health-Care Law], *as amended* in April 24, 2013, Article 479, Diario Oficial de la Federación [D.O.] 7 de febrero de 1984 (Mex.)

of the right to health. Second, legislation does not make a necessary distinction between drug users without an addiction, drug abusers, and drug addicts. This conceptual division is an essential step towards treating and controlling a disease: substance abuse and dependence (Article 12.2(c) of the ICESCR). It is true that Article 479 of the FHCL allows the possession of a certain amount of drugs for personal use and, to a certain extent, enforces a sphere of freedom; but it is also true that many drug abusers and addicts need much more than these amounts. Legislation benefits occasional drug users instead of drug abusers and addicts.

The Mexican Supreme Court has held that Articles 478 and 479 of the FHCL do not violate the equal protection clause and constitutional right to health. In the cases of *Amparo en Revisión* 563/2010,[115] *Amparo en Revisión* 576/2010,[116] and *Contradicción de Tesis* 454/2011,[117] the Court concluded that the normative constraints on drug possession for personal use are reasonable, because the objective of the regulation is to avoid the trafficking of specific drugs, to protect public health, and to recover State power/strength and social peace in the country. The Court emphasized that drug possession restrictions (in number and quantity) grant the community greater benefit than a person's freedom to possess and use drugs. Legislation does not aim at sanctioning the use of any particular kind of drug, but to prevent the indiscriminate possession of narcotics.

In this sense, although the Mexican government has a compelling interest in prohibiting drug possession in several specific circumstances, I question these Mexican Supreme Court opinions and suggest that legislation is disproportionate. The FHCL and the Court analyses focus on the amount of drugs and not on the existence of substance dependence; in other words, a person's possessing 6 grams of marijuana is more important than his or her disease. As explained above, the normative content of the right to health under in-

[115] *See* "Igualdad y derecho a la salud. El artículo 479 de la Ley General de Salud, no es violatorio de los citados principios constitucionales al limitar la cantidad de narcóticos que debe considerarse para su estricto e inmediato consumo personal," Primera Sala de la Suprema Corte de Justicia [S.C.J.N.] [First Chamber of the Supreme Court of Justice], Semanario Judicial de la Federación y su Gaceta, Novena Época, tomo XXXIII, Febrero de 2011, Tesis 1a./J. 73/2010, Página 471 (Mex).

[116] *See* "Farmacodependencia. Constituye una causa excluyente del delito condicionada a las dosis máximas establecidas en el artículo 479 de la Ley General de Salud," Primera Sala de la Suprema Corte de Justicia [S.C.J.N.] [First Chamber of the Supreme Court of Justice], Semanario Judicial de la Federación y su Gaceta, Novena Época, tomo XXXIII, Febrero de 2011, Tesis 1a./J. 74/2010, Página 368 (Mex).

[117] *See* "Farmacodependencia. Constituye una causa excluyente del delito prevista en el artículo 15, fracción IX, del Código Penal Federal, condicionada a la posesión de narcóticos y en las cantidades establecidas en la tabla prevista en el artículo 479 de la Ley General de Salud," Primera Sala de la Suprema Corte de Justicia [S.C.J.N.] [First Chamber of the Supreme Court of Justice], Semanario Judicial de la Federación y su Gaceta, Décima Época, Libro XI, Agosto de 2012, Tesis 1a./J. 43/2012, Página 341 (Mex).

ternational and constitutional law compels Mexico to offer treatment and rehabilitation to all drug abusers and addicts.

The prosecution of a person who, for instance, keeps more than the permitted amount of cocaine at home and there is no indication that he or she sells drugs, does not increase social benefits. Instead, the State is punishing a sick individual just because he or she does not fulfill a formal, restricting legal requirement that is partially related to public health. The public prosecutor should have the power to analyze the existence of the following elements on a case by case basis: a) drug abuse or substance dependence; b) the amount of drugs recovered; and c) unlawful behaviors such as production, manufacture, cultivation and distribution of narcotics with the intent to commercialize them. If the authority has sufficient evidence of the last element, it should present criminal charges, while ensuring treatment for the abusers or addicts. In the other scenario, the prosecutor must evaluate the proportionality between the drugs that were found and the person's physiological tolerance to and dependence on the drug.

In sum, to ensure the enjoyment of the right to health, the procedure for prosecuting drug abusers or addicts should be more flexible and focus on the protection of the individual and not on the amount of narcotics. As noted, Mexico has ratified the CESCR and other international and regional conventions that recognize this right; therefore, it is obligatory to respect, protect, and fulfill all its normative content under Article 1, paragraphs one, two and three, of the Mexican Federal Constitution.

V. Conclusion

The balance between the protection of human rights and drug control is a difficult scenario for States to maintain. It is challenging not only in the legal arena, but also in a much broader sense: drug use and its causes and effects are not only legal problems, but also social, cultural, economic, and political dilemmas. The arguments explained in this essay do not intend to diminish the tough position most countries face concerning drug production and use. Instead, the purpose of this article is to highlight legal arguments that support a wider-ranging concept of the right to health. This essay shows that under international law States should at least take this right into account in every decision regarding drug control. The right to the highest standard of health, including people that commit illegal actions, deserves careful government analysis. This right is not a programmatic privilege, but an essential human right.

Recibido: 7 de noviembre de 2012.
Aceptado para su publicación: 16 de agosto de 2013.