Where Is the Opioid Use Epidemic in Mexico? A Cautionary Tale for Policymakers South of the US–Mexico Border

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WHERE IS THE OPIOID USE EPIDEMIC IN MEXICO?

In 2016, the opioid epidemic accounted for close to 80% of the 64,000 drug-related deaths in the United States, and is now the country’s leading cause of accidental deaths. The United States also leads the world in opioid prescriptions with close to 82 opioid prescriptions per 100 persons annually, twice as many as Canada, the second-highest-ranking nation. Of concern, this rate has quadrupled from 1999 to 2010. Even though prolonged nonmedical use of opioids after a prescription is low (6%), given the magnitude of prescription opioid use in the United States and Canada, the availability of prescription opioids has been implicated as a factor in the opioid overdose epidemic. This is further complemented by illicit or nonmedical prescription opioid use, which contributes to increasing prevalence of heroin use at a rate of 2.8% per year. In the Veterans Aging Cohort Study, for example, nonmedical prescription opioid users had 5 times higher rate of heroin initiation. In recent years, data from addiction treatment centers suggested that an increased proportion of individuals started directly with heroin, likely because of increased barriers in accessing prescription opioids. There exists a high volume of trade and mobility as well as close cultural ties among the United States, Canada, and Mexico, the 3 countries that make up continental North America. Furthermore, continental drug trafficking patterns and similar approaches to opioid prescribing suggest that the current opioid use epidemic has likely been similar in the United States and Canada because of cultural and prescribing similarities.

Curiously, Mexico has yet to document patterns suggestive of a national trend toward higher levels of opioid use (Table 1). Nonetheless, as a country bridging both North America and Latin America, it has suffered disproportionately from America’s drug epidemic relative to other Latin American countries. This has been largely related to its role as a transit and production country from which illicit drugs are trafficked to the United States, the ensuing violence associated with domestic efforts to disrupt this traffic, and a high prevalence of injection drug use at its northern border and along drug trafficking routes leading into the United States. Given the similarities and differences between Mexico and its 2 northern neighbors—the United States and Canada—in this essay, we seek to examine the individual and structural factors that have limited the use of oral opioids in Mexico and, so far at least, have allowed Mexico to evade the worst of the opioid use “epidemic” experienced by its neighbors to the north. For the purpose of this essay, we define the opioid use epidemic as a rapid increase in the use of prescription and nonprescription opioids leading to intentional and unintentional harms (i.e., opioid use disorder, injection drug use, nonfatal and fatal overdose, or infectious disease transmission).

We propose this definition to assess the risk that Mexico will experience its own opioid use epidemic and investigate strategies to mitigate these risks.

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According to the International Narcotics Control Board, the low coverage in Mexico was estimated to meet only 36% of the population need for narcotic analgesics, whereas the United States and Canada had excess opioid coverage of 3150% and 3050%, respectively.24 Before 2015, limits on the prescribed use of opioids in Mexico were largely attributable to legislative restrictions, which were extensive in comparison with those in the other North American countries.25 Barriers included clinicians’ difficulties in obtaining opioid prescribing licenses that could only be obtained at single state-wide governmental offices during limited hours, risks to providers who were required to place their names on prescriptions, a limited number of prescriptions per prescriber, complex guidelines on the storage and protection of opioids at pharmacies, and rejection of prescriptions at pharmacies because of minor technicalities (e.g., orthographical errors or discrepancies with patients’ identification cards).26,27

Another structural barrier had been the cost of opioids. Reasons for the higher costs of opioids in Latin American countries were identified in the WHO’s 1995 Declaration of Florianopolis: (1) large multinational pharmaceutical companies chose to sell more expensive products protected by patents, (2) local smaller pharmaceutical companies were not aware of the size of the potential market or had been discouraged by bureaucratic regulations from producing or distributing opioids, (3) it was difficult to introduce morphine powder that could later be compounded by local pharmacies, and (4) pharmacists feared the potential legal consequences of preparing and

### TABLE 1—Comparison of Substance Use, Palliative Opioid Use, and Drug-Related Deaths in North America: 2015–2016

<table>
<thead>
<tr>
<th>Substance</th>
<th>Illicit use substance, last year&lt;sup&gt;a,b,c&lt;/sup&gt;</th>
<th>Prescription opioids (misuse), %</th>
<th>Heroin</th>
<th>Cannabis</th>
<th>Cocaine</th>
<th>Methamphetamine</th>
<th>Morphine equivalence per capita, mg&lt;sup&gt;d&lt;/sup&gt;</th>
<th>Palliative care need met, %&lt;sup&gt;e&lt;/sup&gt;</th>
<th>Opioid-related overdose death&lt;sup&gt;f,g,h&lt;/sup&gt;</th>
<th>Homicides (% organized crime)&lt;sup&gt;i&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mexico</td>
<td>United States</td>
<td>Canada</td>
<td>&lt;1.0</td>
<td>&lt;0.1</td>
<td>2.1</td>
<td>0.8</td>
<td>0.2</td>
<td>4.3</td>
<td>378 (all drugs)</td>
<td>22,932 (25.4–52.8)</td>
</tr>
<tr>
<td></td>
<td>4.3</td>
<td>0.3</td>
<td>0.4</td>
<td>13.9</td>
<td>1.9</td>
<td>0.5</td>
<td>853.2</td>
<td>36</td>
<td>42,249</td>
<td>14,661 (4.6)</td>
</tr>
<tr>
<td></td>
<td>3150</td>
<td>3090</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2816</td>
<td></td>
</tr>
</tbody>
</table>

Source: <sup>a</sup>Mexico’s National Survey on Drug, Alcohol and Tobacco Consumption, 2016–2017; <sup>b</sup>US National Survey on Drug Use and Health, 2016; <sup>c</sup>Canadian Tobacco Alcohol and Drugs Survey, 2016; <sup>d</sup>United Nations Office of Drugs; <sup>e</sup>Centers for Disease Control and Prevention, National Center for Health Statistics, 2016; <sup>f</sup>Canadian Tobacco, Alcohol and Drugs Survey, 2016; <sup>g</sup>Justice in Mexico Project, 2016.

### SCOPE OF THE PROBLEM IN MEXICO

Historically, Mexico has been a country with a low prevalence of substance use, with alcohol by far the substance most commonly used. According to Mexico’s 2016–2017 National Survey on Drug, Alcohol, and Tobacco Consumption (Encuesta Nacional de Consumo de Drogas, Alcohol y Tabaco [ENCODAT]), drug use in the past year, other than alcohol, was reported by 2.9% of individuals aged 12 to 65 years, with cannabis the most commonly reported drug (2.1%).13 Even though heroin use was reported in 26 of Mexico’s 31 states and Mexico City, heroin use in the past year was reported by only 0.03% of respondents. The highest prevalence of heroin use occurred in men aged between 18 and 34 years, reaching 0.6% of this subpopulation.13

National estimates obscure the fact that a high prevalence of heroin use has been well documented in specific settings, especially in Mexico’s northern border region. For instance, although less than 2% of drug rehabilitation admissions in nongovernmental treatment centers were related to heroin use in the central and southern regions of Mexico, more than 10% of admissions were related to its use in the northern region states in 2016,14 with the highest proportions occurring in the border states of Chihuahua (20%), Baja California (15%), and Sonora (13%). Heroin use in this region has been associated with economic disadvantage, sex work, internal displacement, and the presence of drug-trafficking routes.15 Particularly high prevalence of use has been observed among deportees from the United States who reside in the north of Mexico.16–18 Recent data from federally funded Centers for Juvenile Integration (Centros de Integración Juvenil) highlight other hidden pockets of high prevalence of heroin use. For instance, the highest proportions of heroin-related admissions were again in states on the border with the United States—Chihuahua (18% of admissions) and Baja California (6%). However, heroin use was also detected in states in the interior and south of the country, namely Morelos, Puebla, Guerrero, and Oaxaca.19

### UNIQUE FACTORS IN MEXICO

Misuse of prescription opioids in Mexico has been low. A recent national survey estimated that it occurred among less than 1% of respondents.13 The low prescription opioid misuse in Mexico is related to structural, cultural, and individual factors as outlined in the next sections.

#### Structural Factors

In 1988, morphine was first regulated in Mexico.20 Since then, palliative care in the country has been evolving through the creation of treatment centers within major hospitals, outpatient pain clinics, and hospices.20,21 Despite this expansion, the overall level of opioid prescribing in Mexico has remained very low. Since the 1990s, several efforts by the World Health Organization (WHO) and national palliative care advocacy groups had failed to increase coverage of opioid analgesics in the Mexican market.21,22

For example, in 2015, Mexico had a morphine equivalence use per capita well below the Latin American average (4.3 vs 7.9 mg per capita); by comparison, the United States, on average, used 677.8 milligrams of morphine equivalence per capita.23

Another structural barrier had been the cost of opioids. Reasons for the higher costs of opioids in Latin American countries were identified in the WHO’s 1995 Declaration of Florianopolis: (1) large multinational pharmaceutical companies chose to sell more expensive products protected by patents, (2) local smaller pharmaceutical companies were not aware of the size of the potential market or had been discouraged by bureaucratic regulations from producing or distributing opioids, (3) it was difficult to introduce morphine powder that could later be compounded by local pharmacies, and (4) pharmacists feared the potential legal consequences of preparing and
distributing opioids in the community. These factors contributed to high out-of-pocket costs for patients in Mexico. For example, in 2004, it was reported that a monthly supply of opioid therapy could cost more than twice the mean monthly salary in Mexico. In 2017, the reported cost of purchasing prescription morphine in Mexico was more than 4-fold higher than the lowest international price reported in the WHO’s International Drug Price Indicator Guide.

### Individual and Cultural Factors
Scant literature exists on Mexicans’ perceptions of prescription opioids. However, a survey on risk perceptions of analgesics undertaken among more than 500 medical students and residents reported morphine as being perceived as the riskiest, with its potential for addiction of highest concern. A patient survey undertaken by the Mexican National Institute of Cancerology reported that 54% of patients believed morphine was only for terminally ill patients, 57% believed it was illegal, and 65% stated that it was too expensive. No other data, to our knowledge, are available on perceptions of these drugs specifically in Mexico. Nonetheless, a systematic review from the United States suggested that Hispanic American patients noted concerns about using strong pain medications, like opioids, and were more likely to use stoicism,

### SUMMARY OF FACTORS LIMITING AN OPIOID USE EPIDEMIC IN MEXICO, PLACING THE COUNTRY AT RISK FOR ONE, AND POTENTIAL MEASURES THAT COULD BE INTRODUCED TO MITIGATE THESE RISK FACTORS

<table>
<thead>
<tr>
<th>Factors Limiting Opioid Epidemic</th>
<th>Factors Placing the Country at Risk</th>
<th>Potential Measures to Limit Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>High cost of opioids comparable to per capita income</td>
<td>Expanded opioid coverage by national insurance (Seguro Popular)</td>
<td>Prescribing based on evidence-based conditions and only when nonpharmacologic therapies and other analgesics have been tried</td>
</tr>
</tbody>
</table>
| High burden of infectious and preventable diseases | Change in the country’s disease burden:  
- Increasing population age  
- Increasing prevalence of chronic conditions and their complications (e.g., diabetic neuropathy)  
- Increasing prevalence of malignancy and late-stage diagnosis | Use of nonopioid pain medications and adjuvants  
Limit opioids only to malignancy-related pain  
Disposal programs for no-longer-needed opioids  
Evidence-based early detection and treatment programs (e.g., cervical cancer screening) |
| Regulations limiting prescribing (before 2015):  
- Difficulty obtaining controlled-substances prescribing licenses  
- Limited prescriptions (50) per block  
- Low availability in pharmacies because of storage and logging difficulties | Loosening of opioid prescribing regulations (after 2015):  
- Decreased wait time for prescribing licenses  
- Electronic prescription system  
- Increased prescriptions (200) per block | National prescription drug monitoring program  
Training:  
- Mandatory pain management and palliative care rotations during medical school  
- Continuing medical education programs on opioid prescribing and pain management after training |
| Clinicians’ perception of high potential for addiction  
Population beliefs against “strong” pain medications | Marketing from pharmaceutical industry:  
- Industry-sponsored advisory panels  
- Branded terms “opiognorance” and “opiophobia”  
- Shift of opioid prescribing to primary care and for chronic nonmalignant pain conditions | Increasing medication-assisted treatment programs:  
- Expansion of methadone services  
- Introduction of new pharmacological agents for opioid addiction:  
  - Buprenorphine/naloxone  
  - Extended-release naloxone  
  - Diacetylmorphine  
- Other harm-reduction infrastructure:  
  - Syringe exchange programs  
  - Police force training in naloxone administration  
  - Safe injection facilities  
  - Treatment of related infections (HIV/HCV) |
| Low burden of illicit substance use including heroin | Increased deportation  
- Heroin use epidemic at US–Mexico border  
- Increased opium poppy cultivation, heroin production, and trafficking  
- New clusters of heroin use in the interior of the country | Note. HCV = hepatitis C virus.
relational coping, and catastrophizing, while also preferring nonpharmacologic treatments for pain (though this review was not specific to Mexican Americans). Relatedly, data from the US National Health and Nutrition Examination Survey, support these findings, suggesting that Hispanic Americans had a 28% lower odds of opioid use compared with non-Hispanic White respondents and a 34% lower odds of using any prescribed analgesic. Studies from the same group recently reported changing cultural norms among later-generation Mexican Americans, who were more likely to report chronic pain compared with first-generation Mexican Americans.

INCORPORATING RISKS FOR AN OPIOID EPIDEMIC IN MEXICO

Both domestic and international pressures are shifting those structural, cultural, and individual factors that have limited Mexico’s ability to escape unharmed from the current North American opioid use epidemic. These changes and their potential impacts in promoting an opioid use epidemic are summarized in the next sections.

Regulations and Increased Coverage

In 2014, the structural barriers reported previously were highlighted in a report by Human Rights Watch, which stated that the lack of training for medical providers, their difficulties in prescribing opioids, and patient barriers to accessing palliative care services left many terminally ill patients needlessly in pain. This report, in conjunction with pressure from the Mexican Health Foundation (Fundación Mexicana para la Salud) and other palliative care organizations, led to the Mexican federal government approving measures relaxing some restrictions on opioid prescribing in 2015. These measures included an electronic prescription system, a bidimensional bar code for authentication of prescriptions, an increase in the number of available prescriptions to providers from 50 to 200 per prescription pad, and a decreased wait time for providers to receive prescriptions. These measures consequently led to a 50,000% increase in prescription opioid dispensations within 1 year. Prescribing providers were mostly pain management specialists, with close to three quarters of prescriptions concentrated in Mexico’s 3 largest metropolitan areas: Mexico City, Guadalajara, and Monterrey. Finally, since 2016, Mexico’s national health insurance (Seguro Popular), the largest insurer in the country, has included coverage for outpatient options for treatment of pain in palliative care including buprenorphine, morphine, oxycodone, and tramadol.

Pressure From the Pharmaceutical Industry

In the United States, as the harms of opioid use have become increasingly widespread, the Food and Drug Administration requested that the highly addictive oral opioid oxymorphone hydrochloride (Opana ER, Endo Pharmaceuticals) be removed from the formulary, while various states have initiated legal action against Purdue Pharma (the maker of OxyContin) and others for their role in contributing to the ensuing opioid overdose epidemic. In response, US-based pharmaceutical companies have shifted focus to emerging markets, such as Latin America, through associations with international partners. This expansion has led to increased advertising by pharmaceutical companies to doctors in Latin America. Industry-sponsored advisory panels have recommended further permitting access to opioids in Latin America and Mexico and have promoted terms such as “opioignorance” and “opiophobia” to help providers overcome hesitation around prescribing opioids. This has also taken the form of publishing guidelines and advocating the shift of the responsibility for prescribing from pain specialists to primary care physicians, as well as seeking to increase the use of opioids for the control of chronic nonmalignant pain (i.e., noncancer pain). This marketing strategy resembles that used in the 1990s leading up to the current opioid prescribing and opioid overdose epidemic in the United States. Furthermore, opioid manufacturers’ shift toward international markets resembles tobacco industry tactics in the 1990s after major lawsuits and increased taxation in the United States incentivized marketing pushes in low- and middle-income countries. Given the aging population in Mexico, it might be argued that traditional cultural beliefs that have limited opioid use may persist; nonetheless, the increased need for pain medication caused by chronic diseases may precipitate a change in beliefs, and lobbying by the pharmaceutical industry and increasing ease of prescribing may change beliefs at the provider level. Changes in attitudes toward opioids tied with structural factors opening up opioid prescribing may tilt the balance toward an epidemic.
**Forced Migration and Risk of Opioid Misuse**

Deportation has been identified as a key risk factor for heroin injecting along the US–Mexico border. In Tijuana, Mexico, a city bordering San Diego, California, more than 40% of people who inject drugs (PWID) are estimated to have been deported from the United States, and close to 95% report injecting heroin. Furthermore, in a qualitative study of PWID in Tijuana, more than half reported initiating drug use, including “hard” drugs (e.g., opioids, cocaine, and amphetamine-type stimulants) while in the United States. After deportation, increased drug-using behaviors were reported attributable to individual, social, and environmental factors such as widespread availability and perceived lower cost of drugs, syringes, and other injection paraphernalia compared with in the United States and the presence of shooting galleries as well as a large and visible local drug-user population.

In a review of the effect of forced migration on substance use, Horynack et al. hypothesized that these populations may be at a higher risk of uptake of illicit substances because of a number of factors: witnessed or personal experience of stress and trauma, acculturation challenges and assimilation to adhere to mainstream norms, and social and economic inequalities experienced by displaced individuals. We would also suggest adding to this list the impact of anomic (exogenous) depression (a kind of depression caused by disruption or deprivation of familiar work, social, and cultural structures from events beyond the person’s control) as a factor likely leading to substance use uptake among deportees given the disruption of preexisting family structure and social change after deportation.

This is in line with data from 2012, suggesting that deportees reported poorer self-perceived health, 5 times more depressive symptoms, and lower levels of access to care compared with nondeported migrants. In a follow-up study, mental health disorders were reported among 16% of deportees, with higher levels reported among women (40%).

To our knowledge, data linking depression to the uptake of opioids in Mexico do not currently exist, though data from the US National Survey on Drug Use and Health suggested that close to a third of patients with opioid use disorder also had a major depressive episode (29%), and in a separate study, a previous depressive disorder was found to increase the rate of subsequent long term opioid use by 94%. The current US administration’s proposal to increase levels of deportation will therefore likely further increase the prevalence of PWID at the US–Mexico border.

**Increasing Production, Trafficking, Availability**

Mexico has become the United States’ leading supplier of heroin, and this increase in local production may also lead to increased availability in Mexico. Currently, Mexico is the world’s third-largest producer of heroin, with more than 28,000 hectares (close to 70,000 acres) of land believed to be used for opium cultivation, potentially producing 499 tons of heroin per year. Production is concentrated in the southwest Pacific states of Sinaloa, Nayarit, Michoacan, Guerrero, and Oaxaca. Mexican trafficking of heroin to the United States has risen and fallen since the 1970s. Most recently, Mexican heroin accounted for 50% of American heroin seizures in 2011 and close to 80% in 2014. The crude number of US seizures of Mexican-produced heroin doubled between 2010 and 2015. In the United States, Mexican heroin, generally of the less pure black tar variety, is more frequently distributed west of the Mississippi, whereas Colombian white powder heroin, a purer form, is more commonly present on the East Coast. Recently, Mexican cartels have increased their production and traffic of white powder heroin and illicit fentanyl into the United States, with which they have laced black tar heroin, thereby creating a more potent product at a cheaper cost, which is then distributed nationwide.

The increase in Mexican production and trafficking of heroin has been accompanied by expanded use within the country. In the 1970s, during a period of increased Mexican production, heroin use surged by more than 700% in the border state of Baja California. A study in the 1990s among prisoners using heroin in Baja California suggested that availability as a result of local production or trafficking was a primary factor contributing to their initiation of heroin use. Recently, small clusters of heroin use have been reported in cities in the interior of the country including Puebla, Cuernavaca, and Oaxaca, which have not been traditional hotspots for heroin use (Figure 1).

**PREVENTING AN OPIOD EPIDEMIC AND RELATED HARMs**

Given these factors, we note the real possibility of a widespread opioid use epidemic in Mexico in the coming years, particularly as the population ages. Mexico has the chance to mitigate the risks of widespread opioid use and their related complications (see the box on page e3).

**Provider Training and Prescription Surveillance**

Because of the previous inaccessibility of opioids and low prescribing, Mexican providers (e.g., doctors and dentists) may need additional training to deter inappropriate prescribing and identify and refer opioid misuse. Evidence-based prescribing methods are being adopted and tested in the United States and could be tailored for Mexican providers. Furthermore, future generations of clinicians should receive this training during medical school education.

**Medication-Assisted Treatment**

Of concern, Mexico largely remains without access to key interventions that could limit potential opioid-related morbidity and mortality, such as...
FIGURE 1—Map Showing the Interrelationship of (a) Drug Trafficking, Poppy Cultivation, and Heroin Production, and (b) Deportation, Heroin Use, and Methadone Treatment Centers
adequate medication-assisted treatment (MAT; e.g., methadone, buprenorphine/naloxone, extended-release naloxone, or prescription diacetylmorphine) and ancillary harm-reduction infrastructure. Although MAT is in principle available in Mexico, and a recent set of national clinical guidelines has been developed to support further implementation and improvements in quality of care, scale-up is severely limited: only 2 government clinics and 16 private clinics provide methadone nationally. Although buprenorphine is available by prescription, it is only regulated for the use of pain management and there is no coformulation with naloxone (i.e., Suboxone) as a treatment of opioid use disorder. Also, emerging data suggest that, given that injecting practices can be communicated through social networks, MAT may—beyond its treatment effectiveness—also have a secondary preventive impact on reducing the risk that PWID initiate others into injecting.

Other Harm-Reduction Interventions

Mexico could also implement or expand a variety of harm-reduction strategies that have been shown to reduce potential opioid-related harm or risk behavior. These include syringe distribution services, improving the interface of law enforcement and people who use drugs, provision of naloxone, and medically supervised injection facilities. Syringe distribution services have been implemented and found to be cost-effective in Mexico, although these are limited to major cities, and considerable stigma exists in Mexico regarding the purchase of syringes from commercial pharmacies. In 2009, a federal law was passed in Mexico decriminalizing possession and use of small quantities of drugs for personal use, shifting drug possession charges from the federal to the state and local levels, and giving the option for repeat offenders to be referred to drug treatment. However, analysis of its impact in the border city of Tijuana actually suggested that official drug-related arrests increased since its inception and that arrests may be more common among deportees found possessing illegal drugs. Nonetheless, an initiative to train the Tijuana Municipal Police Department, which incorporates HIV prevention, occupational safety measures with respect to needle-stick injuries, and changes in attitudes toward PWID, is underway and could be disseminated nationwide. Another harm-reduction strategy is equipping law enforcement officials with naloxone to reverse overdoses, given that they are often the first responders to the scene of an overdose.

Finally, supervised injection facilities where PWID can use heroin or other drugs with sterile equipment under medical supervision have demonstrated health and cost savings in analyses undertaken in cities including Vancouver, Canada, and Sydney, Australia. Moreover, modeling of the construction and operation of medically supervised injection facilities in 2 US cities, San Francisco, California, and Baltimore, Maryland, have suggested that sites in these cities would also be cost-effective. Although these analyses have not been applied to cities in medium-income countries such as Mexico, supervised injection facilities may be appealing in Mexican cities with large populations of PWID such as Tijuana, Hermosillo, and Ciudad Juárez.

Implementation of these interventions may be challenging and, therefore, this process must incorporate Mexico’s health belief model to be successful (while also ensuring appropriate measurement of outcomes). Scale up of MAT in Mexico will face, at minimum, similar challenges to those faced in the United States and Canada; for instance, unless a concerted public effort for provision of MAT is enacted, the cost of MAT is likely to be prohibitive for most Mexicans with an opioid use disorder. Beyond cost, any intervention migrated from high-resource settings should be adapted to ensure that it is culturally appropriate by taking into account Mexican culture and beliefs of drug use. Another challenge is ensuring that MAT is available by taking into account Mexican culture and beliefs of drug use. Another challenge is ensuring that MAT is available to all PWID, is equity in funding and resource allocation, and that MAT is culturally appropriate by taking into account Mexican culture and beliefs of drug use.

FUTURE DIRECTIONS

Mexico faces unique vulnerabilities given its geographic location, changing population demographics, and population disease burden, all of which place it at great risk of a widespread opioid use epidemic similar to that of the United States and Canada. The intersection of a fragile emerging social structure as a result of nationals returning through deportation from the United States; structural challenges in the treatment of pain; lobbying from pharmaceutical companies; increasing local production, distribution, and availability of heroin; and a lack of infrastructure to support evidence-based treatment of opioid use disorder are likely to increase the risk of a generalized Mexican opioid use epidemic. However, a range of cultural and social factors, as outlined previously, may heighten the country’s resistance to the widespread misuse of opioids. Nevertheless, previous examples of increased usage in settings with increased domestic availability of opioids as a result of international drug trafficking suggest that a grave risk exists that the combination of expanded access to prescribed opioids and local heroin production may lead Mexico past the threshold for an opioid use epidemic.

Mexico has the opportunity to respond effectively through a combination of targeted public health surveillance of high-risk groups, preparation of appropriate infrastructure to support evidence-based treatment, and interventions and policies to avoid a fate similar to that of its neighbors. Of note, recent President-Elect Andrés Manuel López Obrador has called for an open public debate on drug legalization, and his transition team has hinted at a gradual process of full decriminalization. Possession of small quantities of drugs was de jure decriminalized in 2009, though the law’s implementation has not been carried out. Internally, corruption may limit the implementation of decriminalization as police authorities may benefit from “shake
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downs” of people found with drugs, and policymakers and implementers may benefit from bribes from the drug trade industry. The new government’s anticorruption measures may be key for decriminalization policies to have a positive health impact similar to that seen in Portugal. Externally, Mexico is likely to face political pressure from the United States if it moves to enact formal regulation of currently illegal drugs and will also face concerns regarding reconciling this policy decision with its role as a signatory to the United Nations conventions on drugs (as have other countries such as Canada in the wake of cannabis legalization).

When one considers the high levels of human mobility among Mexico, the United States, and Canada, there is a shared continental responsibility to champion efforts to reduce the ongoing burden of preventable opioid-related morbidity and mortality. As US drug policy will likely continue to earmark aid toward supply reduction and military counterterrorism campaigns south of the US–Mexico border, Mexico should negotiate support for harm reduction and substance use treatment within its borders to accompany any such aid. Other collaborations could entail capacity building for providers in the areas of the prevention and management of chronic pain–causing conditions and provision of MAT. Finally, if and when new, safer medical drugs for treatment of pain or substance use come to market, preferential drug prices for Mexico should be negotiated and made available.

CONFLICTS OF INTEREST

The authors have no conflicts of interest to disclose.

HUMAN PARTICIPANT PROTECTION

No human participants were part of this research. Institutional review board approval was not necessary.

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