The Universal Declaration of Bioethics and Human Rights: a reference for Health Surveillance in Therapeutic Communities

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Abstract

The serious problem of psychoactive substance abuse may require the temporary admission of dependents. As a result, governments resort to therapeutic communities, which, although criticized by some, host thousands of extremely vulnerable individuals in Brazil, making this sector propitious to the contribution of bioethics. Although they are not part of the public mental health care network, these facilities are governed by RDC 29/2011 of the National Health Surveillance Agency, responsible for their licensing, supervision and health safety requirements. However, in the performance of their duties, parameters of evaluation essential for an ethical reception compatible with the protection of citizenship and respect for the rights of dependents were not employed. The presence of Therapeutic Communities is therefore analyzed in the Brazilian context and the responsibilities of Health Surveillance in these inspections are identified, with the proposal of applying the principles of the *Universal Declaration of Bioethics and Human Rights* to strengthen and enrich these procedures.

Keywords: Bioethics. Therapeutic community. Health surveillance. Drug users. United Nations Educational, Scientific and Cultural Organization.

Resumo

***Declaração Universal sobre Bioética e Direitos Humanos*: referência para vigilância sanitária em comunidades terapêuticas**

O grave problema do abuso de substâncias psicoativas pode exigir internação temporária de dependentes. Consequentemente, governos recorrem às comunidades terapêuticas, que, apesar de criticadas por alguns, acolhem milhares de indivíduos hipervulneráveis no Brasil, tornando-se setor propício para contribuição da bioética. Mesmo não integrando a rede pública de atenção à saúde mental, comunidades terapêuticas são regidas por resolução da Agência Nacional de Vigilância Sanitária (RDC 29/2011), responsável por seu licenciamento, supervisão e requisitos de segurança sanitária. Porém, no desempenho de suas funções não são adotados parâmetros de avaliação indispensáveis a acolhimento ético compatível com a proteção da cidadania e de respeito aos direitos dos dependentes. Assim, analisa-se a presença das comunidades terapêuticas no contexto brasileiro e identificam-se as ações da vigilância sanitária nessas inspeções, propondo-se inserir os princípios da *Declaração Universal sobre Bioética e Direitos Humanos* para fortalecer e enriquecer esses procedimentos.

Palavras-chave: Bioética. Comunidade terapêutica. Vigilância sanitária. Usuários de drogas. Organização das Nações Unidas para a Educação, Ciência e Cultura.

Resumen

***Declaración Universal sobre Bioética y Derechos Humanos*: referencia para la vigilancia sanitaria en comunidades terapéuticas**

El grave problema del abuso de sustancias psicoactivas puede requerir la internación temporal de las personas dependientes. En consecuencia, los gobiernos recurren a las comunidades terapéuticas, las cuales, a pesar de criticadas por algunos, acogen a miles de individuos hipervulnerables en Brasil, haciendo de éste un sector propicio para la contribución de la Bioética. Aunque no integre la red pública de atención a la salud mental, las comunidades terapéuticas se rigen por resolución de la Agencia Nacional de Vigilancia Sanitaria (RDC 29/2011), responsable de su licenciamiento, supervisión y requisitos de seguridad sanitaria. Sin embargo, en el desempeño de sus funciones no se adoptan parámetros de evaluación indispensables para una admisión ética compatible con la protección de la ciudadanía y del respeto a los derechos de los dependientes. Así, se analiza la presencia de las comunidades terapéuticas en el contexto brasileño y se identifican las acciones de la vigilancia sanitaria en estas inspecciones, proponiendo introducir los principios de la *Declaración Universal sobre Bioética y Derechos Humanos* para fortalecer y enriquecer estos procedimientos.

Palabras clave: Bioética. Comunidad terapéutica. Vigilancia sanitaria. Consumidores de drogas. Organización de las Naciones Unidas para la Educación, la Ciencia y la Cultura.

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Declara não haver conflito de interesse.

This article, which discusses bioethics in therapeutic communities, is the first of two submitted to *Revista Bioética*. In this article, these institutions were identified, their relationship with health surveillance was established, and a proposition was made to include the principles of the Universal Declaration on Bioethics and Human Rights (UDBHR) [1] in the health inspections of therapeutic communities (TCs). The second article will discuss bioethical principles and benchmarks towards more humanized and ethical treatment of dependents.

TCs, as they are known today, were started in the 1950s by British army psychiatrist Maxwell Jones to treat shell shock [2]. In his original work "Social Psychiatry in Practice," Jones highlights that his proposal of TCs drew attention and awoke considerable interest in the psychiatric sphere [2], given its success in rehabilitating ex-prisoners of war [3]. Recognizing the importance of social factors in the formation and treatment of mental disorders, Jones had the opportunity to introduce psychosomatic counselling in the social field, creating "transition communities" that helped many English soldiers to recuperate [2].

His vision contributed greatly to social psychiatry, which replaced the traditional authority of the physician with more active participation by patients in their own healing and in that of other patients. The system was, and continues to be, characterized by equality between staff and patients, division of labor, and the value placed on interpersonal interaction [4]. In Brazil, TCs began to emerge in the 1960s to help recovering alcoholics and drug addicts, becoming what is now one of the most sought-after treatment modalities [5].

According to the official definition of the Observatório Brasileiro de Informações sobre Drogas (Brazilian Observatory of Drug Information - OBID) [6], TCs are private, non-profit institutions financed in part by public authorities, that offer free housing to people with disorders resulting from drug use, abuse, or dependence. They are open, completely voluntary institutions designed for people who want and need a protected, residential space to recover from drug addiction. Typically, TCs are located on small farms or ranches in rural areas, and individuals stay for as long as 12 months. Recently, the Instituto de Pesquisa Econômica Aplicada (Institute of Applied Economic Research - IPEA) conducted a broad survey profiling TCs in Brazil [7-9].

According to Law 8.080/1990 [10], the Agência Nacional de Vigilância Sanitária (the Brazilian Health Regulatory Agency - ANVISA) is responsible for coordinating the Sistema Nacional de Vigilância Sanitária (Brazilian Health Regulatory System - SNVS). The system consists of a set of actions able to eliminate, reduce, or prevent health risks, and to intervene in environmental health problems, production- and distribution-related health problems, and health problems related to the healthcare industry. This system can interfere with any determining factor in the health-disease process, such as TCs. Thus, health surveillance is responsible for the licensing and authorization of health facilities, for health education, and for communicating with the public, among other duties.

In addition, regarding TCs specifically, ANVISA issued the Collegiate Board Resolution 29/2011 [11], which establishes health safety requirements for institutions that provide inpatient care to persons with disorders resulting from the use, abuse, or dependence on psychoactive substances. Thus, this article seeks to discuss institutional relationships and the need for a bioethical approach to back health inspections of TCs, suggesting for this purpose the use of the UDBHR to safeguard dependents hosted at these institutions.

Therapeutic Community Treatment Models and Efficacy

In addition to being based in part on the precepts of Alcoholics Anonymous, TCs promote the individual's self-confidence through work therapy, along with discipline and spirituality. Work is part of the therapeutic process, thus the designation, "work therapy". It consists of giving the patient different routine tasks, such as self-care, community maintenance (cooking, cleaning), productive activities (gardening, making crafts, doing repairs), educational activities, and vocational training [7]. The therapeutic process is based on social interventions, which assign roles, rights, and responsibilities to the individuals in treatment [12].

This diversity of treatment also occurs in other countries [13]. Leon [3] emphasizes that the resocialization of the dependent depends, among other things, on positive values (honesty, self-confidence, responsible care, community responsibility, and workplace ethics). In other aspects of recovery, the prevailing approach may be religious/spiritual, medical, care based, psychological, or in many cases, a mixture of these approaches [14,15]. When it comes to resocialization, TCs are particularly focused on helping the dependent to reintegrate into society in order to assume his or her role as a citizen, family member, worker, or student [16].

Permanent contact with the Centros de Atenção Psicossocial (Psychosocial Care Centers - CAPs) of the affiliated region is essential. This is a two-way street, through which patients are referred to CTs by CAPs and receive follow-up treatment in CAPs [17]. Both types of facilities emphasize rehabilitation and the reinsertion of users into society. It is worth noting that abstinence may only be a resource for obtaining employment or improving personal well-being, which may, in turn, contribute to an individual's renewed participation in community activities and social inclusion [18].

Therapeutic Communities in Brazil and Their Social Importance

There are currently an estimated 1,900 TCs in Brazil, most of them in the southeast (41.77%) and south of the country (25.57%), particularly in Minas Gerais and Rio Grande do Sul [8]. In Europe, 1,200 facilities were registered as part of national dependency treatment systems, especially in Italy, Portugal, Spain, and Greece [19]. However, since TCs lack mandatory registration in Brazil, it can be difficult to monitor and qualify TC members and receive them with dignity and respect. This motivated the Public Ministry of Santa Catarina to adopt judicial and extrajudicial measures to ensure TC supervision [20].

TCs are in need of a status to define their profile, duties, and objectives. It is also necessary to establish benchmarks to evaluate their performance, since many TCs receive public funding [8,20]. Other estimates suggest that Brazil has between 2,500 and 3,000 TCs, which could attend to approximately 60,000 people each year, representing more than 80% of the inpatient dependents in the country [5]. Inquiries by the IPEA [7] indicate that there are 1,963 CTs, which can host about 83,600 dependents.

We should bear in mind that Brazilian TCs, in addition to being non-profit [21], are not formally considered health or welfare facilities, in principle. That is, they are not properly institutionalized, so they hold no legal recognition as complementary, temporary residential units for substance dependents [21,22]. In spite of this, many paradoxically receive funding from the federal government and several states, such as Santa Catarina, which created the project: "Revive - Innovation in the Care of Substance Dependents in the State of Santa Catarina", distributing several million Brazilian *reais* to dozens of TCs [23].

At the national level, there is the Integrated Plan to Combat Crack and Other Drugs, which seeks to expand and strengthen healthcare and social assistance networks by coordinating the actions of the Brazilian Sistema Único de Saúde (Unified Health System - SUS) with those of the Sistema Único de Assistência Social (Unified Social Assistance System). The plan resulted in public edicts of financial support to shelter users of crack cocaine and other drugs [17]. The reasons given were the increasing use of crack and its effects on the lives of users, leading to dependence and mental disorders that require a period of abstinence treatment in long-term hospitalization units [17], a service that is insufficient in the public system [14].

Since the 2012 launch of the program "Crack: It Can Be Beaten", the federal government has paid for places in TCs via the National Secretary of Drugs using resources from the National Anti-Drug Fund. However, before even the federal government, states and municipalities had already been paying for places in TCs, despite criticism [8]. This type of public funding characterizes outsourcing of the duties of the program. In addition to being a blunder, this outsourcing would reflect poorly on the government for failing to live up to its mental health policy, as the miniscule number of Drug and Alcohol CAPs makes TCs an easy alternative for public administrators. This public funding of TCs has been criticized by the Conselhos Federais de Psicologia e de Serviço Social (the Federal Counsel of Psychology and Social Work) [7].

Damas [14], who has a psychiatric background and voluntary experience in TCs, performed a descriptive analysis of these units from a historical, sociological, and community health point of view. The basis of the study was a reading of the current drug problem, especially crack, and the role of TCs from the perspective of public and community health. TCs were analyzed from a phenomenological and socio-historical perspective, seeking to describe their current presence in Brazil and their correlation with national drug policy.

The following conclusions stand out: 1) TCs are the most accessible solution for treating the majority of Brazilians affected by drugs, as they attend to individuals with a more severe pattern of chemical dependence in terms of social problems such as poverty, low levels of education, underemployment, unemployment, low professional qualifications, community and family problems, and legal problems; 2) they are expanding rapidly and are responsible for treating more than half the users in the country; 3) to deny that TCs are a widely used measure to care for chemical dependents would be even more severe than simply defending them or approving them

 http://dx.doi.org/10.1590/1983-80422017253203

across the board; 4) more research is needed about these facilities in Brazil, and international studies are scarce and suffer from methodological flaws [14].

At the request of the National Secretary on Drug Policy, the IPEA recently carried out extensive and unprecedented scientific research to profile TCs [7-9]. The method used included a quantitative approach, consisting of the examination of 500 TCs, and qualitative ethnographic studies in ten facilities. Partial results address inquiries and critiques of the TC model, such as connections to churches and religious organizations, methods and therapeutic practices used, and disciplinary measures imposed on patients. TCs were found to be predominantly linked to religious organizations, to use scientific methods and techniques (medication, individual or group psychotherapy), and to converge markedly in their methods and daily activities.

The results suggest a certain degree of standardization within the model, that work therapy is not geared toward preparing patients for the job market and, finally, that criticism of TCs as "detention units" may be slightly exaggerated, although important restrictions do exist which impinge on certain civil and human rights [10,21]. This study builds on the tiny body of similar initiatives, as well as delving into the field of public policy, which is marked by prejudice and disinformation [7-9].

Health Surveillance in Therapeutic Communities

Historically, health surveillance is one of the oldest public health practices in the modern world, and more recently, its functions, responsibilities, and duties have been greatly expanded. Its operations are essentially preventive and, as such, encompass all medical and health practices, such as health promotion, protection, recovery, and rehabilitation [25], which are essential for the safety and well-being of the dependents sheltered in TCs.

The Brazilian Health Regulatory System is composed of the respective state and municipal agencies, which act in a decentralized manner with an emphasis on the municipalization [26]. Thus, the challenge of health surveillance is to be truly focused on quality of life and health, and to be accepted as an important activity in municipal health planning and programming.

In performing its duties, health surveillance may undermine economic interests, its failure to intervene, even by means of its sometime necessary police presence, may be damaging to community health interests [27], which shows its essential role in the defense and care of the community, as identified in RDC 29/2011 [11]. Thus, with its municipalization, health surveillance must be a component of integrated health care, and for this reason it must be included in the planning of all programmed healthcare operations through the relevant public policies.

Oliveira and Dallari [28] state that societal participation in developing policies for health protection and promotion must be a pillar of the construction of citizenship. They add that health surveillance, especially in the local sphere, needs to approach health councils as public bodies capable of legitimizing and giving transparency to its actions. In this way, it will be possible to construct the citizenship while ensuring the right to health protection. Clearly, a more productive and ethical relationship between health surveillance and TCs is expected at this level, as both work on a municipal level.

According to the IPEA [7], 44% of TC directors participate in Drug Policy Councils (or similar) in their municipalities, and 40.6% of them are part of Municipal Councils for Social Assistance, representing significant involvement in municipal public policy forums. It is hoped, therefore, that social representation in councils can foster real progress in health surveillance practices, including pertinent ethical issues of immense importance to the health and quality of life of the population [24]. It is recommended that members of health councils, at their various levels, have basic training in bioethics [29] in order to develop public awareness and encourage the people involved to adopt ethical guidelines [30].

For this reason, Costa [31] indicates that TCs, which were previously linked to social assistance through agreements and partnerships, have migrated to healthcare, as chemical dependence is now considered a public health issue. However, she questions whether the healthcare system is prepared to receive, interact with, train, and advise them. The São Paulo Health Surveillance Manual [32], prepared by the State Council on Drug Policy, admits that many TCs are not aware of established health standards. In this sense, health surveillance should provide educational opportunities to TC leaders and staff members so that they understand the legal requirements, especially regarding steps to improve the quality of care and patient safety. The educational role of health surveillance is one of its responsibilities as a state entity [27].

It is the responsibility of each state to implement the corresponding sanitary mechanisms for the safety

of TC residents. It is not enough to create norms regulating hygienic and sanitary conditions, but rather it is necessary to put them in practice and monitor them using not only technical and administrative criteria, but also ethical and problem-solving criteria. It is up to each state to monitor, inspect, and evaluate TCs and their services [20]. Cavalcante, Bombardelli, and Almeida [33] confirm the need to constantly monitor sanitary standards, since the sanitary permit granted does not in itself guarantee conditions that favor the well-being and the health of TC residents. The authors conclude that there is much to be done to improve sanitary issues in TCs.

Finally, it is necessary to establish a healthcare research agenda for health surveillance to contribute more in strengthening society and having a complete public health policy. In addition, health surveillance needs to produce knowledge and reflect on its methods of intervention [27]. There has been significant growth in scientific production in the area of health surveillance from 2000 to 2010, but this production is still nascent given the importance of the sector for the economy and health of the population [34,35].

Thus, bioethics can be a valuable research tool to aid reflection on health surveillance operations. As the component of the health system with the broadest crossover into law, health surveillance must promote studies and research that assess TC adherence to SUS principles and guidelines [37]. For this task, we recommend that health surveillance include bioethical parameters in its evaluations of TCs to create a more coherent vision of their social role as a state entity and, at the same time, to encourage a culture of routine evaluations in TCs [18,38].

Bioethics in Health Surveillance

Bioethics can be defined according to its object of study or its method and purpose, meaning there is no single definition. It can be considered part of applied ethics. One definition, related to the ethical problems of TCs, refers to bioethics as *a new human sensibility that leads us to care for, protect, and promote human dignity and quality of life* [39]. Recognized in its early days in the USA as individualistic bioethics focused on doctor-patient relations, the field was adapted to better fit the social realities of other regions, changing its scope to emphasize social bioethics over clinical bioethics.

Thus, bioethics in Latin America relates to the region's enormous social and economic inequality, especially regarding healthcare. Junges [40] emphasizes that bioethics relates directly to poverty and exclusion, as these are the main causes of healthcare problems in our population, and that a strong "social flavor" qualifies bioethics on our continent. Therefore, in Latin American, bioethics has emphasized the need to create conduits of social protection and intervention to aid the underprivileged, emphasizing principles and benchmarks that better relate to conditions here.

Corroborating these ideas, Pessini [41] acknowledges that Latin America's reality calls for a social ethics concerned with the common good, justice, and equity, rather than with individual rights, as the overarching need in these poor countries is an equitable allocation of resources and distribution of healthcare services. For Garrafa [42], *ethics must no longer be seen as an abstract philosophical question and be added to the list of our dearest public needs.* However, relating bioethics to health surveillance is not an easy task; rather, the complexity and breadth of healthcare [43] operations make it difficult.

Fortes emphasizes that it is essential to link ethics to public health practices, specifically health surveillance, which cannot be looked at from solely a technical, legal, or administrative point of view. It is inherently ethical, in that the decisions it makes and operations it performs interfere directly or indirectly with people and with societal well-being [44]. Health surveillance extols the autonomy of individuals and the community as a guiding ethical principle, and must divulge its findings so that citizens can make autonomous decisions to protect their health and avoid or minimize the harm that they may suffer from healthcare-related goods and services [45].

To be committed to the population's healthcare and improved quality of life, health surveillance operations must have a technical and ethical foundation, as well as social responsibility [46-48]. Fortes [45] also points out that the ethical responsibility of health surveillance actions, or failures to act, will have repercussions not only now, but also on future generations. This reinforces how important it is for health evaluations of TCs to be performed according to strict ethical parameters so that the environment offers good conditions to shelter dependents, both in the present and future.

In addition, Garrafa [29] believes that the rights set out in legislation need to be transformed to be effectively materializable and reach the true citizenry. To do so, the principle of equity – among others - emphasized by the SUS and the UDBHR, needs to be effectively incorporated into public policy to reduce existing social inequalities [29]. Ethics

 http://dx.doi.org/10.1590/1983-80422017253203

and responsibility are among ANVISA's cited values, and RDC 29/2011 [11] states among its requirements the following ethical parameters for the patient admission process: 1) respect for the person; 2) privacy according to ethical and legal standards, including anonymity; 3) compliance with the resident's rights as a citizen.

However, inspection manuals from the state of São Paulo [32] and inspections carried out in the South [49] and mid-west regions of the country [33] in 135 and 29 TCs, respectively, covered only the formal verification of organizational matters, architectural design, physical infrastructure, equipment, materials, and human resources, without specifying ethical issues related to the care and services provided. It seems that, regarding TC inspections, advancing from theory to practice is a leap that requires much more than intent and desire. In order to perform ethically sound inspections, health surveillance would need regulatory instruments and manuals that consider bioethical principles in the context of collective action.

Therefore, must use adequate ethical reference to carry out these actions [50]. For this purpose, managers and staff members of different levels should have basic training in bioethics [29,51], a fundamental activity to sensitize teams and enable them to adopt an ethical view of TC inspections. In other words, it is necessary to help develop public awareness in order to sway decision-makers to adopt the correct ethical guidelines [30]. One proposal is to create Comitês Intermunicipais de Bioética (Inter-municipal Bioethics Committees) [52], which, if implemented, could be the center of basic bioethics training for municipal councilmembers and staff members of both local health surveillance agencies and the basic healthcare system, whose joint action could strengthen the social management of the healthcare system [48].

The social responsibility of public and private organizations has become relevant thanks to their ethical approach, especially when incorporated in their operations in order to meet society's demands [53]. Institutions are bioethically responsible when they base their operations on respecting the values, dignity, and integrity of human beings, as well as life, health, and the environment. In order to have an impact, these institutional attitudes need, above all, to protect health, human rights, and dignity, and be integrated in the orientation, formulation, and implementation of public policy [53].

Sanitary bioethics defends as morally justifiable, among other ethical positions, the prioritization of public policies that benefit the largest number of people for the longest time and with the best outcomes. In addition, from a private and individual perspective, it is necessary to reanalyze dilemmas such as autonomy × justice/equity; individual benefits × collective benefits; individualism × solidarity; omission × participation; and superficial changes × concrete and permanent transformations [54].

The Proposed Adoption of the UDBHR for Health Surveillance Operations in TCs

Garrafa [55] emphasizes that the bioethical agenda of the 21st century has been definitively expanded with the release of the UDBHR [1], which has provided diverse possibilities for action by uniting the health, social, and environmental fields. From a political standpoint, the Declaration, which has concrete domestic juridical value, provides sufficient tools for those who strive for a bioethics that is closer to the daily problems and dilemmas of the global public at large [56]. The issues experienced by TC managers and patients exemplify these problems, making it reasonable to create an ethical approach based on UDBHR principles.

Public administrators have an ethical obligation to base their decisions on careful deliberation that includes workers, producers, and users. In this sense, the community, through social participation, is an important agent to help health surveillance define its mechanisms of constructing citizenship [45,48]. This approach is supported by the SUS tenets, in which the right to health, integrality, universality, and equity are in agreement with the UDBHR. Accordingly, the Declaration, in addition to claiming equality among human beings, proposes equity as an essential element in the life and health of people, stimulating efforts and studies that hold up equity and equality as guiding principles [57].

Despite controversies regarding the insertion of human rights in the UDBHR, the social and environmental rights it proclaims have been widely accepted [58]. However, in certain situations, such as the development of Resolution CNS 466/2012, which regulates research ethics in Brazil, the UDBHR was not a source of inspiration [59]. Meanwhile, for Bergel [56], the Declaration has little value in relation to other international documents. Despite these assertions, the UDBHR represents an important international consensus on the fundamental principles of bioethics, even though there are still many challenges ahead to ensure its effective implementation [60].

According to Ten Have [61], the UDBHR is the result of global efforts, which is why the definitions of crucial terms were not included as they are country-specific. This is in keeping with other observations that recognize its limitations but reinforce its value for bioethics, especially in countries without an adequate ethical structure [62], because it respects different cultures [63,64]. Neves [65] puts the UDBHR in the "fourth generation" of human rights and emphasizes that it contains social principles, reinforced by the globalization of bioethics.

In Brazil, the ethical benchmarks of the Declaration are in line with the principles of SUS [66], and the social and environmental benchmarks relate in many ways to the universal ethics of Paulo Freire. This opens the door to a joint analysis of ethics and politics in developing countries [67], noting that in Latin America the UDBHR has been receiving increasing acceptance [57]. Adding to these considerations about the applicability of the UDBHR, the fact that several Latin American researchers, especially from Brazil, played an important role in its passing should be a motivational factor for its adoption by national powers and organs in the public sphere [68].

The inclusion in the UDBHR of social and economic determinants of healthcare and life can be seen as opening bioethics up to politics. Regarding the theme "Social Responsibility and Healthcare", Article 14 of the UDBHR is indispensable for responding to ethical conflicts in public healthcare [69]. In the same vein, Hossne, Pessini, and Barchifontaine [51] argue that bioethics can and should be joined with politics, but not with the party politics of groups, dogmas, and allegiances. These authors coined the term "to bioethicalize" politics; that is, politics, in the philosophical sense, must be based on ethics and bioethics. On this subject, Ten Have [61] emphatically states that bioethics and biopolitics cannot be separated, and Bolonheis-Ramos and Boarini [70] propose that politico-economic questions must consider the problem of psychoactive substance use.

Garrafa and collaborators [50] conclude that organizations and staff members working with regulatory activities, such as heath surveillance, can take advantage of bioethical principles and guidelines, in particular those of the UDBHR, in their professional practice, expanding their approaches to the health and social fields. With the adoption of the bioethical principles of UDBHR by the Brazilian government, new topics were included in the conduct of managers and stakeholders, such as privacy and confidentiality, equality, justice and equity, non-discrimination and non-stigmatization, respect for cultural diversity and pluralism, solidarity and cooperation, social responsibility, health, and the preservation of future generations [50], encompassing all the dimensions of bioethics [65].

These principles can serve as an ethical guideline to address preventive and interventionary regulatory actions, as is the case with health surveillance as a public practice responsible for the sanitary control of healthcare services [50]. It is also possible to extend them to health inspections in TCs, a public healthcare surveillance procedure [71].

For these reasons, the UDHBR has been prioritized in this approach to public health and TC policies since most of its articles can be related to health surveillance functions. For example, the UDBHR is a milestone in bioethics as it includes the themes of vulnerability and social responsibility, guided by ethical principles that respect human dignity, human rights, and fundamental freedoms [72]. This condition is clearly present among TC patients, since most of them are, historically, made up of people subject to poverty [14,31].

It is also up to health surveillance to establish parameters for the adoption of equipment and technology for the healthcare system and to create mechanisms to monitor the adverse effects of technological resources, as well as to provide risk evaluation and management. These concerns are found in Articles 4 and 20 of the UDBHR, respectively [73]. The first concern relates to utilitarian ethics, since it is a question of maximizing benefits and minimizing damages, while the latter allows that ethics has sufficient intellectual resources to approach the subject rationally in the search for just solutions [74].

Other points of the UDBHR are also significant, particularly Article 10, which can be considered an ethical stimulus to health surveillance involvement in TCs, as it asserts that *the fundamental equality of all human beings in dignity and rights must be respected so that they can be treated fairly and equitably* [1]. As Berlinguer [75] teaches, the right to health cannot be understood in terms of equality, but of equity, which consists of creating or favoring, the possibility for each individual to pursue and achieve the necessary level of health that he or she deserves. It is in the light of these bioethical definitions that Visa should use the UDBHR to supervise TCs, in order to promote more effective, just, and equitable behavior towards residents.

One health surveillance objective relates to international relations in the protection and security of the population, and we find that the UDBHR welcomes this attitude of international cooperation. In Article

 http://dx.doi.org/10.1590/1983-80422017253203

24, the Declaration recommends that *States must support the international dissemination of scientific information and encourage the free circulation and sharing of scientific and technological knowledge* [1]. We could feasibly search for ethical support for health surveillance among international TC organizations that work in close coordination with executive powers. Examples include the World Federation of Therapeutic Communities, the European Federation of Therapeutic Communities, and their counterparts in sanitary surveillance around the world.

Perhaps the only UDBHR article that does not correlate with any field of public health policy in Brazil is Article 19, which recommends the creation of bioethics committees and the education, sensitization, and mobilization of the public in this regard. This is because, regrettably, Brazil does not yet have a National Bioethics Committee, although proposals have been made for many years [76,77]. Caetano and Garrafa [78] highlight the need to publicize the UDBHR, as included in Article 22, and conclude that the declaration is not heard the public or the various spheres of power in order for its ethical parameters to be put into practice by individuals, communities, and countries.

If such a goal is achieved, it will be possible to design public policy for the country based on the bioethical recommendations of the UDBHR [78], including those related to health surveillance behavior regarding TCs. For this reason, we again lament the absence of a National Bioethics Committee in Brazil, as it is an important mechanism for the diffusion of the UDBHR to raise awareness about ethical parameters for institutions and the population [79-81]. Also, we emphasize the importance of education towards ethics in public health [82], as emphatically pointed out by Kanekar and Bitto: *in our current era of confronting public health challenges nationally and internationally, having public health professionals that are untrained in ethics is, possibly, immoral and unethical, and it puts the population's health at risk* [83].

Final considerations

In conclusion, it is proposed that health surveillance adopts actions in line with its preventive role in protecting psychoactive substance dependents in TCs. We propose that health surveillance incorporates the principles of social bioethics found in the Universal Declaration on Bioethics and Human Rights [1], an instrument capable of enriching health assessments.

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Recebido: 10.3.2017
Revisado: 31.5.2017
Aprovado: 3.10.2017

 http://dx.doi.org/10.1590/1983-80422017253203