United Nations system ACC/2000/17

Administrative Committee on Coordination

15 January 2001

English only

Consultative Committee on Programme and Operational Questions

Report of the ACC Subcommittee on Drug Control on its eighth session

(Vienna, 28 and 29 September 2000)

Contents

01-21416 (E) 130201

Annexes

I. Introduction

1. The eighth session of the Administrative Committee on Coordination (ACC) Subcommittee on Drug Control was held at the Vienna International Centre on 28 and 29 September 2000. The agenda is contained in annex I, the list of participants in annex II.

II. Matters to be brought to the attention of the Administrative Committee on Coordination

2. In the context of the umbrella framework for inter-agency coordination on drug control, the Subcommittee is finalizing a draft ACC guidance note for submission to the Consultative Committee on Programme and Operational Questions (CCPOQ) for clearance.

3. The Subcommittee endorsed the draft United Nations system position paper on preventing the transmission of human immunodeficiency virus (HIV) among drug abusers (annex IV) for submission to CCPOQ for clearance.

III. Work of the Subcommittee

A. Actions taken and decisions adopted by the Subcommittee

4. The Subcommittee decided to prepare an ACC guidance note for United Nations system activities to counter the world drug problem.

5. The Subcommittee decided to draft concept papers on the identification of best practices in alternative development and in demand reduction, for consideration at its next session.

6. The Subcommittee decided that the theme for the observance in 2002 of the International Day against Drug Abuse and Illicit Trafficking should be substance abuse and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS).

B. Summary of discussion

7. The Chairperson welcomed the participants, especially the newcomers to the group, and outlined the tasks that the Subcommittee had before it at the present session.

8. The provisional agenda was adopted.

1. Review of the interim action plan and framework for cooperation

9. The Subcommittee had before it a compilation of information on the status of drug control cooperation in the 18 countries addressed in the interim action plan (IAP). The Chairperson introduced the item, saying that the information it contained had been gathered mainly from the United Nations International Drug Control Programme (UNDCP) field offices. Focal points of other member agencies of the Subcommittee had also been invited to provide input but no responses had been received. It was recognized by the participants that it was difficult to compile information on country-level activities at Headquarters.

10. Note was taken of the fact that whereas five thematic groups on drugs (Bolivia, Colombia, Peru, Thailand and Viet Nam) had previously existed in the 18 countries,[1] such groups were now either established or planned in 10 countries, Lebanon, Mauritius, Nigeria, Turkey and Uzbekistan being the additions. It was also noted that the drug problem was or would be addressed in all but one of the Common Country Assessments (CCAs) for these countries and that it was therefore to be expected that the issue would be included in the United Nations Development Assistance Frameworks (UNDAFs).

11. Several participants noted that their agencies were involved in activities that had not been included in the list. In this context, the Joint United Nations Programme on Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (UNAIDS), the Food and Agriculture Organization of the United Nations (FAO) and the International Labour Organization (ILO) drew attention to complementary activities. It was mentioned that a lack of communication had led to various cases of duplication by UNDCP and the World Health Organization (WHO). They indicated that additional information would be made available in the near future. It was agreed that the report would be amended on receipt of these inputs in order to make it more comprehensive.

12. The participants noted the good but uneven progress made in inter-agency coordination at the field level, and discussed both how to increase and how to

extend it. Besides the problems with communication and reporting mentioned above, discussion centred on changes in United Nations system coordination since the IAP had been adopted. At the time, the creation of country-level theme groups on drug control had been deemed the best course of action, and the IAP was to have been followed by the planned cooperation framework. However, since the launch of the CCA/UNDAF process, the idea of unilaterally promoting separate, sectoral theme groups outside that mechanism had been called into question, as had the need for a distinct cooperation framework solely addressing drug control.

13. Three issues thus emerged during the Subcommittee's deliberations:

(a) The efficacy of establishing country-level theme groups on drug control when the trend was towards inclusion of specific drug control issues across multiple, often broader UNDAF theme groups;

(b) Specific measures such as preparation of an ACC guidance note aimed at increasing and deepening treatment of these issues in CCA and UNDAF documents, as well as improving cooperation in planning, design and implementation of drug control activities, whether implemented jointly or complementarily;

(c) Ways of enhancing the measurement, monitoring and reporting of the resulting cooperation.

14. In this connection, the Secretariat suggested that the draft ACC guidance note for United Nations system activities to counter the world drug problem be finalized with the specific intention of providing authoritative guidance to United Nations country teams in their coordination of and support to various levels of intervention, from assessments and plans (for example, CCAs and UNDAFs) to technical cooperation programmes and projects in their country or countries of operation. This was considered particularly important, as the discussion of drug control indicators plainly showed that participants thought those included in the current CCA/UNDAF guidelines were inadequate and should be enhanced. The ACC guidance note would provide a vehicle for cooperation at the country level.

15. Recognizing that the twin issues of monitoring and reporting of inter-agency cooperation on drug control remained high priorities, the guidance note would include an appropriate section with specific instructions to ensure complete and timely information-sharing with the Subcommittee. At the macro-, system-wide level, the CCA/UNDAF Learning Network and periodic reviews would ensure that drug control issues were at least addressed in conjunction with other development issues. At the microlevel, the Subcommittee would compile reports charting progress towards the achievement of its mandated drug control objectives for submission to ACC. It would also continue to provide a forum for substantive deliberation and guidance, in a continuous cycle of improvement. Once the guidance note had been adopted by ACC and the system was in place, it would obviate the need for either the IAP or a cooperation framework.

16. The participants agreed that the Secretariat would revise the draft guidance note along the lines discussed and circulate it to members for adoption by email as soon as possible, so that it could be submitted to CCPOQ for approval.

2. Thematic discussion: harm reduction

17. The Subcommittee had before it a draft United Nations system position paper on preventing HIV transmission among drug abusers, which had been prepared by UNDCP in collaboration with UNAIDS and WHO. A representative of UNDCP introduced the paper, saying that it contained an objective description of related policy documents and outlined known strategies that worked. While the primary concern of UNAIDS and WHO was to reduce the risk of HIV transmission at all costs, UNDCP's mandate called for such action only within an overall drug demand reduction programme. It was confirmed that the paper contained nothing that was contrary to the international conventions on drug control. Final negotiation on the text was undertaken and the Subcommittee adopted the joint position paper for submission to CCPOQ.

3. Thematic discussion: best practice

18. UNAIDS introduced the paper on best practice and explained that the accepted term "best practice" was used to cover either a product on success stories and lessons learned or a process leading to them. Other participants considered that the definition was too broad and that there was a risk of including practices that might be unsuitable. The participants agreed that best practice in the context of illicit drug control

should be clearly defined before specific practices could be identified as such. It was therefore agreed that the subject required further review and UNDCP proposed to take the lead in developing a common concept paper on best practice, specifically in drug demand reduction and alternative development, for consideration at the Subcommittee's ninth session.

4. Other business

(a) Theme for the observance in 2002 of the International Day against Drug Abuse and Illicit Trafficking

19. A suggestion was made and accepted by the participants that the theme centre on substance abuse and HIV/AIDS. The slogan would be worked out at a later date. It was also suggested that the World AIDS Campaign in 2002 adopt the same theme in order to pool resources in a joint campaign. There was also a possibility of WHO's joining within the framework of World Mental Health Day.

(b) Brief on the draft United Nations Convention against Transnational Organized Crime and Palermo conference

20. A representative of the Centre for International Crime Prevention briefed the Subcommittee on the status and content of the draft United Nations Convention against Transnational Organized Crime (A/55/383, sect. IV, draft resolution, annex) which had been prepared by the intergovernmental Ad Hoc Committee on the Elaboration of a Convention against Transnational Organized Crime, comprising 123 States. The final text was being submitted to the current session of the General Assembly and a high-level signing ceremony was being planned for 12-15 December 2000 in Palermo, Sicily, at the invitation of the Italian Government.[2] The following three additional protocols were still under discussion:

- Protocol to prevent, suppress and punish trafficking in persons, especially women and children (A/55/383, annex II);
- Protocol against the smuggling of migrants by land, sea and air (A/55/383, annex III);
- Protocol against the illicit manufacturing of and trafficking in firearms, their parts and components and ammunition.

(c) Dates and venue for the ninth session

21. The Subcommittee agreed to hold its ninth session in principle in June 2001, depending on the scheduling of other important meetings in the United Nations system. Regarding the venue, a suggestion was made that it would be useful to hold the meeting in a programme country, especially one targeted by the IAP. However, ACC meetings took place only in headquarters duty stations, and long-distance travel was not considered justified. It was generally felt that it would be advantageous to hold the meeting in New York so as to attract important United States of America-based Subcommittee members that were otherwise not usually represented at the meetings (for example, the United Nations Development Programme (UNDP), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), World Bank). Alternatively, it should be held in Europe. The Secretariat would investigate the possibility of holding the meeting in New York, and if that did not appear feasible then Geneva-based agencies would be contacted regarding their potential to host the next meeting.

(d) Provisional agenda for the ninth session

22. The Subcommittee agreed to the provisional agenda for its ninth session as contained in annex III.

(e) Adoption of the report on the eighth session

23. The Subcommittee adopted the present report on its eighth session.

Notes

[1] Afghanistan, Bolivia, Brazil, Colombia, the Lao People's Democratic Republic, Lebanon, Mauritius, Myanmar, Nigeria, Pakistan, Peru, the Russian Federation, South Africa, Thailand, Turkey, Ukraine, Uzbekistan and Viet Nam.

[2] In its resolution 55/25 of 15 November 2000, the General Assembly adopted the United Nations Convention against Transnational Organized Crime (annex I), the Protocol to Prevent, Suppress and Punish Trafficking of Persons, Especially Women and Children (annex II), and the Protocol against the Smuggling of Migrants by Land, Sea and Air (annex III).

Annex I

Agenda

1. Adoption of the agenda.
2. Review of the interim action plan and framework for coordination.
3. Thematic discussion: harm reduction.
4. Thematic discussion: best practice.
5. Other business:
   (a) Theme for the International Day against Drug Abuse and Illicit Trafficking, 2002;
   (b) Brief on the draft United Nations Convention against Transnational Organized Crime;
   (c) Dates and venue for the ninth session;
   (d) Provisional agenda for the ninth session;
   (e) Adoption of the report of the eighth session.

Annex II

List of participants

United Nations International Drug Control Programme	Ms. Sumru Noyan (Chairperson) Ms. Christine Oguz Mr. Mathieu Mounikou Ms. Muki Daniel Ms. Susan Mlango (Secretary)
Centre for International Crime Prevention	Mr. Andres Finguerut
Office for Outer Space Affairs	Mr. Viktor Kotelnikov
Office of the United Nations High Commissioner for Refugees	Ms. Yuka Hasegawa
United Nations Office for Project Services	Mr. Hans-Ulrich Hugo
Joint United Nations Programme on HIV/AIDS	Mr. Werasit Sittitrai
International Labour Organization	Ms. Judith Peterson
Food and Agriculture Organization of the United Nations	Mr. John Latham
World Health Organization	Dr. Maristela G. Monteiro
Resource persons, United Nations Office for Drug Control and Crime Prevention (partial attendance)	Mr. Jean-Paul Laborde Ms. Valérie Lebaux Mr. Chris van der Burgh Mr. Paul Griffith Mr. Stefano Berterame

Annex III

Provisional agenda for the ninth session

1. Adoption of the agenda.
2. Revision of the terms of reference of the Subcommittee.
3. Thematic discussion: best practice in demand reduction and alternative development.
4. Thematic discussion: drug abuse and young people.
5. Review of field-level coordination.
6. Other business:
   (a) Themes for the International Day against Drug Abuse and Illicit Trafficking, 2002 and 2003;
   (b) Dates and venue for the tenth session;
   (c) Provisional agenda for the tenth session;
   (d) Adoption of the report of the ninth session.

Annex IV

Preventing the transmission of human immunodeficiency virus (HIV) among drug abusers

Draft position paper of the United Nations system

Background

1. The aim of the present paper is to present a United Nations system-wide position on policy and strategies to prevent the transmission of human immunodeficiency virus (HIV) among drug abusers. Drug abuse and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) issues cut across much of the work of the United Nations family. Both kinds of issues are directly and indirectly associated with many complex public-health and social problems. They affect the workplace, undermine social and economic development, and affect the lives and well-being of children.

2. This paper is based on the experiences of various United Nations agencies and programmes in their work to prevent and treat drug abuse and HIV infection as well as on relevant policy principles guiding the work of the United Nations. It draws on research findings to recommend evidence-based practice, to provide general guidance, and to indicate some programming principles for the prevention of drug abuse and HIV/AIDS.

3. Sharing or use of contaminated needles is a very efficient way of spreading HIV. Since injecting drug abusers are often linked in tight networks and commonly share injecting equipment, HIV can spread very rapidly in these populations. Currently, 114 countries have reported HIV infection among drug injectors. Injecting drug abuse is the main or a major mode for transmission of HIV infection in many countries of Asia, Latin America, Europe and North America.

4. In 1998, 136 countries reported the existence of injecting drug abuse. This is a significant increase as compared with 1992, when 80 countries reported injecting. This illustrates a worrying trend for diffusion of injecting into an increasing number of developing countries and countries in economic transition, where previously the behaviour was often virtually unknown.

5. Numerous studies have also found drug injectors to be disproportionately likely to be involved in the sex industry or to engage in high-risk sexual activities. Drug injecting may also contribute to an increased incidence of HIV infection through HIV transmission to the children of drug injecting mothers, and through sexual contacts between drug injectors and non-injectors.

6. HIV risk among drug abusers does not arise only from injecting. Many types of psychoactive substances, whether injected or not, including alcohol, are risky to the extent that they affect the individual's ability to make decisions about safe sexual behaviour. Studies have associated crack cocaine use with elevated levels of high-risk sexual behaviours, for example, in the United States of America, where crack cocaine abusers account for an increasing proportion of AIDS cases.

7. Deciding on the implementation of the intervention strategies to prevent HIV in injecting drug abusers is one of the most urgent questions facing policy makers. Studies have demonstrated that HIV transmission among injecting drug abusers can be prevented and that the epidemic already has been slowed and even reversed in some cases. HIV prevention activities that have shown impact on HIV prevalence and risk behaviour include AIDS education, access to condoms and clean injecting equipment, counselling and drug abuse treatment.

8. *Drug abuse treatment* is one approach that may have an impact on preventing HIV infection. Many large-magnitude studies have shown that patients participating in drug substitution treatment such as methadone maintenance, therapeutic communities, and outpatient drug-free programmes decrease their drug consumption significantly. Several longitudinal studies examining changes in HIV risk behaviours for patients currently in treatment have found that longer retention in treatment, as well as completion of treatment, is correlated with reduction in HIV risk behaviours or an increase in protective behaviours. However, studies have found more effectiveness for changing illicit drug use than for changing sexual risk behaviour.

9. Drug abuse treatment is not chosen by all drug abusers at risk for HIV infection, or may not be

attractive to drug abusers early in their injecting career. In addition, recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment. Relapses to drug abuse and risk behaviour can occur during or after successful treatment episodes. Various *outreach activities* have been designed to access, motivate and support drug abusers who are not in treatment in order to change their behaviour. Findings from research indicate that outreach activities that take place outside the conventional health and social care environments reach out-of-treatment drug injectors, increase drug treatment referrals, and may reduce illicit drug use risk behaviours and sexual risk behaviours as well as HIV incidence.

10. Several reviews of the effectiveness of *syringe and needle exchange programmes* have shown reductions in needle risk behaviours and HIV transmission and no evidence of increase in injecting drug use or other public-health dangers in the communities served. Furthermore, such programmes have been shown to serve as points of contact between drug abusers and service providers, including drug abuse treatment programmes. The benefits of such programmes increase considerably if they go beyond syringe exchange alone to include AIDS education, counselling and referral to a variety of treatment options.

United Nations system policy

11. Several United Nations documents provide the framework/foundation for the formulation of strategic approaches to preventing the transmission of HIV among injecting drug abusers.

United Nations drug control conventions and the Declaration on the Guiding Principles of Drug Demand Reduction

12. The policy of permitting the use of narcotic drugs for medical and scientific needs, while preventing their use for non-medical purposes, goes back to the late nineteenth and early twentieth centuries. At that time, there was an increasing awareness of the dangers associated with the narcotic drugs that had previously been widely used for pain relief, especially opium-based preparations. Hence, many countries began to restrict the distribution of such drugs, while permitting their use for medical and scientific purposes.

13. This policy is articulated in the preamble to the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol,[a] which reads, in part, as follows:

> "*Recognizing* that the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes,
>
> "*Recognizing* that addiction to narcotic drugs ... is fraught with social and economic danger to mankind ...,
>
> "*Desiring* to conclude a generally acceptable international convention replacing existing treaties on narcotic drugs, limiting such drugs to medical and scientific purposes ..."

The Convention further specifies that "the Parties shall give special attention to the provision of facilities for the medical treatment, care and rehabilitation of drug addicts" (article 38).

14. Also the Convention on Psychotropic Substances of 1971,[b] in its article 20, paragraph 1, states that parties to the convention shall take all appropriate "measures for the prevention of abuse of psychotropic substances and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved".

15. The United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988,[c] in its article 14, paragraph 4, indicates that parties to the convention "shall adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and narcotic substances, with a view to reducing human suffering".

16. In 1998, the General Assembly adopted the Declaration on the Guiding Principles of Drug Demand Reduction,[d] the first international instrument to deal exclusively with the problem of drug abuse. The Declaration emphasizes that demand reduction programmes should cover all areas of prevention, from discouraging initial use to reducing the negative health and social consequences of drug abuse for the individual and society as a whole.

United Nations human rights documents

17. The Universal Declaration of Human Rights,[e] which was adopted over 50 years ago as a common standard of achievement for all peoples and all nations, states:

> "Everyone, as a member of society, has the right to social security and is entitled to realization ... of the economic, social and cultural rights indispensable for his dignity and the free development of his personality" (article 22);
>
> "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services ..." (article 25, para. 1).

18. In 1999, the Commission on Human Rights adopted resolution 1999/49[f] which invited States, and United Nations bodies as well as international and non-governmental organizations "to take all necessary steps to ensure the respect, protection and fulfilment of HIV-related human rights".

19. In May 2000, the Committee on Economic, Social and Cultural Rights, which is the United Nations human rights monitoring body, adopted General Comment No. 14 (2000)[g] on the right to the highest attainable standard of health. The Comment proscribes "any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health" (para. 18).

United Nations health promotion policy documents

20. Respect for human rights and the achievement of public-health goals are complementary. Health, as defined in the Constitution of the World Health Organization (WHO)[h] (1946), is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The Constitution proclaims that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".

21. The concept and vision of Health for All, which was adopted in 1977 by the Thirtieth World Health Assembly,[i] set the main social target of Governments and WHO as "the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (para.1).

22. The Ottawa Charter for Health Promotion[j] (1986) outlines five areas for action: building public health policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services. These areas are all relevant to drug abuse issues and HIV/AIDS.

23. During its session in May 1998, the World Health Assembly endorsed the new World Health Declaration[k] and the new global health policy Health for All in the Twenty-first Century. [l] Health for All in the Twenty-first Century guides action and policy for health at all levels and identifies global priorities and targets for the first two decades of the twenty-first century. Key values such as human rights, equity, ethics and gender sensitivity should underpin and be incorporated in all aspects of health policy. A key feature is the strengthening of the participation of people and communities in decision-making and actions for health.

24. Important "global health for all targets" by 2020 include the following:

> "... the *worldwide burden of disease will be substantially decreased*. This will be achieved by implementation of sound disease-control programmes aimed at reversing the current trend of increasing incidence and disability caused by tuberculosis, HIV/AIDS (para. 38.A.3);
>
> "... all countries will have introduced, and be actively managing and monitoring, strategies that *strengthen health-enhancing lifestyles* and *weaken health-damaging ones*, through a combination of regulatory, economic, educational, organizational and community-based programmes (para. 38.B.6)."

Principles and strategic approach

25. *Protection of human rights is critical for the success of prevention of HIV/AIDS*. People are more

vulnerable to infection when their economic, health, social or cultural rights are not respected. Where civil rights are not respected, it is difficult to respond effectively to the epidemic.

26. *HIV prevention should start as early as possible.* Once HIV has been introduced into a local community of injecting drug abusers, there is the possibility of extremely rapid spread. On the other hand, experience has shown that injecting drug abusers can change their behaviour if they are appropriately supported.

27. *Interventions should be based on a regular assessment of the nature and magnitude of drug abuse as well as trends and patterns of HIV infection.* Interventions need to build on knowledge and expertise acquired from research, including empirical knowledge about the social milieu around which drug-taking revolves as well as lessons learned from the implementation of previous projects and interventions.

28. *Comprehensive coverage of the entire targeted populations is essential*. For prevention measures to be effective in changing the course of the epidemic in a country, it is essential that as many individuals in the at-risk populations as possible are reached.

29. *Drug demand reduction and HIV prevention programmes should be integrated into broader social welfare and health promotion policies and preventive education programmes*. Specific interventions for reducing the demand for drugs and preventing HIV should be sustained by a supportive environment in which healthy lifestyles are attractive and accessible, including poverty reduction and opportunities for education and employment. It is desirable to include multidisciplinary activities and provide appropriate training and support to facilitate joint working.

30. *Drug abuse problems cannot be solved simply by criminal justice initiatives*. A punitive approach may drive the people most in need of prevention and care services underground. Where appropriate, drug abuse treatment should be offered, either as an alternative or in addition to punishment. HIV prevention and drug abuse treatment programmes within criminal justice institutions are also important components in preventing the transmission of HIV.

31. *The ability to halt the epidemic requires a three-part strategy*: (a) preventing drug abuse, especially among young people; (b) facilitating entry into drug abuse treatment; and (c) establishing effective outreach to engage drug abusers in HIV prevention strategies that protect them and their partners and families from exposure to HIV, and encourage the uptake of substance abuse treatment and medical care.

32. *Treatment services need to be readily available and flexible*. Treatment applicants can be lost if treatment is not immediately available or readily accessible. Treatment systems need to offer a range of treatment alternatives, including substitution treatment, to respond to the different needs of drug abusers. They also need to provide ongoing assessments of patients' needs, which may change during the course of treatment. Longer retention in treatment, as well as completion of treatment, is correlated with reduction in HIV risk behaviours or an increase in protective behaviours.

33. *Developing effective responses to the problem of HIV among drug abusers is likely to be facilitated by considering the views of drug abusers and the communities they live in*. Programmes need to be reality-based and meaningful to the people they are designed to reach. The development of such responses is likely to be facilitated by assuring the active participation of the target group in all phases of programme development and implementation.

34. *Drug abuse treatment programmes should provide assessment for HIV/AIDS and other infectious diseases*, and counselling to help patients change behaviours that place them or others at risk of infection. Attention should be paid to drug abusers' medical-care needs, including on-site primary medical-care services and organized referrals to medical-care institutions.

35. *HIV prevention programmes should also focus on sexual risk behaviours among people who inject drugs or use other substances*. Epidemiological research findings indicate the increasing significance of sexual HIV transmission among injecting drug abusers as well as among crack cocaine abusers. Drug abusers perceive sexual risk in the context of a range of other risks and dangers, such as risks associated with overdose or needle sharing, which may be perceived to be more immediate and more important. The sexual transmission of HIV among drug abusers may often be overlooked.

36. *Outreach work and peer education outside the normal service settings, working hours and other conventional work arrangements are needed* to catch

those groups that are not effectively contacted by existing services or by traditional health education. It is necessary to have a back-up of adequate resources to respond to the increase in the client and casework load that is likely to result from outreach work.

37. *A comprehensive package of interventions for HIV prevention among drug abusers could include:* AIDS education, life skills training, condom distribution, voluntary and confidential counselling and HIV testing, access to clean needles and syringes, bleach materials, and referral to a variety of treatment options.

38. *Care and support, involving community participation, must be provided to drug abusers living with HIV/AIDS and to their families*, including access to affordable clinical and home-based care, effective HIV prevention interventions, essential legal and social services, psychosocial support and counselling services.

Notes

[a] United Nations, *Treaty Series,* vol. 520, No. 7515.

[b] Ibid., vol. 1019, No. 14956.

[c] See *Official Records of the United Nations Conference for the Adoption of a Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, Vienna, 25 November-20 December 1988*, vol. I (United Nations publication, Sales No. E.94.XI.5).

[d] General Assembly resolution S-20/3, annex.

[e] General Assembly resolution 217 A (111).

[f] See *Official Records of the Economic and Social Council, 1999, Supplement No. 3* (E/1999/23), chap. II, sect. A.

[g] E/C.12/2000/4, CESCR, of 4 July 2000.

[h] World Health Organization, *Basic Documents, Thirty-sixth Edition* (Geneva, 1986), pp. 1-18.

[i] Resolution WHA30.43 of May 1977 as contained in *Handbook of Resolutions and Decisions of the World Health Assembly and the Executive Board, vol. II, 1973-1984: 26th to 37th World Health Assemblies; 51st to 74th sessions of the Executive Board* (Geneva, WHO, 1985).

[j] Available on the World Wide Web (at http://www.who.int/hpr/docs/ottawa.html). Access on 5 February 2001.

[k] World Health Organization document WHA51.7 of 16 May 1998, annex.

[l] See World Health Organization document A51/5.