Policy Statements

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1.Foreword

As we enter the 21st Century, the pace of change seems to be accelerating at an exponential rate. Technological changes are bringing many of us closer together. The world is becoming increasingly interlinked economically and culturally and globalisation has become both a process and an outcome.
These economic and technological developments are portrayed as progress, and perhaps they are, but we must never forget that development is rarely spread evenly. There are always some people left behind.
It is sometimes said in my country that you can judge the value of our society by the way it treats its most disadvantaged. International society should also be judged by how it treats it's most disadvantaged – how it addresses abject poverty, malnutrition and displacement.
By any indicator, the abuse of alcohol, tobacco and other drugs is a major contributor to global economic and social disadvantage. Hand in hand with the globalisation of the world's economy has come the globalisation of alcohol and other drug abuse. No part of the world is now free from such abuse. Drug abuse is a worldwide problem.
Of course drug abuse is not simply a global problem. It is a regional problem and it is a local problem. There is a need, therefore, for local, national and global solutions.
The international community has begun to recognise the need for action. There is now a strong international regime governing the manufacture, distribution, trade and use of illicit drugs. Similarly, in May 2003 the World Health Assembly adopted an International Framework Convention on Tobacco Control. However, despite the fact that alcohol abuse is one of the leading contributors to premature death worldwide, there is no international alcohol control regime.
Non-government Organisations have played a leading role in pushing for international action. The International Federation of Non-Government Organisations (IFNGO) has played a significant role in fostering collaboration between non-government drug abuse prevention and treatment agencies throughout the world.
This Policy Statement takes IFNGO's work a step further by providing a framework for national action and advocacy by peak drug NGOs in their own countries. It provides a roadmap for IFNGO and its member bodies.
As we enter the 21st Century, the IFNGO's commitment to collaboration and communication across cultures is a cause for hope and celebration. Together we can do much to combat disadvantage. Together we can do much to prevent drug abuse. I commend IFNGO's Policy Statement to you.
PROFESSOR IAN WEBSTER, AO
PRESIDENT 2000-2003

2. INTRODUCTION

The abuse of drugs is one of the most significant health, social and economic issues facing the world today. The devastation caused by the abuse of tobacco, alcohol, prescription drugs, inhalants, cannabis, heroin, cocaine, amphetamines, ecstasy and other drugs is a major impediment to economic development and social cohesion.

As the 1981 Kuala Lumpur IFNGO Joint Declaration acknowledges, substance abuse transcends ethnic, geographical, political, cultural and religious boundaries, and requires the active participation of the whole community for its control, reduction and eventual eradication (IFNGO, 1996).

Twenty years after the Kuala Lumpur Declaration, it is cause for great concern that these issues are still a major challenge to the global community. Non-government Organisations throughout the world play a leading role in preventing and treating drug abuse. Through the IFNGO, non-government Organisations can share ideas and learn from others' experiences to create a safer world.

The IFNGO has demonstrated leadership and direction on these issues through its biennial conferences and ASEAN NGO workshops. At its 10th IFNGO ASEAN Workshop it agreed to a number of wide ranging resolutions, which are outlined in Appendix C. Importantly, the workshop resolved to create an ASEAN-NGO Clearinghouse on the Prevention of Drug Abuse, Treatment, Rehabilitation and Research.

At subsequent workshops IFNGO voiced its support for the Framework Convention on Tobacco Control (11th IFNGO Workshop, refer Appendix D) and emphasised the importance of maximising the use of Indigenous sports and the Arts as alternative strategies for drug abuse prevention (12th IFNGO Workshop, refer Appendix E).

At its 18th International Conference in Brisbane, Australia, IFNGO outlined its shared vision and way forward. The Recommendations from the 2000 ASEAN Workshop and the Learning's and Way Forward for IFNGO July 2000 are at Appendix F.

One of the agreed Ways Forward from the 18th IFNGO Conference related to leadership in advocating policies and implementing best practice. It was agreed that IFNGO should develop a common policy statement.

This policy statement recognises that each country has begun the process of addressing the enormous issue of the abuse of drugs and that many member countries are at a different stage of development of a national response.

This policy statement seeks to:

outline the extent of the global problem and the global strategies that are being put in place to address the problem;
outline the problems and strategies at a regional level;
in selected cases, outline country specific problems and strategies; and
outline actions that can be taken by individual Organisations and by the IFNGO collectively.

3. A GLOBAL PROBLEM

The Global Burden of Disease report clearly articulates the enormous damage caused by drugs – alcohol, tobacco and illicit drugs – in all countries (Murray and Lopez, 1996).
According to the Global Burden of Disease report, alcohol is the most significant cause of death and disease in the world. This is closely followed by tobacco. Illicit drugs continue to be responsible for the deaths of a large number of people each year. The following table clearly outlines the extent of harm caused by the abuse of drugs.

Drug	Deaths (Thousands)	As % of total deaths	Years of Lives Lost (thousands)	% of Total Years of Lives Lost	Disability Adjusted Life Years (thousands)
Tobacco	3 038	6.0	26 217	2.9	36 182
Alcohol	774	1.5	19 287	2.1	47 687
Illicit Drugs	100	0.2	2 634	0.3	8 467

(Murray and Lopez, 1996, p311)

Alcohol abuse leads to more years of life disabled than tobacco, unsafe sex, measles and malaria. This is because the damage caused by alcohol impacts most heavily on young people and deprives them and their communities of future income and contribution to the community.
While there is limited evidence to suggest that the moderate consumption of alcohol may have health benefits, any such benefits accrue late in life. The economic benefit to the community is very low compared to the high cost resulting from the death and injury of young people. This is particularly important in developing countries where young people play such a significant role in economic development.
While alcohol abuse creates greater disability than tobacco use, tobacco remains the second greatest killer of people throughout the world, after malnutrition. Deaths from tobacco use continue to rise, and as the tobacco industry seeks out new markets in developing countries and countries in transition, these rates will inevitably rise.
The morbidity and mortality rate from the abuse of illicit drugs is significantly lower than that for alcohol and tobacco. Nonetheless, more than 100 000 people die each year through the abuse of illicit drugs, and this figure continues to rise. In addition to death and disease, the abuse of illicit drugs causes inestimable damage to sovereign nations and to communities in those nations through terrorism, corruption, violence, crime and family breakdown.

4. Tobacco

There are currently more than 1.2 billion (thousand million) smokers throughout the world. In 2002, this translated into approximately 4.9 million deaths of which 50% were from the developing countries. By 2020, when the annual death toll doubles to 10 million, 70% of the deaths will be in developing countries. Tobacco contributes to 6% of all deaths worldwide.
There is general consensus that there are four stages of the tobacco epidemic worldwide (Corrao et al, 2000):
the first stage is characterised by smoking prevalence below 20% in men and minimal smoking among women. These countries have generally not been drawn into the global tobacco industry.

the second stage is characterised by increases in smoking prevalence to above 50% in men, an increase in smoking among women and rising death rates from lung cancer among men. In these countries, there are limited tobacco control activities and the health risks of tobacco use are poorly understood.
the third stage is characterised by a significant decrease in smoking prevalence among men, a more gradual decline in women, and continued increases in mortality. In these countries, there is growing support for controls on smoking.
the fourth stage is characterised by further declines in smoking prevalence among men and women. Deaths attributable to smoking among men peak at about 30-35% of all deaths and 20-25% of all deaths for women.
The existence of the four stages of the tobacco epidemic must shape the responses to the epidemic. It means that in addition to country specific responses, there must be regional and global responses.

REGIONAL CONSUMPTION PATTERNS

Asia
Tobacco was introduced to Asia in the early 16th century and with time has gained a place in many traditional practices and in various cultures. The diversity of Asian countries is reflected in the diversity of the extent of the tobacco problem, with all four stages of the tobacco epidemic evidenced in the region.

China is the largest market for tobacco products in the world, with an estimated 30% of total global consumption (Yang 2000). In terms of per capita consumption, Japan has the second highest levels of cigarette consumption and South Korea the fifth highest.

Tobacco use is very high among men (50-80%) in China, Taiwan, Vietnam, South Korea and Malaysia. At the same time, tobacco use is very low among women in these countries, although this is starting to change.
Hong Kong (SAR China) and Singapore are major markets for the import and re-export of tobacco products to other Asian countries, despite the fact that both areas have small and declining domestic markets. The three major multinational tobacco companies have significant bases in these areas. At the same time, however, smoking rates for men in Hong Kong have dropped from 32.8% in 1984 to 27.1% in 1998. In Singapore, the prevalence rate is 26.9% for men (Yang 2000).

Thailand's approach to the regulation of tobacco has been described as comparable to the best in the world (Gupta 2000). In Thailand, cigarette taxes are high, cigarette advertising is completely banned and there are strong warning labels on all tobacco products.

The tar and nicotine content of cigarettes manufactured in South East Asian nations is higher than those manufactured in most developed countries (Gupta 2000).
There is still a great need for tobacco control throughout South East and South Asia. Despite considerable successes in a number of countries, there is still generally low political commitment to tobacco control (Gupta 2000). There is a need for greater resourcing of tobacco control programs, including the work of non-government Organisations. There is also a need for considerable research into patterns of use and good practice strategies for the region.

Africa
There is a lack of information about tobacco use in Africa. However, it is understood that smoking prevalence is, on the whole, relatively low (Saloojee, 2000). Cigarette smoking is particularly low in comparison to other regions because of the common use of other forms of tobacco.
Cigarette use among women ranges from less than 2% in Nigeria and Zimbabwe to 11% in South Africa. For men, cigarette smoking ranges from less than 25% in Malawi and Nigeria to approximately 45% in Algeria and South Africa. At the same time, however, it is estimated that in Senegal approximately 90% of men and 11% of women use some form of tobacco.

Cigarette smoking does not appear to be increasing significantly throughout Africa, although the continent remains one of the last untapped markets for manufactured cigarettes. This should be of concern for all public health advocates.

Americas
Smoking prevalence varies significantly throughout the Americas region, from 9% of the adult population in Barbados to 40.9% in Peru. Among men, smoking prevalence ranges from 10.7% in Haiti to 51% in Nicaragua. Among women, it varies from 5.5% in Paraguay to 35.5% in Chile.
Tobacco consumption has increased in recent years in 15 countries throughout the region, while it has decreased in 11 countries.

Europe
Each year, approximately 1.2 million people die in Europe from tobacco related causes (Haglund, 2000). This represents 14% of all deaths. Premature death from tobacco related causes has become a major problem in Eastern and Central Europe, where two thirds of all smoking related deaths occur among people in their middle age.
Approximately 35% of all adults in Europe are regular daily smokers. Smoking rates among men are particularly high, ranging from 45% in Southern Europe and in the countries in transition through to approximately 30% in the United Kingdom, Sweden and Finland. The highest rates of smoking among women can be found in Denmark, Greece, Germany and the Netherlands, where it is approximately 30%.

INTERNATIONAL RESPONSE

In May 1999, the World Health Assembly, the governing body of the World Health Organisation, unanimously endorsed a resolution calling for work to begin on a Framework Convention on Tobacco Control. An Intergovernmental Negotiating Body on the WHO Framework Convention on Tobacco Control was established and convened on six occasions to negotiate the Convention.

The International Non Governmental Coalition Against Tobacco (INGCAT) and the Framework Convention Alliance lobbied extensively and successfully for a framework convention. It argued for a strong treaty that will allow national governments to make decisions in favor of public health and enable their citizens to be protected from the devastating health, social and economic effects of tobacco use. INGCAT argued that it would be unforgivable to allow the problems resulting from tobacco use to continue to be imported to the poorest areas in the world (INGCAT 2001). IFNGO is a member of INGCAT.

At their 11th workshop in September 2001, IFNGO ASEAN NGO's pledged their full support for the draft World Health Organisation Framework Convention on Tobacco Control (FCTC) and agreed to lobby their respective governments to endorse the FCTC (refer Appendix D).

The sixth and final round of negotiations on the Framework Convention on Tobacco Control came to a close on 28 February 2003 and the historic Convention was adopted by the Fifty-Sixth World Health Assembly on 21 May 2003. The Convention includes international rules on tobacco advertising and promotion; smoking prevention and treatment, sales to minors, protection from exposure to environmental tobacco smoke, packaging and labeling of tobacco products; product regulation; illicit trade; and taxation.

After the lapse of ninety days following ratification by forty countries, the Framework Convention becomes law for those countries and thereafter for other countries that ratify it (WHO 2003). IFNGO maintains its support for the Framework Convention on Tobacco Control and accordingly will exert all efforts to urge governments of member countries to sign and ratify the Convention expeditiously .

SUGGESTED ACTION BY INDIVIDUAL IFNGO MEMBERS

Towards achieving this goal each IFNGO member should find out the process for ratification in one's country and ensure that necessary measures are taken for early ratification of the Framework Convention on Tobacco Control.
Each IFNGO member should also develop an understanding of the extent of the problem in their country. The International Non Governmental Coalition Against Tobacco (INGCAT) has developed a checklist for the development of baseline or core data. This is at http://www.ingcat.org/html/quest.html.

The FCTC has set clear goals for international, regional, and national level control of tobacco and each IFNGO member should advocate for the optimal interpretation of the provisions of the FCTC in amending the legal provisions for tobacco control in one's own country. INGCAT has developed model legislation that will assist in the process and this can be found at http://www.ingcat.org/html/law.html.

The WHO publication (2003) 'Tools for Advancing Tobacco Control in the XXI st Century - Tobacco Control Legislation: An Introductory Guide' will also be a useful resource.

SUGGESTED ACTION BY IFNGO COLLECTIVELY

The IFNGO should include tobacco control as one of its priority areas. Collectively, the IFNGO should advocate for:
the early signature and ratification of the Framework Convention on Tobacco Control by all its member nations.
The establishment of baseline data on tobacco consumption patterns in each of its member nations.

More funds to be allocated to researching the risk factors that lead to young people taking up smoking, especially young women.

The implementation of good practice, culturally appropriate, tobacco cessation programs.
the introduction of good practice tobacco control legislation for optimal implementation of the provisions of the FCTC in each of its member nations.

WHO website on FCTC - http://www.who.int/tobacco/framework/en/

FCTC own website - http://www.fctc.org

5. Alcohol

The abuse of alcohol causes immense economic, social and health harms to countries throughout the world. Nonetheless, the damage caused by alcohol is still significantly underrated. Alcohol abuse now causes the death of more than 750 000 people each year (WHO 2001), with 80% of those deaths occurring in developing countries.

According to the Global Burden of Disease report, alcohol abuse leads to more years of life disabled than tobacco, unsafe sex, measles and malaria. This is because the damage caused by alcohol impacts most heavily on young people and deprives them and their communities of future income and contribution to the community.

There has been a decline in alcohol consumption worldwide since 1983, with most of this decline attributed to reductions in drinking levels in developed countries. However, consumption rates continue to increase in developing countries and countries in transition. Importantly, the level of economic development and religious observance appear to be the most influential indicators of national alcohol consumption (WHO 2001).

The other major difference in consumption patterns between developed and developing countries and countries in transition is that in the latter two groups the difference between male and female drinking is much starker. The World Health Organisation has argued that this has led to the situation where men suffer the bulk of direct consequences of drinking, while women are the primary sufferers of the indirect effects of alcohol abuse, such as domestic violence, abandonment, poverty, and suicide.

REGIONAL CONSUMPION PATTERNS

Using the World Health Organisation's regional categories, one can see that there are significant differences in alcohol consumption across and within regions (WHO 2001).

In the African Region, men tend to drink and become intoxicated more frequently than women. Older people tend to consume traditional drinks while younger people tend to be more influenced by the marketing of multinational companies.
In the American Region, consumption rates remain extremely high. In the United States and Mexico, men are six times more likely to drink heavily than women. Consumption rates are quite low in the Eastern Mediterranean Region, and this has been attributed to the critical role that Islam plays in many of these countries.

The European Region has the highest rates of drinking in the world, with relatively small differences in consumption between men and women. One of the most disturbing trends in recent years has been the dramatic decline in life expectancy among males in the Russian Federation that in part is related to the high levels of alcohol consumed (World Health Organisation, 2001).

The Southeast Asian Region is a key target of the global alcohol industry. It has a growing market in alcohol and alcohol consumption is on the increase. According to the Global Alcohol Policy Alliance (GAPA) Bangkok consultation (2002), the principal countries of growth are: Thailand, where a doubling of growth is expected in the next five years; India which will increase by over two thirds; Indonesia by four fifths; and Vietnam by half. However, countries are fortunate that there are relatively low rates of consumption by women in most countries and the influence of religion throughout the region is also high. To maintain this position is a challenge faced by the Region.

The Western Pacific Region has a relatively high rate of consumption, although drinking trends differ throughout the region. In Australia and New Zealand consumption rates remain high, although they are declining, and binge drinking among young people is an issue of considerable concern. In both Japan and South Korea, consumption rates are increasing.

GLOBAL RESPONSE

The global response to the abuse of alcohol has been more fractured than for illicit drugs or tobacco. Alcohol plays a significant role in many countries and is strongly associated with both traditional customs and more recent expressions of celebration. There is no international framework for the regulation of alcohol and alcohol does not appear to be a major issue for any international governmental body. The need to develop an international network of public health advocates to promote policies about alcohol, based on evidence without influence from the commercial sector, was one of the main conclusions of an international conference held in Syracuse, New York State, in August 2000 co-sponsored by the WHO and the IOGT. The outcome was the Global Alcohol Policy Alliance (GAPA) of NGOs. The World Health Organisation has, in 1999, published the Global Status Report on Alcohol (WHO/SAB/99.11), which is a major international monitoring exercise, and has established partnerships with research Organisations throughout the world. An 'Alcohol Policy Strategy Advisory Committee' (APSA) under the chairmanship of Professor Sally Casswell of New Zealand was set up by the former Director General of the WHO, Dr. Gro Brundtland, to advise her on alcohol related issues.

REGIONAL RESPONSE

The European Union is playing a leading role in addressing alcohol abuse, assisted by the World Health Organisation. The first European Alcohol Action Plan ran from 1992 to 1999 and has led to the development of country-based action plans on alcohol in half of the 33 countries. The member states are now implementing the second European Alcohol Action Plan 2000 – 2005. The Declaration on Young People and Alcohol (WHO 2001b) establishes an ambitious agenda for the European Union. It builds on the principles of the European Charter on Alcohol by outlining targets that should be achieved by 2006, promotes a series of effective policy measures and establishes a broad process to implement the strategies and achieve the targets.

SUGGESTED ACTION BY IFNGO MEMBERS INDIVIDUALLY

In any response to alcohol abuse, there is a need for a multifaceted approach. The World Health Organisation has called on all Governments to adopt comprehensive national programs to prevent alcohol related problems and improve their monitoring of alcohol consumption and related problems.

IFNGO member Organisations have a critical role to play in both advocating for the adoption of comprehensive alcohol abuse prevention and treatment programs and in providing services to people affected by the abuse of alcohol. A comprehensive approach would address such issues as:

prohibition - Most commonly this refers to restrictions on the sale of alcohol to young people, however in some countries alcohol has been completely prohibited. In other countries, some defined communities have agreed to prohibit the sale and consumption of alcohol in those communities.

licensing – In most countries, the sale and production of alcohol is heavily regulated. This has been shown to be successful in influencing consumption patterns and some of the harms associated with alcohol, such as violence outside of licensed premises.

taxation – Alcohol is a price sensitive product, and alcohol taxation can be used as leverage for reducing the consumption of alcoholic products or encouraging the consumption of less harmful products, such as low alcohol beer. In some countries, the revenue generated from taxation has been returned to alcohol abuse prevention and treatment programs.
restrictions on alcohol advertising and promotion – at least 37 countries have placed restrictions on some kind of alcohol advertising and promotion (WHO 2001). Advertising bans have been shown to correlate with fewer motor vehicle accidents.

Treatment - There is a need for a wide range of treatment options for alcohol dependent people. Brief interventions, and particularly assistance provided by general medical practitioners, have been shown to be a very effective mechanism for addressing alcohol abuse.

Legislation – Many countries lack proper legislation to: ensure continuity and integrate the diverse components of a multifaceted alcohol control programme; and restrict the activities of the alcohol industry in support of health measures.

SUGGESTED ACTION BY IFNGO COLLECTIVELY

The IFNGO should include the prevention of alcohol abuse as one of its priority areas. It should urge the Asian Ministers of Health/appropriate ministers to: take up with the World Health Organisation the development of an Asian Alcohol Action Plan; and follow up on the WHO SEARO consultation held in Bangkok in 1998 that drew up a Plan of Action for Alcohol Control for that region. The IFNGO should also assist members in advocating for the introduction of legislation and comprehensive alcohol abuse prevention and treatment programs through the sharing of information on good practice services.

The principles of the European Charter on Alcohol provide a set of values that deserve further consideration by IFNGO:
1. all people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption;
2. all people have the right to valid impartial information and education, starting early in life, on the consequences of alcohol consumption on health, the family and society;
3. all children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages;
4. all people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care; and
5. all people who do not wish to consume alcohol, or who cannot do so for health or other reasons, have the right to be safeguarded from pressures to drink and be supported in their non-drinking behaviour (WHO 2001b).

6. ILLICIT/PHARMACEUTICAL DRUGS

The continued supply of and demand for illicit drugs remains a major economic, social and political issue for the global community. Strong links between illicit drugs and their trafficking and terrorism has also threatened the sovereignty of many a nation. It is estimated that at least 100 000 people die each year from the abuse of illicit drugs. In addition to the death toll, the abuse of illicit drugs causes untold damage to communities through the destruction of families, corruption of public officials and violence and property crime.
The term illicit drugs covers a wide range of substances including heroin, cocaine, amphetamine type stimulants (including ecstasy), LSD, cannabis, inhalants and illicit use of pharmaceuticals such as benzodiazepines. Cannabis is by far the most used substance followed by amphetamine type stimulants and cocaine and heroin (UNDCP 2001).
It is estimated that approximately 180 million people use illicit drugs worldwide (4.2% of the population aged 15 and over). Of this figure, 144.1 million use cannabis and 28.7 million use amphetamine type stimulants. There has been a significant increase in the abuse of amphetamine type stimulants worldwide over the last five years, although the United Nations Office of Drugs and Crime (UNODC – formerly known as the United Nations Drug Control Program - UNDCP) has suggested that the peak in the use of these drugs in Western Europe may have passed and the situation is now stabilising (UNDCP 2001).

According to the UNODC, more countries are reporting declines than increases in the abuse of morphine, barbiturates, inhalants and LSD.

REGIONAL CONSUMPTION PATTERNS

There are very significant differences in consumption patterns across and within regions and between the different drugs. This makes comparison difficult.

The abuse of opiates is a major issue in most regions. In Europe, it accounts for more than 70% of all alcohol and other drug treatment demand. However, it should be noted that consumption patterns appear to be decreasing in Western Europe but increasing in Eastern Europe.

In Asia and Oceania, the abuse of heroin continues to increase. South East Asia is one of the major production areas for opiates and the supply is easily matched by demand. There have been some significant successes, however, in reducing the supply of opiates in recent years with the cultivation of the opium poppy in Vietnam reduced by 90% over the past decade, and a very significant reduction in Thailand (UNDCP 2000).

Data from the Americas region suggests that there continues to be an increase in the abuse of heroin, although the rate of increase appears to be slowing. There are believed to be approximately 1 million heroin abusers in the United States.
Data from Africa appears to suggest that the consumption of opiates is quite low, although it appears to be increasing. The International Narcotics Control Board has noted that civil war, poverty, HIV/AIDS, crime and corruption are strongly linked to the drug control problems in the region (INCB 2001).

GLOBAL RESPONSE

The international community has long been concerned about the abuse of illicit drugs, and there is now a significant international legal framework that shapes nations' responses to illicit drug issues.
the 1961 Single Convention on Narcotic Drugs codified the principal provisions of the various international instruments introduced since 1912.

the 1971 Convention on Psychotropic Substances extended international controls to synthetic hallucinogens, stimulants and sedatives. It differentiates between those substances that are completely prohibited except for very limited scientific and medical purposes, and those whose manufacture, distribution, trade and use are restricted to medical purposes.
the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances strengthens and enhances the legal means of international cooperation in criminal matters for suppressing the international criminal activities relating to the illicit traffic in drugs.

the 1998 Political Declaration on the Guiding Principles of Drug Demand Reduction provides the framework for global action on drug demand reduction.

While each of the international treaties are of critical importance in governing the operations of sovereign nations in addressing the abuse of illicit drugs, it is the 1998 Political Declaration on the Guiding Principles of Drug Demand Reduction that provides the basis for ongoing work for IFNGO members at both a national and international level.
Under the Declaration, member states of the United Nations recognised that demand reduction was an indispensable pillar in the global approach to countering the world drug problem and committed themselves to:

- introduce into their national programs the strategies set out in the Declaration;

- work closely with the UNODC to develop action-oriented strategies to assist in the implementation of the Declaration; and establish 2003 as a target date for new or enhanced drug demand reduction strategies and programs set up in close collaboration with public health, social welfare and law enforcement authorities.

Under the Declaration, member states have also agreed to undertake a sustained political, social, health and educational commitment to investing in demand reduction programs that contribute towards reducing public health problems, improving individual health and wellbeing, promoting social and economic integration, reinforcing family systems and making communities safer. The Action Plan for the Implementation of the Declaration on the Guiding Principles of Drug Demand Reduction seeks to provide a comprehensive and balanced approach involving demand and supply reduction, each reinforcing the other (UNGA 2000).

The Under-Secretary General of the United Nations for crime and drugs, Mr Pino Arlacchi, has said that "if we have one main task in sight as a world community in addressing the threat of drugs it is on the demand side: to reduce addiction. Beyond that, we all have to realise that long-term prevention is surely the best, and certainly the cheapest, strategy" (World Drug Report, 2000).

Forfeited Assets

The forfeiture of the assets of convicted drug traffickers provides a useful mechanism for preventing the continued use of those assets by people associated with the trafficker. It may also act as a deterrent to criminal behaviour by other people. In some countries, forfeited assets have been placed into a special fund to be redistributed to substance abuse prevention

and treatment programs. This should be supported by the IFNGO, and its individual members should advocate for specific funds to be established in their countries.

REGIONAL RESPONSE

Asia and the Pacific

The United Nations Economic and Social Commission for Asia and the Pacific resolution 51/10 on Regional Cooperation for the Eradication of the Demand for Drugs Subject to Abuse and Related Problems (2000) provides a framework for action in the region. Among other things, it calls on nations in the region to:

- establish national focal points on demand aspects of drug abuse control and to provide them with the requisite mandates and resources to enable them to discharge their duties effectively; and

- substantially promote their activities and methods for treatment and rehabilitation for drug abusers.

Importantly, it also invites all concerned non-governmental, private, voluntary and community-based Organisations to offer their facilities, and to work in close coordination with Governments in the region in the common effort to reduce the demand for drugs subject to abuse (ESCAP 1996).

The ASEAN and China Cooperative Operations in Response to Dangerous Drugs Accord, is a Plan of Action developed on 12 October 2000, which provides for four things:

- "Proactively advocating civic awareness on the dangers of drugs and social response;
- Building consensus and sharing best practices on demand reduction;
- Strengthening the rule of law by an enhanced network of control measures and improved law enforcement cooperation and legislative review; and
- Eliminating the supply of illicit drugs by boosting alternative development programs and community participation in the eradication of illicit crops". (ASEAN, 2000).

Europe

The European Union Drugs Strategy (2000-2004) and the accompanying Action Plan on Drugs provide a clear framework for European action to address the abuse of illicit drugs. It also provides a useful framework for consideration by other regional bodies (Council of the European Union, 2000).

SUGGESTED ACTION BY IFNGO MEMBERS INDIVIDUALLY

Individual IFNGO members could use the Political Declaration on the Guiding Principles of Drug Demand Reduction as a guide for their own services and their own advocacy work.
The Political Declaration states that a community wide participatory and partnership approach is crucial to the accurate assessment of the problem, the identification of viable solutions and the formulation and implementation of appropriate policies and programs. IFNGO members have a critical role to play in reducing demand.

SUGGESTED ACTION BY IFNGO COLLECTIVELY

The Political Declaration on the Guiding Principles of Drug Demand Reduction, and its accompanying Action Plan, provides a framework for action by the IFNGO. The IFNGO should give priority to reducing the demand for illegal drugs. It should endorse the Action Plan.

7. DRUG ABUSE RELATED INFECTIOUS DISEASES

The spread of HIV/AIDS and other blood borne virus's such as hepatitis B and C through unprotected sexual and injecting practices remains one of the most significant public health issues throughout the world, and it is an issue that must be addressed through drug abuse prevention programs.
PREVALENCE OF HIV/AIDS AND HEPATITIS B AND C
Approximately 36.1 million people throughout the world are living with HIV/AIDS (UNAIDS, 2001). It is estimated that 90% of all people with HIV/AIDS live in developing countries, with 75% of all people with HIV/AIDS living in sub-Saharan Africa. In the Asia/Pacific region, it is estimated that there are over 6 million people living with HIV/AIDS (UNAIDS and UNDCP, 2000).

As a recent UNAIDS/UNODC report has indicated, "drug use and HIV vulnerability remain issues of great concern for many countries in Asia and the Pacific because surveys indicate that in some geographical areas more than 60 per cent of all injecting drug users are HIV positive" (UNAIDS and UNDCP, 2000).

It is estimated that approximately 2 billion people worldwide are infected with the hepatitis B virus (HBV), and more than 350 million of these have chronic infections (WHO 2000a). Those with chronic HBV infections are at high risk from death due to liver disease, for example cirrhosis or cancer. The prevalence of hepatitis B in injecting drug using populations has been estimated to be 40-60%, but higher rates are not uncommon (WHO 1998).

Globally approximately 170 million people are chronically infected with hepatitis C (HCV) , a major cause of acute hepatitis and chronic liver disease, and it is estimated that there are 3 to 4 million new infections each year (WHO 2000b). Hepatitis C is one of the most prevalent infectious complications in injecting drug users worldwide, with 60-70% of injectors having antibodies to hepatitis C, although rates of 80-100% are not uncommon (WHO 1998). Approximately 20% of those with HCV will develop cirrhosis of the liver and a proportion of these will go on to develop liver failure or cancer (WHO 1998).

GLOBAL RESPONSE TO HIV/AIDS

The United Nations Declaration of Commitment on HIV/AIDS 'Global Crisis – Global Action" provides some direction for action on this critical issue. The Declaration is reproduced at Appendix G (UN 2001).

8. PRIORITY AREAS FOR FURTHER ACTION

This Policy Statement has outlined future directions for action by IFNGO members individually and for IFNGO as an Organisation.

The IFNGO acknowledges the enormous damage caused to nation states, communities and international society by the use of alcohol, tobacco and illicit drugs. Its aim is to prevent the problematic use of drugs.
The IFNGO also acknowledges that there are similar economic and social determinants for the misuse of alcohol, tobacco and illicit drugs. This means that drug abuse cannot be addressed in isolation, and must be accompanied by efforts to reduce poverty and promote sustainable development, retain young people in schools, improve mental health and improve employment opportunities.

Following are the key priority areas for action by IFNGO members individually and by the IFNGO collectively which relate to all drugs and to root causes of drug abuse:

EARLY RATIFICATION AND SIGNING OF THE WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL.

The FCTC was adopted by the World Health Assembly for ratification by member countries in May 2003 and a minimum of 40 countries have to ratify for its entry into force. This process must be expedited.

INCREASE THE INVESTMENT, INCLUDING FINANCIAL SUPPORT, IN PRIMARY PREVENTION AND EARLY INTERVENTION

In all nations, there needs to be a better balance between demand reduction and supply reduction. Primary prevention and early intervention are powerful, but underrated, ways to reduce the problems caused by alcohol, tobacco and other drugs.

INCREASE THE INVESTMENT, INCLUDING FUNDING, FOR DRUG ABUSE TREATMENT AND REHABILITATION SERVICES.

The provision of treatment and rehabilitation services has been shown to reduce the problems caused alcohol, tobacco and other drugs. It is important that there is the widest possible range of evidence based treatment options available to meet the needs of people with alcohol, tobacco and other drug problems. There also need to be services that deal with multiple problems, so that drug issues are not treated in isolation from other physical or mental health problems.

PROVIDE SUPPORT FOR FAMILIES.

Families remain the cornerstone of societies in all cultures throughout the world. It is important that families are provided with the economic and social resources such as education, spiritual guidance and life skills to strengthen the resilience against the use of alcohol, tobacco and other drug abuse. There must be adequate resources for employment, housing and support services. It is also important that families that are suffering from the consequences of drug abuse are assisted to cope with problems arising from drug use.

ENHANCE AND PROMOTE MORAL, ETHICAL AND SPIRITUAL VALUES.

Concepts of ethics and spirituality lie at the heart of all communities. These concepts provide the structure for decision-making and they provide the framework for determining needs, penalising and punishing illegal behaviour, and/or providing support and programs. Governments and citizens must take responsibility for actively enhancing and promoting positive moral, ethical and spiritual values.

DEVELOP MORE CULTURALLY APPROPRIATE PROGRAMS AND IMPLEMENT INDIGENOUS PROGRAMS.

Drug abuse transcends ethnic, geographical, political, cultural and religious boundaries but the responses to drug abuse must be tailored to reflect the cultural, religious and economic circumstances of a particular community. It must be recognised that there is no one single solution that can be transposed on particular communities. It is critical that communities have ownership of the programs that are being established in their communities.

IMPLEMENT GOOD PRACTICE DRUG RESEARCH, EVALUATION AND MONITORING PROGRAMS.

Research, evaluation and monitoring provides the basis for the provision of good practice services. Governments must support research programs that provide evidence of what works and doesn't work in drug abuse prevention and treatment. Governments and service providers must ensure that funded programs are properly evaluated and monitored to assess the implementation of the program and provide further evidence of what works and doesn't work.

PROMOTE EDUCATION AND ENHANCE TREAINING AND RESOURCING OF PROFESSIONAL, PARA PROFESSIONALS AND VOLUNTEERS FOR DRUG PREVENTION.

Paid and unpaid workers in the field of drug abuse prevention are the key to preventing and reducing drug abuse. Alcohol and other drug workers need to be recognised for their contribution to society. Paid workers should be properly remunerated for their very difficult work. Volunteers need to be rewarded with praise and ongoing support. Both volunteers and paid workers need to be properly trained, especially in life skills education, to ensure that they are providing the best possible service and to avoid harm to patients.

USE LEGISLATION, REGULATION, TAXATION AND FORFEITED ASSETS FOR EFFECTIVE RESOURCING OF DRUG ABUSE PREVENTION PROGRAMS.

Legislation, regulation and taxation are important mechanisms that governments can use to prevent and reduce the problems associated with drug abuse. Legislation should be used to control the possession and supply of illicit drugs, and to provide appropriate penalties where laws are broken. Legislation and regulation can also be used to control the supply and use of alcohol and tobacco, such as through bans on under age sales, licensing restrictions, and bans on smoking in public places.

The forfeiture of assets of drug traffickers can act as a deterrent to future criminal behaviour. Governments should channel the income received from forfeited assets back into drug abuse prevention and treatment programs.

FOSTER THE DEVELOPMENT AND IMPLEMENTATION OF SCHOOL AND WORKPLACE DRUG POLICIES.

Schools and workplaces are important places to intervene in people's lives to prevent drug abuse and related damage. Most people spend considerable time at school or work, and both places are significant influences on people's lives, so it makes sense to take advantage of these settings to promote positive health and lifestyle messages.

Effective school-based prevention and early intervention programs can prevent and address drug use by young people. Drug preventative education should involve the whole school community and, where possible, members of the broader community. Involving parents is particularly important, as they are role models for young people. School based programs should promote positive moral, ethical and spiritual values.

The use of alcohol and other drugs can have a significant impact on workplaces in terms of accidents, lost productivity and absenteeism. Workplace related factors, such as stress, can also lead to drug use. Alcohol and other drug abuse should be addressed as an occupational health and safety issue. Governments should encourage businesses to establish workplace alcohol and other drug policies.

URGE HEALTH MINISTERS/OTHER RELEVANT MINISTERS OF THE ASIA REGION AND THE WHO TO INSTITUTE AN ASIAN ALCOHOL ACTION PLAN.

The key target of the global alcohol industry is the Asia Pacific region. Based on the successes seen in Europe as a result of its Alcohol Action Plans, implemented with WHO assistance, a similar plan should be developed and implemented in the Asia Pacific region.

Appendix A

MEMBERSHIP OF IFNGO

The IFNGO Constitution provides for four (4) classes of membership:

- Founding Members.
- Ordinary Members.
- Associate Members.
- International & Regional Members.

At August 2003 there were 7 Founding Members, 27 Ordinary Members and 37 Associate Members, 11 International/Regional Organisations/Agencies, making a total of 82 Members from 39 Countries as follows: Australia, Bangladesh, Barbados, Brunei Darussalam, Cambodia, Canada, China, Egypt, Fiji, Germany, Greece, Hong Kong S.A.R. China, India, Indonesia, Italy, Japan, Korea, Macao S.A.R. China, Malaysia, Maldives, Malta, Mauritius, Myanmar, Nepal, New Zealand, Pakistan, Philippines, Portugal, Russia, Saudi Arabia, Singapore, South Africa, Spain, Sri Lanka, Sudan, Taiwan, Thailand, United States of America and Vietnam.
IFNGO MEMBER NATIONS BY REGIONS - 82 MEMBERS

Region	No of Members
Asia	57
Pacific	4
Europe	10
Africa	6
Americas	5

Appendix B

RELATIONSHIP OF IFNGO NGOS WITH THE UNITED NATIONS, REGIONAL AND INTERNATIONAL ORGANISATIONS AND GOVERNMENT COORDINATION ORGANISATIONS

IFNGO co-operates and collaborates with the following United Nations Specialized Agencies:

- United Nations Economic and Social Council (UN ECOSOC)
- United Nations Economic and Social Commission for Asia and the Pacific (UN ESCAP)
- United Nations World Health Organisation (UN W.H.O.)
- United Nations Educational, Scientific and Cultural Organisation (UNESCO)
- United Nations International Labour Organisation (UN I.L.O.)

IFNGO cooperates and collaborates regionally with:

Association of South East Asian Nations (ASEAN) Secretariat
South Asian Association for Regional Cooperation (SAARC) Secretariat
The Colombo Plan Secretariat – Drug Advisory Program
The IFNGO also cooperates and collaborates with national governments through IFNGO Affiliates in 36 Countries.

RELATIONSHIPS WITH REGIONAL AND INTERNATIONAL NGO's

IFNGO has collaborative strategies with the following IFNGO Members:

- World Islamic Association for Mental Health (WIAMH).
- World Assembly of Muslim Youth (WAMY).
- South Asian Federation of NGOs for the Prevention of Drug and Substance Abuse (SAFNGO).
- International Organisation of Good Templars (IOGT) Regional Council for South & South East Asia.

IFNGO has cross-membership with the following international NGOs/Regional Agencies:

- Asia & Pacific Family Organisations (APFO).
- Asian Federation of Therapeutic Communities (AFTC).
- Asia Pacific NGO for the Prevention of Drug & Substance Abuse (ASPAC-NGO).
- RAINBOW International Association against Drugs.

IFNGO has action strategies with the following international NGO's

- International Council on Alcohol and Addictions (ICAA)
- Parents' Resource Institute for Drug Education (PRIDE)
- International Organisation of Good Templars (IOGT)
- Drug Prevention Network of the Americas (DPNA)
- Drug Free America Foundation (DFAF)
- Prevention Through Service Alliance (PTSA)
- Global Network Coordinating Committee
- European Cities Against Drug Abuse
- Worldview Foundation
- International Narcotics Enforcement Officers Association (INEOA).
- International Non-Government Coalition Against Tobacco (INGCAT).

Appendix C

RECOMMENDATIONS OF 10TH IFNGO-ASEAN NGOS WORKSHOP,
26-29 APRIL 2000, BANGKOK, THAILAND
THEME: ASEAN SOLIDARITY ON THE PREVENTION OF DRUG AND SUBSTANCE ABUSE

RECOMMENDATION 1

To consolidate ASEAN solidarity, ASEAN-NGOs should re-dedicate themselves to be fully involved in the relevant ASEAN and ASEAN-NGO activities and forums. Develop structure, mechanism and program to enhance ASEAN-NGO relevancy, effectiveness and cohesiveness.

RECOMMENDATION 2

ASEAN NGOs should re-dedicate themselves to implement Youth Exchange Programmes on Drug Abuse Prevention and Youth Empowerment.

RECOMMENDATION 3

ASEAN NGOs should focus attention and advocate global concern on the connection between war, armament and illicit drug trade.

RECOMMENDATION 4

ASEAN Senior Officials on Drug Matters Meeting and IFNGO ASEAN NGOs Workshop should work more closely together for greater government and non-government co-operation and collaboration.

RECOMMENDATION 5

ASEAN Member Countries should exchange legislation on drug control to harmonize prevention and control of drug abuse in the ASEAN Region.

RECOMMENDATION 6

ASEAN Member Countries are urged to promote the setting up within existing facilities e.g. Institutions of Higher Learning, Comprehensive-Multidisciplinary Training Centres on Drug Abuse Prevention, Control and Research.

RECOMMENDATION 7

That IFNGO creates an ASEAN-NGO Clearinghouse on the Prevention of Drug Abuse, Treatment, Rehabilitation and Research.

That this Clearinghouse includes links to NGOs, Government sites and other quality information sites.
That an Alumni of workshop participants be established to provide ongoing support, information and encouragement to increase the use of computers by IFNGO Affiliates. PEMADAM Malaysia to act as Convener.
That the key role of IFNGO Affiliates in the prevention of drug and substance abuse be the guiding principle behind improving IFNGO's use of information and information technology.

RECOMMENDATION 8

UN Agencies and ASEAN Secretariat should act as role models and advocate, persuade and encourage government Organisations to support and collaborate with NGOs.

RECOMMENDATION 9

We support the ASEAN Foreign Minister Joint Declaration for a Drug-Free ASEAN and urge the establishment of programs to tackle the growing problems of Amphetamine-Type Stimulants - ATS.

RECOMMENDATION 10

Urge ASEAN Mass-Media to introduce Social-Responsibility Media Programs to:

Promote appropriate moral, social and religious values.
Promote alternative activities for youth and society.
Avoid distasteful sensational presentations.
ASEAN NGOs should initiate public recognition for innovative social responsible media programs

RECOMMENDATION 11

ASEAN Governments are urged to exclude the "Gateway-Drugs" of alcohol and tobacco from proposed Tax Incentives under AFTA – ASEAN FREE TRADE AREA. Gateway-Drugs should not be granted duty-free status in Tax-Free shops.

ASEAN NGOs should implement early primary prevention programs for "Gateway-Drugs".

RECOMMENDATION 12

ASEAN Families are urged to preserve traditional eastern values with parents as positive role models inculcating religious foundations with the right moral values for a stable family environment.

RECOMMENDATION 13

The theme of the next IFNGO ASEAN NGOs Workshop should focus on Primary Prevention.

Appendix D

RECOMMENDATIONS OF 11th IFNGO ASEAN NGOs'WORKSHOP 13th - 16th SEPTEMBER 2001, BANDA SERI BEGAWAN, BRUNEI DARUSSALAM.

Theme: New Dimension in Drug Abuse Prevention

11.1 The 11th IFNGO ASEAN NGOs Workshop formally adopts the Keynote Message of Her Royal Highness Pengiran Isteri Hajah Mariam Binti Hj Abdul Aziz that the task of preventing the widespread use of "Gateway Drugs" should not only be addressed with the formulation of policies or strategies. It should be complemented with continuous research and studies by academics, professionals, think-tanks as well as through the involvement of the youth themselves.

11.2 ASEAN NGOs should lobby their respective Governments to channel a proportion of the tobacco and alcohol tax and excise duties to support NGO programs for Prevention of Tobacco and Alcohol Use.

11.3 IFNGO ASEAN NGOs pledge full support for the WHO draft for FCTC Framework Convention on Tobacco Control, and to lobby their respective governments to endorse the F.C.T.C.

11.4 The sponsorship by tobacco and alcohol industries of cultural, sports and social events should be banned. Respective governments are urged to provide financial support for such events, or alternatively, to find substitute sponsors.

11.5 IFNGO ASEAN NGOs should initiate serious dialogues with sports Organisations and sports personalities to realize the UN IDADAIT Theme 2001 (United Nations International Day Against Drug Abuse and Illicit Trafficking) of "SPORTS AGAINST DRUGS"

11.6 IFNGO ASEAN NGOs support the drafting of an IFNGO Policy Statement to be circulated to all IFNGO affiliates for discussion and comment. The final draft of IFNGO Policy Statement should be tabled for deliberation at the 19th IFNGO International Conference in Dhaka, Bangladesh, 12th - 16th December, 2002

11.7 Family members and loved ones who are "Silent Sufferers" should be assisted and encouraged to form informal groups or clubs to support each other

11.8 ASEAN NGOs should highlight the plight of the "Silent Sufferers" as well as the need to prevent family violence.

11.9 Drug preventive education should be intensively provided to families so that they are sensitive and aware of the acts of violence related to alcohol, drug and substance abuse

11.10 ASEAN NGOs urge families and religious groups to inculcate parental love and religious values as well as to provide guidance in their efforts to prevent drug abuse

11.11 ASEAN NGOs advocate enhancement of public awareness on the social, economic and health dangers of Illicit Drugs, Tobacco and Alcohol Abuse, and their impact on the quality of health and quality of life of the afflicted individuals and their families.

11.12 Therapeutic, rehabilitative, and counseling programs should be intensified to provide hope and quality of life for the afflicted individuals and their families.

11.13 ASEAN NGOs urge their respective governments to step up preventive efforts in Demand Reduction and Primary Prevention, and to mobilize religious, social, and civil societies to address the pervasive problems of Alcohol, Tobacco, Amphetamine-Type Stimulants (A.T.S.) and other Illicit Drugs.

11.14 ASEAN NGOs take cognizance of the increasing threat of “Gateway Drugs” and A.T.S. and urge parents, families, religious groups, and communities, to lay the foundations of early “immunization” and protection to ensure the healthy and productive future of adolescents and youth.

11.15 IFNGO ASEAN NGOs pledge total support to all ASEAN governments to instill a sense of urgency to ensure a Drug-Free ASEAN by the year 2015.

11.16 ASEAN NGOs urge the United Nations Special Session on Children in the Year 2001, with theme of “SAY YES FOR CHILDREN”, to include the impending threat of “Drug and Substance Abuse” in the Plan of Action so as to ensure the healthy and wholesome future of the new generation.

11.17 IFNGO ASEAN NGOs should make its presence felt at international fora.

11.18 To ensure effective follow-up action to implement IFNGO ASEAN NGOs’ Workshop recommendations, each ASEAN NGO should appoint an Implementation Task Force of Volunteers.

Appendix E

RECOMMENDATIONS OF THE 12TH IFNGO ASEAN N.G.O.s WORKSHOP, 7-9 OCTOBER, 2002, MANILA, PHILIPPINES.

THEME: MAXIMIZING THE UTILIZATION OF INDIGENOUS SPORTS AND THE ARTS AS ALTERNATIVE STRATEGIES FOR DRUG ABUSE PREVENTION.

1. There must be a specific policy statement by ASEAN NGOs on the issue of the utilization of indigenous sports and the arts as alternative strategies for drug and substance abuse prevention.

2. The involvement of members of the community is critical, whether t hey be community or political leaders or famous personalities such as artists. Strategies employed must be creative and able to attract youth. These programs and strategies must be monitored, evaluated and documented.

3. The programmes developed must contain the elements of socialization, recreation and discipline. The implementation need to be holistic in nature.

4. Publicity is essential to create public awareness. Public and government support can be garnered through adequate publicity.

5. NGOs must be involved and the will to succeed must prevail if the relevant and accredited programmes are to be successfully implemented.

6. The ASEAN Region must deliberately support and promote ASEAN indigenous sports and the arts through annual festivals at national and ASEAN levels.

7. ASEAN NGOs must promote and provide opportunities to involve the youth in indigenous sports and the arts. In future deliberations, the participation of the youth and their views need to be taken into consideration.

Appendix F

“WAY FORWARD” FROM THE 18TH INTERNATIONAL IFNGO CONFERENCE,
BRISBANE, AUSTRALIA, JULY 2000.
WAY FORWARD – TOWARDS MORE EVIDENCE –BASED RESEARCH & BASELINE INFORMATION.

The focus on research, rather than on community workers’ projects, and on Australian projects to provide the basis for new learnings. Nothing is learnt, if nothing is applied; and research gives us the basis to apply new learnings.
WAY FORWARD – A SHIFT IN FOCUS FROM ILLICIT TO LICIT – ALCOHOL AND TOBACCO.

Many countries do not focus enough on licit drugs and this needs to change, so alcohol and tobacco prevention should have a greater focus.
WAY FORWARD – DEVELOPMENT OF COMMUNITY- BASED BEST PRACTICE MODELS.

It is important not merely to continue doing what we have always done, but to ensure we use best practice for community action, and good models for community development. Some excellent models of best practice must be widely shared.
WAY FORWARD – CULTURALLY APPROPRIATE METHODS ESPECIALLY FOR INDIGENOUS PEOPLES.

Many of our IFNGO member countries have indigenous peoples, yet the planning and implementation of projects affecting them have been undertaken without the cooperation of the indigenous peoples. We must involve them to ensure that the methods will have the potential to succeed; we must do better.
WAY FORWARD – IMPLEMENT INDIGENOUS POLICIES.

There has been a little progress since the 1986 IFNGO Conference in Sydney in developing a national indigenous alcohol and other substance abuse policy, recommending comprehensive programs including public health promotion, training and education of workers. We must not accept another 14 years delay in resourcing and implementing programs with the potential to reduce drug problems among indigenous peoples.
WAY FORWARD – LINK DRUG PROBLEMS WITH WIDER DEVELOPMENT.

Drug problems are strongly linked with development problems. We must work to ensure that employment, housing, economic development, social support, etc. are all addressed. If we deal with some of the root causes of drug abuse we will go some way towards reducing drug problems.
WAY FORWARD – LINK EPIDEMIOLOGY WITH ETHNOGRAPHY.

It is important to study health outcomes from morbidity and mortality data, and to link this with the drug problems and risk factors for specific populations. It is important to target programs and activities specifically.
WAY FORWARD – FOCUS ON PREVENTION.

There is insufficient effort towards good practice preventive programs and resourcing them at a level where they will be effective. E.g. health promotion and early intervention programs. There is a need for IFNGO Affiliates to take a stronger role in urging governments to give greater priority to financial incentives and legislation as key preventive measures. This includes allocating a percentage of excise monies to alcohol and tobacco demand reduction, and legislation to restrict and ultimately to ban advertising and promotion of alcohol, tobacco and other drugs.
WAY FORWARD – LINK WITH SPIRITUAL VALUES.

Although organized religion is not overt in Drug Prevention programs, the point was made that people's values and beliefs were a part of decision-making process in counseling and education relating to preventive, treatment and rehabilitative programs. Spiritual values existed in most programs as part of the holistic approach to health (physical, mental, social and spiritual). We must ensure the spiritual side is not forgotten.
WAY FORWARD – LEARN FROM OTHER COUNTRIES AND MODIFY.

The point was made that many of the learnings were transferable to other settings, but that some would need to be modified. There is something of value in most approaches that can be used.
WAY FORWARD – PRE AND POST CONFERENCE WORKSHOPS.

The small number of delegates who attended the pre-conference workshops found it extremely valuable. It was recommended that pre and post conference workshops should be a regular feature of IFNGO in future.
WAY FORWARD – SIX MONTHLY IFNGO NEWSLETTER AND A WEBSITE.

ADCA has agreed to produce the next IFNGO newsletter to circulate by e-mail (and then possibly it could be produced each 6 months). Hard copies will be printed and circulated by the IFNGO Secretariat in Malaysia. It was suggested that this was overdue and that IFNGO also needs to develop a website.
WAY FORWARD – LEADERSHIP- ADVOCATING POLICIES (IFNGO POLICY STATEMENT) AND IMPLEMENTING BEST PRACTICE.

Comment was made that there was not sufficient leadership from IFNGO. We need to have strong policies that we advocate jointly and cooperatively. IFNGO delegates were very impressed with ADCA's Drug Policy 2000, and would like to use that as a model in developing an IFNGO Policy Statement.
WAY FORWARD – CONFERENCE ACTION PLAN AND ITS MONITORING.

It was stated that IFNGO needs to be very proactive in furthering the "ways forward" proposed, and monitor actions relating to these on a regular basis.

Appendix G

United Nations Declaration of Commitment on HIV/AIDS
"Global Crisis - Global Action"

1. We, Heads of State and Government and Representatives of States and Governments, assembled at the United Nations, from 25 to 27 June 2001, for the twenty-sixth special session of the General Assembly convened in accordance with resolution 55/13, as a matter of urgency, to review and address the problem of HIV/AIDS in all its aspects as well as to secure a global commitment to enhancing coordination and intensification of national, regional and international efforts to combat it in a comprehensive manner;

2. Deeply concerned that the global HIV/AIDS epidemic, through its devastating scale and impact, constitutes a global emergency and one of the most formidable challenges to human life and dignity, as well as to the effective enjoyment of human rights, which undermines social and economic development throughout the world and affects all levels of society — national, community, family and individual;

3. Noting with profound concern, that by the end of the year 2000, 36.1 million people worldwide were living with HIV/AIDS, 90 per cent in developing countries and 75 per cent in sub-Saharan Africa;

4. Noting with grave concern that all people, rich and poor, without distinction of age, gender or race are affected by the HIV/AIDS epidemic, further noting that people in developing countries are the most affected and that women, young adults and children, in particular girls, are the most vulnerable;

5. Concerned also that the continuing spread of HIV/AIDS will constitute a serious obstacle to the realization of the global development goals we adopted at the Millennium Summit;

6. Recalling and reaffirming our previous commitments on HIV/AIDS made through:

The United Nations Millennium Declaration of 8 September 2000;

The Political Declaration and Further Actions and Initiatives to Implement the Commitments made at the World Summit for Social Development of 1 July 2000;

The Political Declaration and Further Action and Initiatives to Implement the Beijing Declaration and Platform for Action of 10 June 2000;

Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development of 2 July 1999;

The regional call for action to fight HIV/AIDS in Asia and the Pacific of 25 April 2001;

The Abuja Declaration and Framework for Action for the Fight Against HIV/ AIDS, Tuberculosis and other Related Infectious Diseases in Africa, 27 April 2001;

The Declaration of the Ibero-America Summit of Heads of State of November 2000 in Panama;
The Caribbean Partnership Against HIV/AIDS, 14 February, 2001;

The European Union Programme for Action: Accelerated Action on HIV/ AIDS, Malaria and Tuberculosis in the Context of Poverty Reduction of 14 May 2001;

The Baltic Sea Declaration on HIV/AIDS Prevention of 4 May 2000;

The Central Asian Declaration on HIV/AIDS of 18 May 2001;

7. Convinced of the need to have an urgent, coordinated and sustained response to the HIV/AIDS epidemic, which will build on the experience and lessons learned over the past 20 years;

8. Noting with grave concern that Africa, in particular sub-Saharan Africa, is currently the worst affected region where HIV/AIDS is considered as a state of emergency, which threatens development, social cohesion, political stability, food security and life expectancy and imposes a devastating economic burden and that the dramatic situation on the continent needs urgent and exceptional national, regional and international action;

9. Welcoming the commitments of African Heads of State or Government, at the Abuja Special Summit in April 2001, particularly their pledge to set a target of allocating at least 15 per cent of their annual national budgets for the improvement of the health sector to help address the HIV/AIDS epidemic; and recognizing that action to reach this target, by those countries whose resources are limited, will need to be complemented by increased international assistance;

10. Recognizing also that other regions are seriously affected and confront similar threats, particularly the Caribbean region, with the second highest rate of HIV infection after sub-Saharan Africa, the Asia-Pacific region where 7.5 million

people are already living with HIV/AIDS, the Latin America region with 1.5 million people living with HIV/AIDS, and the Central and Eastern European region with very rapidly rising infection rates; and that the potential exists for a rapid escalation of the epidemic and its impact throughout the world if no specific measures are taken;

11. Recognizing that poverty, underdevelopment and illiteracy are among the principal contributing factors to the spread of HIV/AIDS and noting with grave concern that HIV/AIDS is compounding poverty and is now reversing or impeding development in many countries and should therefore be addressed in an integrated manner;

12. Noting that armed conflicts and natural disasters also exacerbate the spread of the epidemic;

13. Noting further that stigma, silence, discrimination, and denial, as well as lack of confidentiality, undermine prevention, care and treatment efforts and increase the impact of the epidemic on individuals, families, communities and nations and must also be addressed;

14. Stressing that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS;

15. Recognizing that access to medication in the context of pandemics such as HIV/AIDS is one of the fundamental elements to achieve progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health;

16. Recognizing that the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic, including in the areas of prevention, care, support and treatment, and that it reduces vulnerability to HIV/AIDS and prevents stigma and related discrimination against people living with or at risk of HIV/AIDS;

17. Acknowledging that prevention of HIV infection must be the mainstay of the national, regional and international response to the epidemic; and that prevention, care, support and treatment for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the epidemic;

18. Recognizing the need to achieve the prevention goals set out in this Declaration in order to stop the spread of the epidemic and acknowledging that all countries must continue to emphasize widespread and effective prevention, including awareness-raising campaigns through education, nutrition, information and health-care services;

19. Recognizing that care, support and treatment can contribute to effective prevention through increased acceptance of voluntary and confidential counselling and testing, and by keeping people living with HIV/AIDS and vulnerable groups in close contact with health-care systems and facilitating their access to information, counselling and preventive supplies;

20. Emphasizing the important role of cultural, family, ethical and religious factors in the prevention of the epidemic, and in treatment, care and support, taking into account the particularities of each country as well as the importance of respecting all human rights and fundamental freedoms;

21. Noting with concern that some negative economic, social, cultural, political, financial and legal factors are hampering awareness, education, prevention, care, treatment and support efforts;

22. Noting the importance of establishing and strengthening human resources and national health and social infrastructures as imperatives for the effective delivery of prevention, treatment, care and support services; 23. Recognizing that effective prevention, care and treatment strategies will require behavioural changes and increased availability of and non-discriminatory access to, inter alia, vaccines, condoms, microbicides, lubricants, sterile injecting equipment, drugs including anti-retroviral therapy, diagnostics and related technologies as well as increased research and development;

24. Recognizing also that the cost availability and affordability of drugs and related technology are significant factors to be reviewed and addressed in all aspects and that there is a need to reduce the cost of these drugs and technologies in close collaboration with the private sector and pharmaceutical companies;

25. Acknowledging that the lack of affordable pharmaceuticals and of feasible supply structures and health systems continue to hinder an effective response to HIV/AIDS in many countries, especially for the poorest people and recalling efforts to make drugs available at low prices for those in need;

26. Welcoming the efforts of countries to promote innovation and the development of domestic industries consistent with international law in order to increase access to medicines to protect the health of their populations; and noting that the impact of international trade agreements on access to or local manufacturing of, essential drugs and on the development of new drugs needs to be further evaluated;

27. Welcoming the progress made in some countries to contain the epidemic, particularly through: strong political commitment and leadership at the highest levels, including community leadership; effective use of available resources and traditional medicines; successful prevention, care, support and treatment strategies; education and information initiatives; working in partnership with communities, civil society, people living with HIV/AIDS and vulnerable groups; and

the active promotion and protection of human rights; and recognizing the importance of sharing and building on our collective and diverse experiences, through regional and international cooperation including North/South, South/South cooperation and triangular cooperation;

28. Acknowledging that resources devoted to combating the epidemic both at the national and international levels are not commensurate with the magnitude of the problem;

29. Recognizing the fundamental importance of strengthening national, regional and subregional capacities to address and effectively combat HIV/AIDS and that this will require increased and sustained human, financial and technical resources through strengthened national action and cooperation and increased regional, subregional and international cooperation;

30. Recognizing that external debt and debt-servicing problems have substantially constrained the capacity of many developing countries, as well as countries with economies in transition, to finance the fight against HIV/AIDS;

31. Affirming the key role played by the family in prevention, care, support and treatment of persons affected and infected by HIV/AIDS, bearing in mind that in different cultural, social and political systems various forms of the family exist;

32. Affirming that beyond the key role played by communities, strong partnerships among Governments, the United Nations system, intergovernmental Organisations, people living with HIV/AIDS and vulnerable groups, medical, scientific and educational institutions, non-governmental Organisations, the business sector including generic and research-based pharmaceutical companies, trade unions, media, parliamentarians, foundations, community Organisations, faith-based Organisations and traditional leaders are important;

33. Acknowledging the particular role and significant contribution of people living with HIV/AIDS, young people and civil society actors in addressing the problem of HIV/AIDS in all its aspects and recognizing that their full involvement and participation in design, planning, implementation and evaluation of programmes is crucial to the development of effective responses to the HIV/AIDS epidemic;

34. Further acknowledging the efforts of international humanitarian Organisations combating the epidemic, including among others the volunteers of the International Federation of Red Cross and Red Crescent Societies in the most affected areas all over the world;

35. Commending the leadership role on HIV/AIDS policy and coordination in the United Nations system of the UNAIDS Programme Coordinating Board; noting its endorsement in December 2000 of the Global Strategy Framework for HIV/AIDS, which could assist, as appropriate, Member States and relevant civil society actors in the development of HIV/AIDS strategies, taking into account the particular context of the epidemic in different parts of the world;

36. Solemnly declare our commitment to address the HIV/AIDS crisis by taking action as follows, taking into account the diverse situations and circumstances in different regions and countries throughout the world;

Leadership

Strong leadership at all levels of society is essential for an effective response to the epidemic

Leadership by Governments in combating HIV/AIDS is essential and their efforts should be complemented by the full and active participation of civil society, the business community and the private sector

Leadership involves personal commitment and concrete actions

At the national level

37. By 2003, ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that: address the epidemic in forthright terms; confront stigma, silence and denial; address gender and age-based dimensions of the epidemic; eliminate discrimination and marginalization; involve partnerships with civil society and the business sector and the full participation of people living with HIV/AIDS, those in vulnerable groups and people mostly at risk, particularly women and young people; are resourced to the extent possible from national budgets without excluding other sources, inter alia international cooperation; fully promote and protect all human rights and fundamental freedoms, including the right to the highest attainable standard of physical and mental health; integrate a gender perspective; and address risk, vulnerability, prevention, care, treatment and support and reduction of the impact of the epidemic; and strengthen health, education and legal system capacity;

38. By 2003, integrate HIV/AIDS prevention, care, treatment and support and impact mitigation priorities into the mainstream of development planning, including in poverty eradication strategies, national budget allocations and sectoral development plans;

At the regional and subregional level

39. Urge and support regional Organisations and partners to: be actively involved in addressing the crisis; intensify regional, subregional and interregional cooperation and coordination; and develop regional strategies and responses in support of expanded country level efforts;

40. Support all regional and subregional initiatives on HIV/AIDS including: the International Partnership against AIDS in Africa (IPAA) and the ECA-African Development Forum Consensus and Plan of Action: Leadership to Overcome HIV/ AIDS; the Abuja Declaration and Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and Other Diseases; the CARICOM Pan-Caribbean Partnership Against HIV/AIDS; the ESCAP Regional Call for Action to Fight HIV/ AIDS in Asia and the Pacific; the Baltic Sea Initiative and Action Plan; the Horizontal Technical Cooperation Group on HIV/AIDS in Latin America and the Caribbean; the European Union Programme for Action: Accelerated Action on HIV/AIDS, Malaria and Tuberculosis in the context of poverty reduction;

41. Encourage the development of regional approaches and plans to address HIV/AIDS;

42. Encourage and support local and national Organisations to expand and strengthen regional partnerships, coalitions and networks;

43. Encourage the United Nations Economic and Social Council to request the regional commissions within their respective mandates and resources to support national efforts in their respective regions in combating HIV/AIDS;

At the global level

44. Support greater action and coordination by all relevant United Nations system Organisations, including their full participation in the development and implementation of a regularly updated United Nations strategic plan for HIV/AIDS, guided by the principles contained in this Declaration;

45. Support greater cooperation between relevant United Nations system Organisations and international Organisations combating HIV/AIDS;

46. Foster stronger collaboration and the development of innovative partnerships between the public and private sectors and by 2003, establish and strengthen mechanisms that involve the private sector and civil society partners and people living with HIV/AIDS and vulnerable groups in the fight against HIV/AIDS;

Prevention

Prevention must be the mainstay of our response

47. By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 per cent and by 25 per cent globally by 2010, and to intensify efforts to achieve these targets as well as to challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys;

48. By 2003, establish national prevention targets, recognizing and addressing factors leading to the spread of the epidemic and increasing people's vulnerability, to reduce HIV incidence for those identifiable groups, within particular local contexts, which currently have high or increasing rates of HIV infection, or which available public health information indicates are at the highest risk for new infection;

49. By 2005, strengthen the response to HIV/AIDS in the world of work by establishing and implementing prevention and care programmes in public, private and informal work sectors and take measures to provide a supportive workplace environment for people living with HIV/AIDS;

50. By 2005, develop and begin to implement national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services;

51. By 2003, implement universal precautions in health-care settings to prevent transmission of HIV infection;

52. By 2005, ensure: that a wide range of prevention programmes which take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections;

53. By 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection; in full partnership with youth, parents, families, educators and health-care providers;

54. By 2005, reduce the proportion of infants infected with HIV by 20 per cent, and by 50 per cent by 2010, by: ensuring that 80 per cent of pregnant women accessing antenatal care have information, counselling and other HIV prevention services available to them, increasing the availability of and by providing access for HIV-infected women and babies to effective treatment to reduce mother-to-child transmission of HIV, as well as through effective interventions for HIV-infected women, including voluntary and confidential counselling and testing, access to treatment, especially anti-retroviral therapy and, where appropriate, breast milk substitutes and the provision of a continuum of care;

Care, support and treatment

Care, support and treatment are fundamental elements of an effective response.

55. By 2003, ensure that national strategies, supported by regional and international strategies, are developed in close collaboration with the international community, including Governments and relevant intergovernmental Organisations as well as with civil society and the business sector, to strengthen health care systems and address factors affecting the provision of HIV-related drugs, including anti-retroviral drugs, inter alia affordability and pricing, including differential pricing, and technical and health care systems capacity. Also, in an urgent manner make every effort to: provide progressively and in a sustainable manner, the highest attainable standard of treatment for HIV/AIDS, including the prevention and treatment of opportunistic infections, and effective use of quality-controlled anti-retroviral therapy in a careful and monitored manner to improve adherence and effectiveness and reduce the risk of developing resistance; to cooperate constructively in strengthening pharmaceutical policies and practices, including those applicable to generic drugs and intellectual property regimes, in order further to promote innovation and the development of domestic industries consistent with international law;

56. By 2005, develop and make significant progress in implementing comprehensive care strategies to: strengthen family and community-based care including that provided by the informal sector, and health care systems to provide and monitor treatment to people living with HIV/AIDS, including infected children, and to support individuals, households, families and communities affected by HIV/ AIDS; improve the capacity and working conditions of health care personnel, and the effectiveness of supply systems, financing plans and referral mechanisms required to provide access to affordable medicines, including anti-retroviral drugs, diagnostics and related technologies, as well as quality medical, palliative and psycho-social care;

57. By 2003, ensure that national strategies are developed in order to provide psycho-social care for individuals, families, and communities affected by HIV/AIDS;

HIV/AIDS and human rights

Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS

Respect for the rights of people living with HIV/AIDS drives an effective response

58. By 2003, enact, strengthen or enforce as appropriate legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups; in particular to ensure their access to, inter alia education, inheritance, employment, health care, social and health services, prevention, support, treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic;

59. By 2005, bearing in mind the context and character of the epidemic and that globally women and girls are disproportionately affected by HIV/AIDS, develop and accelerate the implementation of national strategies that: promote the advancement of women and women's full enjoyment of all human rights; promote shared responsibility of men and women to ensure safe sex; empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection;

60. By 2005, implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender sensitive framework;

61. By 2005, ensure development and accelerated implementation of national strategies for women's empowerment, promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;

Reducing vulnerability

The vulnerable must be given priority in the response

Empowering women is essential for reducing vulnerability

62. By 2003, in order to complement prevention programmes that address activities which place individuals at risk of HIV infection, such as risky and unsafe sexual behaviour and injecting drug use, have in place in all countries strategies, policies and programmes that identify and begin to address those factors that make individuals particularly vulnerable to HIV infection, including underdevelopment, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection, all types of sexual exploitation of women, girls and boys, including for commercial reasons; such strategies, policies and programmes should address the gender dimension of the epidemic, specify the action that will be taken to address vulnerability and set targets for achievement;

63. By 2003, develop and/or strengthen strategies, policies and programmes, which recognize the importance of the family in reducing vulnerability, inter alia, in educating and guiding children and take account of cultural, religious and ethical factors, to reduce the vulnerability of children and young people by: ensuring access of both girls and boys to primary and secondary education, including on HIV/AIDS in curricula for adolescents; ensuring safe and secure environments, especially for young girls; expanding good quality youth-friendly information and sexual health education and counselling service; strengthening reproductive and sexual health programmes; and involving families and young people in planning, implementing and evaluating HIV/AIDS prevention and care programmes, to the extent possible;

64. By 2003, develop and/or strengthen national strategies, policies and programmes, supported by regional and international initiatives, as appropriate, through a participatory approach, to promote and protect the health of those identifiable groups which currently have high or increasing rates of HIV infection or which public health information indicates are at greatest risk of and most vulnerable to new infection as indicated by such factors as the local history of the epidemic, poverty, sexual practices, drug using behaviour, livelihood, institutional location, disrupted social structures and population movements forced or otherwise;

Children orphaned and made vulnerable by HIV/AIDS

Children orphaned and affected by HIV/AIDS need special assistance

65. By 2003, develop and by 2005 implement national policies and strategies to: build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS including by providing appropriate counselling and psycho-social support; ensuring their enrolment in school and access to shelter, good nutrition, health and social services on an equal basis with other children; to protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;

66. Ensure non-discrimination and full and equal enjoyment of all human rights through the promotion of an active and visible policy of de-stigmatization of children orphaned and made vulnerable by HIV/AIDS;

67. Urge the international community, particularly donor countries, civil society, as well as the private sector to complement effectively national programmes to support programmes for children orphaned or made vulnerable by HIV/AIDS in affected regions, in countries at high risk and to direct special assistance to sub-Saharan Africa;

Alleviating social and economic impact

To address HIV/AIDS is to invest in sustainable development

68. By 2003, evaluate the economic and social impact of the HIV/AIDS epidemic and develop multisectoral strategies to: address the impact at the individual, family, community and national levels; develop and accelerate the implementation of national poverty eradication strategies to address the impact of HIV/AIDS on household income, livelihoods, and access to basic social services, with special focus on individuals, families and communities severely affected by the epidemic; review the social and economic impact of HIV/AIDS at all levels of society especially on women and the elderly, particularly in their role as caregivers and in families affected by HIV/AIDS and address their special needs; adjust and adapt economic and social development policies, including social protection policies, to address the impact of HIV/AIDS on economic growth, provision of essential economic services, labour productivity, government revenues, and deficit-creating pressures on public resources;

69. By 2003, develop a national legal and policy framework that protects in the workplace the rights and dignity of persons living with and affected by HIV/AIDS and those at the greatest risk of HIV/AIDS in consultation with representatives of employers and workers, taking account of established international guidelines on HIV/AIDS in the workplace;

Research and development

With no cure for HIV/AIDS yet found, further research and development is crucial

70. Increase investment and accelerate research on the development of HIV vaccines, while building national research capacity especially in developing countries, and especially for viral strains prevalent in highly affected regions; in addition, support and encourage increased national and international investment in HIV/AIDS-related research and development including biomedical, operations, social, cultural and behavioural research and in traditional medicine to: improve prevention and therapeutic approaches; accelerate access to prevention, care and treatment and care technologies for HIV/AIDS (and its associated opportunistic infections and malignancies and sexually transmitted diseases), including female controlled methods and microbicides, and in particular, appropriate, safe and affordable HIV vaccines and their delivery, and to diagnostics, tests, methods to prevent mother-to-child transmission; and improve our understanding of factors which influence the epidemic and actions which address it, inter alia, through increased funding and public/private partnerships; create a conducive environment for research and ensure that it is based on highest ethical standards;

71. Support and encourage the development of national and international research infrastructure, laboratory capacity, improved surveillance systems, data collection, processing and dissemination, and training of basic and clinical researchers, social scientists, health-care providers and technicians, with a focus on the countries most affected by HIV/AIDS, particularly developing countries and those countries experiencing or at risk of rapid expansion of the epidemic;

72. Develop and evaluate suitable approaches for monitoring treatment efficacy, toxicity, side effects, drug interactions, and drug resistance, develop methodologies to monitor the impact of treatment on HIV transmission and risk behaviours;

73. Strengthen international and regional cooperation in particular North/South, South/South and triangular cooperation, related to transfer of relevant technologies, suitable to the environment in prevention and care of HIV/AIDS, the exchange of experiences and best practices, researchers and research findings and strengthen the role of UNAIDS in this process. In this context, encourage that the end results of these cooperative research findings and technologies be owned by all parties to the research, reflecting their relevant contribution and dependent upon their providing legal protection to such findings; and affirm that all such research should be free from bias;

74. By 2003, ensure that all research protocols for the investigation of HIV-related treatment including anti-retroviral therapies and vaccines based on international guidelines and best practices are evaluated by independent committees of ethics, in which persons living with HIV/AIDS and caregivers for anti-retroviral therapy participate;

HIV/AIDS in conflict and disaster affected regions

Conflicts and disasters contribute to the spread of HIV/AIDS.

75. By 2003, develop and begin to implement national strategies that incorporate HIV/AIDS awareness, prevention, care and treatment elements into programmes or actions that respond to emergency situations, recognizing that populations destabilized by armed conflict, humanitarian emergencies and natural disasters, including refugees, internally displaced persons and in particular, women and children, are at increased risk of exposure to HIV infection; and, where appropriate, factor HIV/AIDS components into international assistance programmes;

76. Call on all United Nations agencies, regional and international Organisations, as well as non-governmental Organisations involved with the provision and delivery of international assistance to countries and regions affected by conflicts, humanitarian crises or natural disasters, to incorporate as a matter of urgency HIV/AIDS prevention, care and awareness elements into their plans and programmes and provide HIV/AIDS awareness and training to their personnel;

77. By 2003, have in place national strategies to address the spread of HIV among national uniformed services, where this is required, including armed forces and civil defence force and consider ways of using personnel from these services who are educated and trained in HIV/AIDS awareness and prevention to assist with HIV/ AIDS awareness and prevention activities including participation in emergency, humanitarian, disaster relief and rehabilitation assistance;

78. By 2003, ensure the inclusion of HIV/AIDS awareness and training, including a gender component, into guidelines designed for use by defence personnel and other personnel involved in international peacekeeping operations while also continuing with ongoing education and prevention efforts, including pre-deployment orientation, for these personnel;

Resources

The HIV/AIDS challenge cannot be met without new, additional and sustained resources

79. Ensure that the resources provided for the global response to address HIV/AIDS are substantial, sustained and geared towards achieving results;

80. By 2005, through a series of incremental steps, reach an overall target of annual expenditure on the epidemic of between US$ 7 billion and US$ 10 billion in low and middle-income countries and those countries experiencing or at risk of experiencing rapid expansion for prevention, care, treatment, support and mitigation of the impact of HIV/AIDS, and take measures to ensure that needed resources are made available, particularly from donor countries and also from national budgets, bearing in mind that resources of the most affected countries are seriously limited;

81. Call on the international community, where possible, to provide assistance for HIV/AIDS prevention, care and treatment in developing countries on a grant basis;

82. Increase and prioritize national budgetary allocations for HIV/AIDS programmes as required and ensure that adequate allocations are made by all ministries and other relevant stakeholders;

83. Urge the developed countries that have not done so to strive to meet the targets of 0.7 per cent of their gross national product for overall official development assistance and the targets of earmarking of 0.15 per cent to 0.20 per cent of gross national product as official development assistance for least developed countries as agreed, as soon as possible, taking into account the urgency and gravity of the HIV/ AIDS epidemic;

84. Urge the international community to complement and supplement efforts of developing countries that commit increased national funds to fight the HIV/AIDS epidemic through increased international development assistance, particularly those countries most affected by HIV/AIDS, particularly in Africa, especially in sub-Saharan Africa, the Caribbean, countries at high risk of expansion of the HIV/AIDS epidemic and other affected regions whose resources to deal with the epidemic are seriously limited;

85. Integrate HIV/AIDS actions in development assistance programmes and poverty eradication strategies as appropriate and encourage the most effective and transparent use of all resources allocated;

86. Call on the international community and invite civil society and the private sector to take appropriate measures to help alleviate the social and economic impact of HIV/AIDS in the most affected developing countries;

87. Without further delay implement the enhanced Heavily Indebted Poor Country (HIPC) Initiative and agree to cancel all bilateral official debts of HIPC countries as soon as possible, especially those most affected by HIV/AIDS, in return for their making demonstrable commitments to poverty eradication and urge the use of debt service savings to finance poverty eradication programs, particularly for HIV/AIDS prevention, treatment, care and support and other infections;

88. Call for speedy and concerted action to address effectively the debt problems of least developed countries, low-income developing countries, and middle-income developing countries, particularly those affected by HIV/AIDS, in a comprehensive, equitable, development-oriented and durable way through various national and international measures designed to make their debt sustainable in the long term and thereby to improve their capacity to deal with the HIV/AIDS epidemic, including, as appropriate, existing orderly mechanisms for debt reduction, such as debt swaps for projects aimed at the prevention, care and treatment of HIV/AIDS;

89. Encourage increased investment in HIV/AIDS-related research, nationally, regionally and internationally, in particular for the development of sustainable and affordable prevention technologies, such as vaccines and microbicides, and encourage the proactive preparation of financial and logistic plans to facilitate rapid access to vaccines when they become available;

90. Support the establishment, on an urgent basis, of a global HIV/AIDS and health fund to finance an urgent and expanded response to the epidemic based on an integrated approach to prevention, care, support and treatment and to assist Governments inter alia in their efforts to combat HIV/AIDS with due priority to the most affected countries, notably in sub-Saharan Africa and the Caribbean and to those countries at high risk, mobilize contributions to the fund from public and private sources with a special appeal to donor countries, foundations, the business community including pharmaceutical companies, the private sector, philanthropists and wealthy individuals;

91. By 2002, launch a worldwide fund-raising campaign aimed at the general public as well as the private sector, conducted by UNAIDS with the support and collaboration of interested partners at all levels, to contribute to the global HIV/ AIDS and health fund;

92. Direct increased funding to national, regional and subregional commissions and Organisations to enable them to assist Governments at the national, subregional and regional level in their efforts to respond to the crisis;

93. Provide the UNAIDS co-sponsoring agencies and the UNAIDS secretariat with the resources needed to work with countries in support of the goals of this Declaration;

Follow-up

Maintaining the momentum and monitoring progress are essential

At the national level

94. Conduct national periodic reviews involving the participation of civil society, particularly people living with HIV/AIDS, vulnerable groups and caregivers, of progress achieved in realizing these commitments and identify problems and obstacles to achieving progress and ensure wide dissemination of the results of these reviews;

95. Develop appropriate monitoring and evaluation mechanisms to assist with follow-up in measuring and assessing progress, develop appropriate monitoring and evaluation instruments, with adequate epidemiological data;

96. By 2003, establish or strengthen effective monitoring systems, where appropriate, for the promotion and protection of human rights of people living with HIV/AIDS;

At the regional level

97. Include HIV/AIDS and related public health concerns as appropriate on the agenda of regional meetings at the ministerial and Head of State and Government level;

98. Support data collection and processing to facilitate periodic reviews by regional commissions and/or regional Organisations of progress in implementing regional strategies and addressing regional priorities and ensure wide dissemination of the results of these reviews;

99. Encourage the exchange between countries of information and experiences in implementing the measures and commitments contained in this Declaration, and in particular facilitate intensified South-South and triangular cooperation;

At the global level

100. Devote sufficient time and at least one full day of the annual General Assembly session to review and debate a report of the Secretary-General on progress achieved in realizing the commitments set out in this Declaration, with a view to identifying problems and constraints and making recommendations on action needed to make further progress;

101. Ensure that HIV/AIDS issues are included on the agenda of all appropriate United Nations conferences and meetings;

102. Support initiatives to convene conferences, seminars, workshops, training programmes and courses to follow up issues raised in this Declaration and in this regard encourage participation in and wide dissemination of the outcomes of: the forthcoming Dakar Conference on Access to Care for HIV Infection; the Sixth International Congress on AIDS in Asia and the Pacific; the XII International Conference on AIDS and Sexually Transmitted Infections in Africa; the XIV International Conference on AIDS, Barcelona; the Xth International Conference on People Living with HIV/AIDS, Port of Spain; the II Forum and III Conference of the Latin American and the Caribbean Horizontal Technical Cooperation on HIV/AIDS and Sexually Transmitted Infections, La Habana; the Vth International Conference on Home and Community Care for Persons Living with HIV/AIDS, Changmai, Thailand;

103. Explore, with a view to improving equity in access to essential drugs, the feasibility of developing and implementing, in collaboration with non-governmental Organisations and other concerned partners, systems for voluntary monitoring and reporting of global drug prices;

We recognize and express our appreciation to those who have led the effort to raise awareness of the HIV/AIDS epidemic and to deal with its complex challenges;

We look forward to strong leadership by Governments, and concerted efforts with full and active participation of the United Nations, the entire multilateral system, civil society, the business community and private sector;

And finally, we call on all countries to take the necessary steps to implement this Declaration, in strengthened partnership and cooperation with other multilateral and bilateral partners and with civil society.

References

1. INGCAT (International Non Governmental Coalition Against Tobacco) (2003) Advocacy, Legislation: a model Tobacco Products Control Act.
http://www.ingcat.org/html/law.html
(Accessed 09/01/03)

2. INGCAT (International Non Governmental Coalition Against Tobacco) (2003) Resource Materials, Baseline or core data.
http://www.ingcat.org/html/quest.html
(Accessed 09/01/03)

3. INGCAT (International Non Governmental Coalition Against Tobacco) (2001) Statement from INGCAT to the WHO Public Hearing on the FCTC.
http://www.ingcat.org/html/ingcat_submission.html
(Accessed 09/1/03)

4. Management of Substance Dependence Non-Communicable Diseases, World Health Organisation (2001) A Summary of Global Status Report on Alcohol.
http://www.who.int/substance_abuse/PDFfiles/who_ncd_msd_2001_2.pdf
(Accessed 09/01/03)

5. Murray CJL, Lopez AD, eds (1996a). The global burden of disease: a comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020. Cambridge, MA, Harvard School of Public Health on behalf of the World Health Organisation and the World Bank (Global Burden of Disease and Injury Series, Vol. I).

6. International Narcotics Control Board (2001) Report of the International Narcotics Control Board for 2001.
http://www.poldoc.be/dailydoc/document/article/incb2001.pdf
(Accessed 09/01/03)

7. United Nations General Assembly (2001) Declaration of Commitment on HIV/AIDS “Global Crisis – Global Action” 26th special session of the General Assembly, 25-27 June 2001. \\Reproduced from the following website:
http://www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html
(accessed 17/09/03)

8. United Nations Office for Drug Control and Prevention (1998) Action Plan for the Implementation of the Declaration on the Guiding Principles of Drug Demand Reduction.
http://www.undcp.org/odccp/resolution_1998-09-08_1.html
(Accessed 09/01/03)

9. United Nations Office for Drug Control and Prevention (2000) World Drug Report 2000
http://www.undcp.org/pdf/world_drug_report_2000/report_2001-01-22_1.pdf
(Accessed 09/01/03)

10. World Health Organisation, European Charter on Alcohol, European Conference on Health, Society and Alcohol, Paris, France 12-14 December 1995.
http://www.who.dk/AboutWHO/Policy/20010927_7
(Accessed 09/01/03)

11. World Health Organisation (2000a), Hepatitis B, Fact Sheet WHO/204, revised October 2000.
http://www.who.int/inf-fs/en/fact204.html
(Accessed 17/09/03).

12. World Health Organisation (2000b), Hepatitis C, Fact Sheet WHO/164, revised October 2000.
http://www.who.int/inf-fs/en/fact164.html
(Accessed 17/09/03).

13. World Health Organisation (2001) The Global Burden of Disease and Injury: Executive Summary, Section 5.
http://www.hsph.harvard.edu/Organisations/bdu/summary.html
(Accessed 09/01/03)

14. World Health Organisation (2003) Media Release, 16 June 2003 Twenty-eight countries and the European Community sign tobacco treaty at first opportunity.
http://www.who.int/mediacentre/releases/2003/pr49/en/
(Accessed 06/08/03)

15. World Health Organisation Regional Office for Europe (2001) WHO Declaration on Young People and Alcohol.
http://www.who.dk/AboutWHO/Policy/20010927_1
(Accessed 09/01/03)

16. World Health Organisation – Substance Abuse Department (1988) The Rapid Assessment and Response Guide on Injecting Drug Use (Eds G.V. Stimson, C.Fitch and T.Rhodes).
http://www.who.int/substance_abuse/docs/idu_rar.pdf
(Accessed 17/09/03)