

# Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS

Outreach and information



Canadian  
HIV/AIDS  
Legal  
Network

Réseau  
juridique  
canadien  
VIH/sida

# 6

This model law resource consists of eight modules, addressing the following issues:

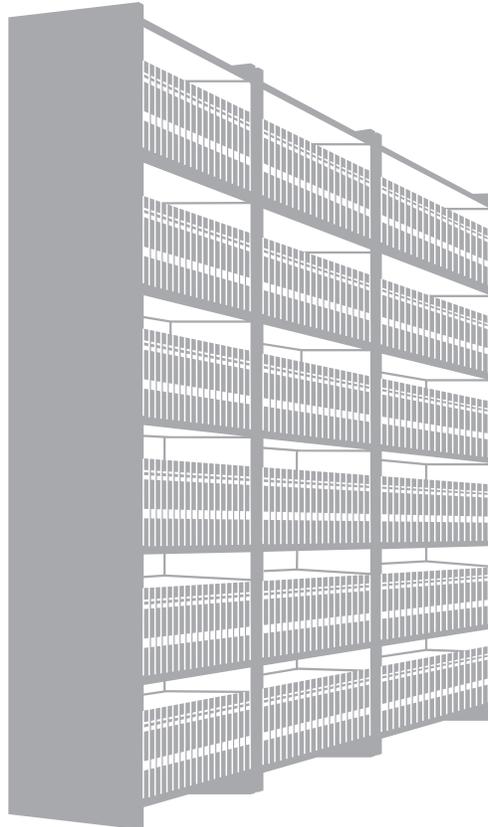
1. Criminal law issues
2. Treatment for drug dependence
3. Sterile syringe programs
4. Supervised drug consumption facilities
5. Prisons
6. Outreach and information
7. Stigma and discrimination
8. Heroin prescription programs

This module, and the other modules, are available in multiple languages on the website of the Canadian HIV/AIDS Legal Network at [www.aidslaw.ca/drugpolicy](http://www.aidslaw.ca/drugpolicy).



Canadian  
HIV/AIDS  
Legal  
Network

Réseau  
juridique  
canadien  
VIH/sida



# Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS

Outreach and information



# **Legislating on Health and Human Rights: Model Law on Drug Use and HIV/AIDS Module 6: Outreach and information**

© 2006 Canadian HIV/AIDS Legal Network

Further copies can be retrieved at [www.aidslaw.ca/drugpolicy](http://www.aidslaw.ca/drugpolicy)  
or obtained through the Canadian HIV/AIDS Information Centre  
([www.aidssida.cpha.ca](http://www.aidssida.cpha.ca))

## **Canadian cataloguing in publication data**

Module 6: ISBN 978-1-896735-70-2  
Complete series: ISBN 978-1-896735-64-1

## **Authorship and acknowledgements**

Richard Pearshouse is the primary author of this resource. Richard Elliott and Joanne Csete wrote text of legal provisions and prefatory notes, and reviewed the entire resource. Invaluable research assistance was provided by Tim Franklin, Sarom Bahk, Katie Gibson and Sara Kushner.

This resource was reviewed by a number of outside reviewers. Special thanks go to Scott Burris and Anya Sarang. Thanks also to the participants of the consultation meeting in Vilnius, Lithuania (7–8 November 2005) who provided feedback and advice on a draft version of this resource: Larisa Bashmakova, Holly Catania, Eszter Csernus, Rumen Donski, Joze Hren, Erik Iriskulbekov, Ainagul Isakova, Murtazokul Khidirov, Vlad Klisha, Tommaso Marilli, David Otiashvili, Ekaterina Paniklova, Alexandr Rumantsyev, Atanas Rusev, Vera Sergunina, Alex Shoshikelashvili, Raminta Stuikyte, Rusudan Tabatadze, Andrey Tolopilo and Thomas Zabransky. We also thank others who provided additional comments on the draft.

Thanks to Glenn Betteridge for his assistance. Lada Mirzalieva provided useful references to legislation from former Soviet Union countries. Thanks to David Garmaise for copyediting the English text, to Liana Ibragimova for translating the resource into Russian, and to Leah Utyasheva for editing the resource in Russian. Cover design was done by Oblik Communications, and layout by Vajdon Sohaili.

Funding for this project was provided by UNAIDS, the International Affairs Directorate of Health Canada, the John M. Lloyd Foundation, and the Open Society Institute. Funding for the consultation meeting in Vilnius, Lithuania was provided by the Conference Secretariat of the Canadian International Development Agency and the Open Society Institute. The opinions expressed in this publication are those of the authors and do not necessarily reflect the official views of Health Canada.

## **About the Canadian HIV/AIDS Legal Network**

The Canadian HIV/AIDS Legal Network ([www.aidslaw.ca](http://www.aidslaw.ca)) promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally, through research, legal and policy analysis, education, and community mobilization. The Legal Network is Canada's leading advocacy organization working on the legal and human rights issues raised by HIV/AIDS.

## Introduction

UNAIDS (the Joint United Nations Programme on HIV/AIDS) suggests that approximately 30 percent of new HIV infections outside sub-Saharan Africa are due to contaminated injection equipment.<sup>1</sup> In eastern Europe and Central Asia, the use of contaminated injection equipment accounts for more than 80 percent of all HIV cases.<sup>2</sup> Yet, globally, less than five percent of people who inject drugs are estimated to have access to HIV prevention services,<sup>3</sup> and even in regions where they account for the majority of HIV infections, people who use drugs are routinely excluded from HIV/AIDS care and treatment.

Many countries with injection-driven HIV/AIDS epidemics continue to emphasize criminal enforcement of drug laws over public health approaches, thereby missing or even hindering effective responses to HIV/AIDS. There is considerable evidence that numerous interventions to prevent HIV transmission and reduce other harms associated with injection drug use are feasible, effective as public health measures and cost-effective.<sup>4</sup> Despite such evidence, millions of people around the world who use drugs do not have access to such services because of legal and social barriers.

International human rights law establishes an obligation on states to respect, protect and fulfill the right to the highest attainable standard of health of all persons, including those who use drugs. Other human rights are equally relevant in the context of the HIV/AIDS epidemic. When human rights are not promoted and protected, it is harder to prevent HIV transmission, and the impact of the epidemic on individuals and communities is worse. Consequently, UN member states have committed to

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 ....<sup>5</sup>

---

<sup>1</sup> UNAIDS, *2006 Report on the Global AIDS Epidemic*, May 2006, p. 114. At [www.unaids.org/en/HIV\\_data/2006GlobalReport/default.asp](http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp).

<sup>2</sup> UNAIDS, *2006 Report on the Global AIDS Epidemic*, p. 114.

<sup>3</sup> United States Agency for International Development et al, *Coverage of selected services for HIV/AIDS prevention, care and support in low and middle income countries in 2003*, June 2004. At [www.futuresgroup.com/Documents/CoverageSurveyReport.pdf](http://www.futuresgroup.com/Documents/CoverageSurveyReport.pdf).

<sup>4</sup> See, for example, N. Hunt, *A review of the evidence-base for harm reduction approaches to drug use*, Forward Thinking on Drugs, 2003. At [www.forward-thinking-on-drugs.org/review2-print.html](http://www.forward-thinking-on-drugs.org/review2-print.html).

<sup>5</sup> *Declaration of Commitment on HIV/AIDS*, UN General Assembly, Res/S-26/2, 27 June 2001, para. 58. At [www.un.org/ga/aids/docs/aress262.pdf](http://www.un.org/ga/aids/docs/aress262.pdf).

UN member states have also committed to ensuring that a wide range of HIV prevention programs is available, including the provision of sterile injecting equipment and harm reduction efforts related to drug use.<sup>6</sup>

The widespread legal, social and political ramifications of the HIV/AIDS epidemic make it necessary to review and reform a broad range of laws. Some countries have adopted national HIV/AIDS laws, but these laws often ignore crucial policy issues, as well as human rights abuses that perpetuate the HIV epidemic. This is particularly true with respect to illegal drug use. HIV prevention, care and treatment services operate best within a clear legal framework that specifically protects the human rights of people who use drugs and enables harm reduction measures to mitigate the impact of HIV. A legislative framework can provide clarity and sustainability for such services. This is particularly important, given the often dominant approach of criminalizing illegal drug use and people who use drugs, which creates additional barriers to delivering health services. Law reform is not a complete solution to effectively addressing the HIV epidemic among people who use illegal drugs, but it is a necessary and often neglected step.

## **The model law project**

In early 2005, the Legal Network established a project advisory committee and, in consultation with the committee, developed a plan to produce model law that would assist states in more effectively addressing the HIV epidemic (and other harms) among people who use drugs, based on evidence of proven health protection and promotion measures, and in accordance with states' human rights obligations.

Comprehensive consultations were conducted during the drafting of the model law. A draft version of the model law was reviewed by a group of legal experts, harm reduction advocates and government representatives from central and eastern Europe, and countries of the former Soviet Union, during a meeting in Vilnius, Lithuania (7–8 November 2005). The document was modified in line with this feedback and recommendations. In early 2006, the model law was circulated in electronic form to a large number of people and organizations, providing a further opportunity to modify and strengthen the resource. This final document has, therefore, benefited from the thinking of a wide range of experts in the fields of HIV/AIDS, human rights and drug policy.

## **About this resource**

This model law resource is a detailed framework of legal provisions and accompanying commentary. It makes reference to examples of law from those jurisdictions that have attempted to establish a clear legal framework for addressing HIV/AIDS issues among people who use drugs.<sup>7</sup> This resource also incorporates human rights principles and

---

<sup>6</sup> *Declaration of Commitment on HIV/AIDS*, para. 52.

<sup>7</sup> References to national legal instruments are included in order to demonstrate the feasibility of establishing progressive legal frameworks so that law reform in other jurisdictions can be informed by such examples.

obligations of states throughout the document. It is annotated in order to highlight critical issues and evidence that supports the measures proposed.

This model law resource is designed to inform and assist policy-makers and advocates as they approach the task of reforming or making laws to meet the legal challenges posed by the HIV epidemic among people who use drugs. The model law resource is not intended for any one country or set of countries. Rather, it is designed to be adaptable to the needs of any of a wide number of jurisdictions. In some instances, the model law presents different legislative options for implementing states' human rights obligations. It is hoped that this resource can be most useful for those countries where injection drug use is a significant factor driving the HIV epidemic, and particularly for developing countries and countries in transition where legislative drafting resources may be scarce.

The model law resource consists of eight modules, addressing the following issues:

- (1) Criminal law issues
- (2) Treatment for drug dependence
- (3) Sterile syringe programs
- (4) Supervised drug consumption facilities
- (5) Prisons
- (6) Outreach and information
- (7) Stigma and discrimination
- (8) Heroin prescription programs

Each of the eight modules in this series is a stand-alone document. Each module begins with the introduction that you are reading now; the text of the introduction is identical in all of the modules.

Following the introduction, each model provides a prefatory note, model statutory provisions and a list of selected resources. (Taken together, the model statutory provisions in all eight modules would form a model law addressing HIV/AIDS and drug use.)

The prefatory note presents a rationale for reforming laws and policies in the area covered by the module. This is followed by a discussion of the relevant UN conventions on drug control, and of states' human rights obligations in this area.

The section on model statutory provisions contains provisions that could be included in a model law on HIV/AIDS and drug use. The provisions are divided into chapters, articles, sections and subsections. The first chapter ("General Provisions") describes the purpose of that Part of the model law, and provides definitions for many of the terms included in the provisions.

---

These references do not imply that the actual practice in the jurisdictions cited represents "best practice." There is often a long way to go in ensuring that actual practice conforms to these legal undertakings.

Some of the provisions are accompanied by a commentary. The commentary provides additional information on, or rationale for, the provision in question. For some model statutory provisions, two options are presented; a note inserted into the text indicates either (a) that one or the other option should be selected, but not both; or (b) that one or the other option, or both options, can be selected. As well, some of the provisions have been labelled as “optional.” This means that these provisions may or may not be applicable, depending on the situation in the country.

The section on selected resources contains a short list of resources which the Legal Network considers to be particularly useful. There are two subsections: one on articles, reports and policy documents, and one on legal documents.

The model law resource is heavily footnoted. The notes provide additional information on the issues being addressed, as well as full references. If the same source is cited more than once in a module, the second and subsequent references to that source are somewhat abbreviated (usually just the name of the author, or organization, and the title of the article or report).

# Module 6: Outreach and Information

*Module 6 contains a prefatory note which discusses the rationale for reforming laws to enable outreach programs directed towards people who use drugs and to ensure that these programs can incorporate harm reduction approaches. The prefatory note describes the relevant international laws and policies, including human rights obligations. This is followed by a section on model statutory provisions. Module 6 concludes with a list of recommended resources.*

## Prefatory Note

### Rationale for reform

Health care provided by mainstream health systems may not reach large numbers of people who use drugs because those people are often socially marginalised and fear persecution from authorities. Outreach programs aim to make contact with people who use drugs and provide them with the information and services they need to reduce the harms associated with drug use. They also provide referrals to drug dependence treatment, health care services (including HIV testing and counselling) and social care (including legal support services).<sup>8</sup> In some jurisdictions, outreach program workers have been trained to administer opioid antagonists, such as naloxone, in emergency situations in order to rapidly reverse the effects of an opioid overdose.

Research and evaluations have demonstrated that outreach programs are consistently effective at reducing the risk of HIV/AIDS and other health risks associated with injection drug use. The World Health Organization (WHO) has stated that the benefits of outreach programs include:

- greater access to underserved or marginalized groups of people who inject drugs and who are at high-risk for HIV/AIDS, making it easier to provide harm reduction services and education, as well as services such as HIV testing and counselling;<sup>9</sup>
- reduced sharing of equipment among people who inject drugs, reduced frequency of drug injection and, in some cases, an end to injection drug use;

---

<sup>8</sup> Other examples of social care might include job training, assistance with housing, financial guidance, support from social workers and participation in peer support groups.

<sup>9</sup> See R.H. Needle et al, *Evidence for action: effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users*, WHO, 2004. Available via [www.who.int/hiv/pub/idu/en](http://www.who.int/hiv/pub/idu/en); P.D. Tinsman et al, "Factors affecting client response to HIV outreach efforts," *Journal of Substance Abuse* 13 (2001): 201–214.

- increased safer sex practices, such as condom use, among people who use drugs; and
- facilitated entry into drug dependence treatment, and higher rates of people staying in treatment.<sup>10</sup>

Peer-driven outreach involves people who currently use or previously used drugs working with or running outreach programs in their communities. Research has confirmed the effectiveness of peer-run outreach compared to outreach conducted by social workers or health professionals.<sup>11</sup> Peers may be more effective in recruiting and educating other people who use drugs because the latter are more likely to listen to people who have lived through the challenges associated with drug use.

## International law and policy

### UN conventions on drug control

The implementation of outreach programs that provide information and education to people who inject drugs is consistent with international treaties on drug control. None of the UN conventions on drug control — the 1961 *Single Convention on Narcotic Drugs*, the 1971 *Convention on Psychotropic Substances* or the 1988 *United Nations Convention Against Illicit Traffic in Psychotropic Substances and Narcotic Drugs* — contain provisions that prohibit disseminating information relating to drug use with the goal of reducing the associated harms.<sup>12</sup> States that are parties to the 1961 Convention “shall

---

<sup>10</sup> Behavioural changes among people who inject drugs, such as cessation or reduction of injection, decreased syringe reuse, and increased frequency of safer-sex practices, are closely associated with outreach services. See WHO, *Policy Brief: Reduction of HIV transmission through outreach — Evidence for action on HIV/AIDS and injecting drug use*, 2004. Available via [www.who.int/hiv/pub/idu/en](http://www.who.int/hiv/pub/idu/en); S. Coyle et al, “Outreach-based HIV prevention for injecting drug users: a review of published outreach data,” *Public Health Report* 113(1) (1998): 19–30; W. Wiebel et al, “Risk behavior and HIV seroincidence among out-of-treatment injection drug users: a four-year prospective study,” *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology* 12 (1996): 282–289.

<sup>11</sup> Studies show that peer influence, in contrast to safe drug use education alone, can lead to significant reductions in high-risk behaviour, such as needle sharing, by people who inject drugs. See, for instance, H. Madray and Y. van Hulst, “Reducing HIV/AIDS high risk behaviour among injection drug users: peers vs. education,” *Journal of Drug Education* 30(2) (2000): 205–211. Peer outreach programs targeting drug users have been effective in reducing risk behaviours among people who inject drugs. See C.A. Latkin, S. Sherman, and A. Knowlton, “HIV prevention among drug users: outcome of a network-oriented peer outreach intervention,” *Health Psychology* 22(4) (2003): 332–339; R. Broadhead et al, “Harnessing peer networks as an instrument for AIDS prevention: results from a peer-driven intervention,” *Public Health Reports* 113(Suppl. 1) (1998): 42–57. In the context of sterile syringe programs, it has been shown that peer-run organizations may be able to access and provide harm reduction measures to high-risk communities not accessible to other harm reduction services. See E. Wood et al, “An external evaluation of a peer-run ‘unsanctioned’ syringe exchange program,” *Journal of Urban Health* 80(3) (2003): 455–464. For a review of community-based and peer-run outreach programs, see R.H. Needle et al, *Evidence for action: effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users*.

<sup>12</sup> *Single Convention on Narcotic Drugs*, 1961, UN, 520 UNTS 331; *Convention on Psychotropic Substances*, 1971, UN, 1019 UNTS 175; *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, 1988, UN Doc. E/CONF.82/15 (1988), 28 ILM 493 (1989).

give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their efforts to these ends.”<sup>13</sup> Furthermore, the 1988 *United Nations Convention Against Illicit Traffic in Narcotic and Psychotropic Substances* requires parties to “adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic substances, with a view to reducing human suffering and eliminating financial incentives for illicit traffic.”<sup>14</sup> Legislation that enables outreach programs may therefore assist countries in fulfilling their obligations under the UN conventions by reducing the harms associated with drug use.

In addition to information and education activities, outreach programs may also distribute sterile syringes and other safer drug consumption materials in order to reduce the HIV transmission risk associated with activities such as syringe sharing. Sterile syringe programs are regarded as an essential measure in the prevention of HIV and other blood-borne infections among people who inject drugs by reducing high-risk behaviour.<sup>15</sup>

## Human rights obligations

The right to disseminate and receive information on the harms associated with drug use, as well as related information on social services such as counselling, is protected by a number of international legal instruments. The *International Covenant on Civil and Political Rights* (ICCPR) states that “everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice.”<sup>16</sup> The ICCPR also guarantees the right to freedom of association.<sup>17</sup> These guarantees enable outreach workers to provide harm reduction information to people who inject drugs.

---

<sup>13</sup> *Single Convention on Narcotic Drugs*, 1961, art. 38.1. A similar provision may be found in Article 20 of the 1971 *Convention on Psychotropic Substances*.

<sup>14</sup> *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, 1988, art. 14.4.

<sup>15</sup> WHO has recognized and promoted the importance of reducing syringe sharing in preventing HIV transmission among people who inject drugs. See Alex Wodak and Annie Cooney, *Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users*, WHO, 2004. At [www.who.int/hiv/pub/idu/pubidu/en/](http://www.who.int/hiv/pub/idu/pubidu/en/). For a more thorough discussion of the international legal issues surrounding sterile syringe programs and model law relating specifically to the operation of such programs, see Module 3 (Sterile Syringe Programs) of this resource.

<sup>16</sup> *International Covenant on Civil and Political Rights* (ICCPR), UN General Assembly, 999 UNTS 171, 1966, art. 19.2 See, also, *Universal Declaration of Human Rights*, UN General Assembly, Resolution 217 A(III), UN GAOR, 3<sup>rd</sup> Session, 183<sup>rd</sup> plenary meeting, 71, UN Doc. A/910 (1948), art. 19.

<sup>17</sup> ICCPR, art. 22. See, also, *Universal Declaration of Human Rights*, art. 20.1.

In the context of HIV/AIDS, the services and information provided by outreach programs may assist countries in meeting obligations regarding health found in international legal instruments. The *Universal Declaration of Human Rights* states that “everyone has the right to a standard of living adequate for health and well-being”, including “medical care and necessary social services.”<sup>18</sup> Similarly, the *International Convention on Economic, Social and Cultural Rights* (ICESCR) recognizes the “right of everyone to the highest attainable standard of physical and mental health.”<sup>19</sup> The services provided to people who inject drugs by outreach programs, including information and education, as well as the provision of sterile syringes, help to fulfill these obligations by preventing the transmission of HIV and other blood-borne infections, as well as connecting people to health services and social care.

UNAIDS and the Office of the High Commissioner for Human Rights (OHCHR) have articulated the need for information and education on the transmission and prevention of HIV. The recommendations of the *International Guidelines on HIV/AIDS and Human Rights* state that “laws and/or regulations should be enacted to enable widespread provision of information about HIV/AIDS through the mass media. This information should be aimed at the general public, as well as at various vulnerable groups that may have difficulty in accessing information.”<sup>20</sup> The *UNAIDS Handbook for Legislators on HIV/AIDS, Law and Human Rights* similarly recommends the widespread provision of information to prevent HIV/AIDS, including group meetings and assemblies.<sup>21</sup>

---

<sup>18</sup> *Universal Declaration on Human Rights*, art. 25.

<sup>19</sup> *International Covenant on Economic, Social and Cultural Rights*, (ICESCR) UN General Assembly, 993 UNTS 3 (1966), art. 12. According to the UN expert committee tasked with monitoring states’ performance of their obligations under the ICESCR, “every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments.” See UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: The right to the highest attainable standard of health (art. 12), UN Doc. E/C.12/2004/4 (2000), para. 1. At [www.ohchr.org/english/bodies/cescr/comments.htm](http://www.ohchr.org/english/bodies/cescr/comments.htm).

<sup>20</sup> Office of the High Commissioner for Human Rights (OHCHR) and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights: Revised Guideline 6— Access to prevention, treatment, care and support*, 2002, Recommendation (n). See, also, Recommendation (e), which calls for states’ legislation, policies, programs, plans and practices to “include positive measures to address factors that hinder equal access of vulnerable individuals and populations to prevention, treatment, care and support ...”

<sup>21</sup> UNAIDS/IPU, *Handbook for Legislators on HIV/AIDS, Law and Human Rights*, 1999, p. 85.

# Model Statutory Provisions

## Chapter I. General Provisions

### Article 1. Purpose of this part

The purpose of this Part is to:

- (a) enable public and private entities to provide information and appropriate services to people who use drugs;
- (b) promote harm reduction approaches to drug use; and
- (c) enable outreach workers to administer an opioid antagonist to another person in need.

### Article 2. Definitions

For the purposes of this Part, the following definitions are used:

“Opioid antagonist” means naloxone hydrochloride or any other similarly acting drug approved by the [relevant public health agency] for the treatment of drug overdose.

“Outreach work” means a community-oriented activity undertaken to contact and provide information and services to individuals or groups from particular populations at risk of blood-borne diseases, particularly those who are not effectively contacted or reached by existing information and services or through traditional health care channels.<sup>22</sup>

“Outreach workers” include the following persons:

- (a) the operator or manager of the program;
- (b) a person engaged by the operator or manager of the program to provide services at the facility, whether under a contract of employment or otherwise; and
- (c) a person engaged by the operator or manager of the program to provide voluntary assistance at the facility.

---

<sup>22</sup> The definition is derived from the Council of the European Union, *Recommendation on the prevention and reduction of health-related harm associated with drug dependence*, 18 June 2003, 2003/488/EC, art. 2(3).

## Chapter II. Operational Elements

### Article 3. National health and drug policies

- (1) National health and drug policies should include guidance on outreach work, particularly peer-driven outreach, and should support appropriate training and development of standards and methods.
- (2) National health and drug policies should encourage the involvement of, and promote training for, peers and volunteers in outreach work.
- (3) National health and drug policies should facilitate access to information and appropriate services among people who use drugs.<sup>23</sup>

### Article 4. Staff

- (1) Outreach workers shall include persons who, be they paid workers or volunteers, have appropriate technical training.<sup>24</sup>
- (2) Outreach workers may include people who currently use drugs, people who formerly used drugs or people who do not use drugs and are trusted by people who use drugs.

#### Commentary: Article 4

Research and experience have demonstrated that the effectiveness of outreach programs may be strengthened by including people who currently use drugs or who have previously used drugs as outreach workers. They may assist outreach programs to gain access to communities of people who use drugs, particularly those who are most marginalized and may be more likely to engage with outreach workers perceived as peers. People with active or past experience with drug use may have a useful understanding of drug-use trends and may be able to establish more easily the important relationships of trust with the individuals or communities whom outreach programs aim to assist.<sup>25</sup>

---

<sup>23</sup> This wording is derived from Council of the European Union, *Recommendation on the prevention and reduction of health-related harm associated with drug dependence*, art. 2(3–4). See, also, *Decree of the Cabinet of Ministers of Ukraine on Approval of the Strategy Concept of the Government’s Activity Aimed at HIV/AIDS Spread Prevention for the Period until 2011*, of 4 March 2004, No 264 [Ukraine]; *National Program for Providing HIV Prevention, Help and Treatment for HIV-Infected and People with AIDS for March 2004-2008*, 4 March 2004 [Ukraine]. See, also, *Action Plan on Drugs and Addiction*, Drug Commissioner of the Federal Government, 2003, s. 3.2 [Germany]. Vietnam’s *Law on the Prevention and Control of HIV/AIDS* (2006), No. 2006/QH11 provides for “harm reduction interventions in HIV/AIDS prevention and control” to be implemented among “populations having high risk behaviours” (art. 21); the legislation specifically requires information and education to be provided to people who use drugs (art. 11.2(b)).

<sup>24</sup> This wording is derived from Article 61(2) of *Decree-Law No. 183/2001*, Portugal.

## Article 5. Supply of information

Outreach workers may provide information including, but not limited to, the following:

- (a) drug dependence treatment services and other health services;
- (b) means of protection against transmissible diseases, including blood-borne diseases such as HIV;
- (c) the risks associated with the use of controlled substances;
- (d) harm reduction information specific to the drug being used, including safe injecting and inhaling practices;
- (e) legal aid services;
- (f) employment and vocational training services and centres; and
- (g) available support services for people with drug dependence and their families.<sup>26</sup>

## Article 6. Supply of material

Outreach workers may provide the following materials:

- (a) sterile syringes and other related material for safer injection drug use, including sterile water ampoules, swabs, filters, safe acid preparations, spoons and bowls and other appropriate materials;<sup>27</sup>
- (b) material to enable safer smoking and inhalation of drugs, such as pipes, stems, metal screens, alcohol wipes and lip balm;<sup>28</sup>
- (c) condoms and other safer sex materials such as water-based lubricants and dental dams, as well as information about reducing the risks of HIV and other sexually transmitted infections; and
- (d) first aid in emergency situations.

---

<sup>25</sup> For a review of community-based and peer-run outreach programs, see R.H. Needle et al, *Evidence for action: effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users*.

<sup>26</sup> This wording is derived from Article 31(1) of Portugal's *Decree-Law No. 183/2001*.

<sup>27</sup> For example, U.K. regulations provide for sterile syringe programs to supply alcohol swabs, utensils for the preparation of a controlled drug, citric acid, a filter and ampoules of water for injection. See *The Misuse of Drugs (Amendment) (No. 2) Regulations 2003*, Statutory Instrument 2003 No. 1653. Note that in the U.K. hypodermic syringes are explicitly exempted from the legal provision prohibiting the supply of articles used in administering or preparing drugs; see *Misuse of Drugs Act 1971*, s. 9a.

<sup>28</sup> For an example of legislative enablement of distribution through harm reduction programs of material for the inhalation or smoking of cocaine, crack or heroin, see *Référentiel national de réduction des risques pour usagers de drogue mentionné à L'article D* [France], Décret No. 2005-347 du 15 Avril 2005, Annexe 31-2, Art. III(1). Studies have identified crack smoking as a possible risk factor for HIV, hepatitis C and tuberculosis; infectious disease may be transmitted via the sharing of implements through which contaminated blood particles are transmitted. See A.E. Weber et al, "Risk Factors associated with HIV infection among young gay and bisexual men in Canada," *Journal of Acquired Immune Deficiency* 28 (2001): S1–S8; J. McMahon and S. Tortu, "A potential hidden source of hepatitis C infection among noninjecting drug users," *Journal of Psychoactive Drugs* 35 (2003): 523–534; S. Tortu et al, "Sharing of noninjection drug-use implements as a risk factor for hepatitis C," *Substance Use & Misuse* 39 (2004): 211–224.

## Article 7. Confidentiality

- (1) The confidentiality of all health care information shall be respected. Records of any person which are obtained in the course of outreach work:
  - (a) are confidential;<sup>29</sup>
  - (b) are not open to public inspection or disclosure;
  - (c) shall not be shared with other individuals or agencies; and
  - (d) shall not be discoverable or admissible during legal proceedings.
  
- (2) No record referred to in Section (1) may be used to:
  - (a) initiate or substantiate any criminal charges against a person who uses outreach services; or
  - (b) act as grounds for conducting any investigation of a person who uses outreach services.
  
- (3) Outreach workers cannot be compelled under [relevant criminal procedure code] to provide evidence concerning the information that was entrusted to them or became known to them in this capacity.<sup>30</sup>
  
- (4) All use of personal information of people who use outreach services and outreach workers in research and evaluation shall be undertaken in conditions guaranteeing anonymity, and any such information shall also be governed by Section (2).

### Commentary: Article 7

The requirement of confidentiality respects the right to privacy articulated under several international instruments.<sup>31</sup> Confidentiality is important in the context of outreach, information and education programs because people who use drugs may be reluctant to seek outreach assistance if there is a possibility that information about their health status, including HIV/AIDS status and drug dependence, may be released. In particular, people who use drugs may fear that information regarding their drug use or dependence may be passed on to police, resulting in increased surveillance or prosecution for drug-related offences. Ensuring confidentiality ensures that people who use drugs may seek the harm reduction services offered by outreach programs without fear of loss of privacy,

---

<sup>29</sup> Some sterile syringe programs use a form of enrolment card which does not record the full name of the program participant, but rather a unique identifier code formed from letters of their name and numbers from their date of birth. No address or other contact information is required.

<sup>30</sup> This wording is derived from Germany's *Code of Criminal Procedure*, s. 53, para. 1, no. 3b.

<sup>31</sup> See, for instance, Article 12 of the *Universal Declaration of Human Rights*, which states that “no one shall be subjected to arbitrary interference with his privacy, family, home or correspondence ....” See also Article 8(1) of the *European Convention for the Protection of Human Rights and Fundamental Freedoms*; Article 17(1) of the *ICCPR*; and Article 11 of the *American Convention on Human Rights*.

stigmatization or discrimination based on health status or drug dependence, or police harassment or prosecution.

## **Article 8. Exemption from criminal and civil liability for outreach work**

- (1) The [relevant drug legislation] does not prevent the giving of advice, information or instruction for safer drug consumption practices by outreach workers nor does it prohibit the sale or supply of syringes and other related material by outreach workers.
- (2) A civil proceeding cannot be brought against any person (including the state or outreach staff) in relation to any act or omission in connection with outreach work, if the act or omission was in good faith for the purpose of executing this Part and was not a reckless or negligent act or omission.

### **Commentary: Article 8**

Education and information offered by outreach services, as well as the provision of sterile syringes, are effective measures in reducing high-risk behaviour among people who use drugs.<sup>32</sup> In some jurisdictions, outreach workers may be at risk of prosecution for offences relating to the “facilitation” or “incitement” of drug use by providing information regarding safer consumption of drugs. Outreach programs which provide sterile syringes, or other materials that reduce the possible harms of unsafe drug use, may also be liable under such laws, as well as under laws prohibiting the possession or distribution of “drug paraphernalia.” To ensure that outreach programs are able to effectively reduce risks associated with drug use, harm reduction programs and outreach workers should not be subject to criminal liability under domestic legislation.

Similarly, in certain jurisdictions, it is conceivable that attempts could be made to hold outreach workers civilly liable in the event that a person who uses drugs suffers some injury as a result of their drug use. A possible argument that might be advanced is that the outreach worker has in some way facilitated the drug use by providing information or materials related to drug use. In reality, the services of outreach workers are directed toward reducing the likelihood that a person suffers harm. It would therefore be inappropriate to impose civil liability on the outreach worker, in the absence of reckless or negligent conduct. However, the possibility of such a claim could serve as a disincentive to such programs. Therefore, in order to encourage the establishment of outreach programs, outreach workers should be exempt from any such threat of civil liability for the provision of syringes or other safer drug use material, or information about safer drug use, in the course of their duties as an outreach worker, except in cases where the injury has resulted from the negligence or recklessness of the worker. Civil

---

<sup>32</sup> The risk-reducing effects of providing sterile syringes to injection drug users have been widely demonstrated in the context of sterile syringe programs. For a review of the studies specifically evaluating the effectiveness of sterile syringe exchange programs, see D. Gibson et al, “Effectiveness of syringe exchange programs in reducing HIV risk behaviour and HIV seroconversion among injecting drug users,” *AIDS* 15(11) (2001): 1329–1341.

liability issues associated with outreach programs are not unique or complex — indeed, they are issues that arise for the operation of any health service — and they should not act as a bar to the establishment of such programs.

## Article 9. Administration of an opioid antagonist

- (1) The Regulations may make provision for the appropriate training of outreach workers in the administration of opioid antagonists.
- (2) An outreach worker may administer an opioid antagonist to another person if:
  - (a) the worker believes, in good faith, that the other person is experiencing a drug overdose; and
  - (b) the worker acts with reasonable care in administering the drug to the other person.
- (3) An outreach worker who administers an opioid antagonist to another person pursuant to Section (1) shall not be subject to civil liability or criminal prosecution as a result of the administration of the opioid antagonist.<sup>33</sup>

### Commentary: Article 9

Opioid antagonists are medicines that can rapidly reverse the effects of opioid overdoses, especially heroin overdose, thereby preventing death. Naloxone is a specific opioid antagonist that reverses the respiratory depression and sedation caused by heroin.<sup>34</sup> This Article exempts outreach workers from civil or criminal liability for administering opioid antagonists (such as naloxone) under specified conditions. This provision should be accompanied by the necessary regulatory reforms to register naloxone as a legal drug. While this provision only addresses outreach workers, it should be noted that a number of feasibility studies regarding peer administration of naloxone have been undertaken.<sup>35</sup> In Italy, naloxone is sold over the counter and has been distributed through sterile syringe

---

<sup>33</sup> See also *New Mexico Statutes*, Chapter 24 (Health and Safety), art. 23, ss. 1 and 2, which exempt health care workers and other professionals from criminal and civil liability for administering opioid antagonists. Available via [http://nxt.ella.net/NXT/gateway.dll?f=templates\\$fn=default.htm\\$vid=nm:all](http://nxt.ella.net/NXT/gateway.dll?f=templates$fn=default.htm$vid=nm:all).

<sup>34</sup> Naloxone is listed in the WHO *Model List of Essential Medicines* (14<sup>th</sup> edition, 2005) as an essential antidote or other substance used in treating poisonings. The *Model List* is at [www.who.int/medicines/publications/essentialmedicines/en](http://www.who.int/medicines/publications/essentialmedicines/en). Naloxone may be administered intravenously, subcutaneously or intramuscularly through injection. Studies have also been conducted in intranasal administration of naloxone, indicating decreased efficacy in certain instances. See E.D. Barton et al, “Intranasal administration of naloxone by paramedics,” *Prehospital Emergency Care* 6 (2002): 54–58.

<sup>35</sup> S. Lenton et al, “Should we conduct a trial of distributing naloxone to heroin users for peer administration to prevent fatal overdose?,” *Medical Journal of Australia* 173 (2000): 260–263; J. Strang et al, “Preventing opiate overdose fatalities with take-home naloxone: pre-launch study of possible impact and acceptability,” *Addiction* 94 (1999): 199–204; K. Dettmer et al. “Take home naloxone and the prevention of deaths from opiate overdose: two pilot schemes,” *British Medical Journal* 322 (2001): 895–896.

programs since 1995.<sup>36</sup> In the U.K., naloxone can be administered by anyone without the need for a prescription for the purpose of saving a life in an emergency.<sup>37</sup>

---

<sup>36</sup> B. Simini, “Naloxone supplied to Italian heroin addicts,” *Lancet* 352 (1998): 967.

<sup>37</sup> The Medicines for Human Use (Prescribing) (Miscellaneous Amendments) Order 2005, Statutory Instrument 2005, No. 1507 (UK). For a review of issues related to the use, distribution, and availability of naloxone, including the possibility of distributing naloxone for take-home use, see C.T. Baca and K.J. Grant, “Take-home naloxone to reduce heroin death,” *Addiction* 100 (2005): 1823–1831.

## Selected Resources

*This section provides a list of resources that the Legal Network considers to be particularly relevant.*

### Articles, reports and policy documents

Baca, C.T., and K.J. Grant. “Take-home naloxone to reduce heroin death.” *Addiction* 100 (2005): 1823–1831.

British Institute of International and Comparative Law. *Draft fourth framework convention on risk management*. 2003. At [www.senliscouncil.net/documents/BIICL\\_HR\\_Framework#search=%22Draft%20fourth%20framework%20convention%22](http://www.senliscouncil.net/documents/BIICL_HR_Framework#search=%22Draft%20fourth%20framework%20convention%22).

Council of the European Union. *Recommendation on the prevention and reduction of health-related harm associated with drug dependence* of 18 June 2003. 2003/488/EC.

Coyle, S. et al. “Outreach-based HIV prevention for injection drug users: a review of published outcome data.” *Public Health Reports* 113(1) (1998): 19–30.

OHCHR and UNAIDS. *International Guidelines on HIV/AIDS and Human Rights*, 1998.

OHCHR and UNAIDS. *International Guidelines on HIV/AIDS and Human Rights: Revised Guideline 6 — Access to Prevention, Treatment, Care and Support*, 2002. At [www.ohchr.org/english/about/publications/docs/g6.pdf](http://www.ohchr.org/english/about/publications/docs/g6.pdf).

Tinsman, P.D. et al. “Factors affecting client response to HIV outreach efforts.” *Journal of Substance Abuse* 13 (2001): 201–214.

UNAIDS/IPU, *Handbook for Legislators on HIV/AIDS, Law and Human Rights*, 1999.

WHO. *Evidence for Action: Effectiveness of Community-Based Outreach in preventing HIV/AIDS among Injecting Drug Users*, 2004. Available via [www.who.int/hiv/pub/idu/en/](http://www.who.int/hiv/pub/idu/en/).

WHO. *Policy Brief: Reduction of HIV Transmission Through Outreach — Evidence for Action on HIV/AIDS and Injecting Drug Use*, 2004. Available via [www.who.int/hiv/pub/idu/en/](http://www.who.int/hiv/pub/idu/en/).

### Legal documents

*Decree of the Cabinet of Ministers of Ukraine on Approval of the Strategy Concept of the Government’s Activity Aimed at HIV/AIDS Spread Prevention for the Period until 2011*, of 4 March, 2004. No. 264 [Ukraine].

*Decree-Law No. 183/2001* of 21 June 2001 [Portugal].

*Law on the Prevention and Control of HIV/AIDS* (2006). No. 2006/QH11 [Vietnam].

*National Program for Providing HIV Prevention, Help and Treatment for HIV-Infected and People with AIDS for March 2004-2008*, of 4 March, 2004 [Ukraine].

*New Mexico Statutes*, Chapter 24 (Health and Safety), art. 23. [New Mexico, U.S.].

*Référentiel national de réduction des risques pour usagers de drogue mentionné à L'article D. 3121-33*. Décret No. 2005-347 du 15 Avril 2005. [France].

*The Medicines for Human Use (Prescribing) (Miscellaneous Amendments) Order 2005*, Statutory Instrument 2005 No. 1507. [U.K.].



Canadian  
HIV/AIDS  
Legal  
Network | Réseau  
juridique  
canadien  
VIH/sida

**Canadian HIV/AIDS Legal Network**  
**1240 Bay Street, Suite 600**  
**Toronto, Ontario**  
**Canada M5R 2A7**  
**Telephone: +1 416 595-1666**  
**Fax: +1 416 595-0094**  
**E-mail: [info@aidslaw.ca](mailto:info@aidslaw.ca)**  
**[www.aidslaw.ca](http://www.aidslaw.ca)**