



**Law Enforcement and HIV Network**

**INTERNATIONAL CONSULTATION ON  
POLICING OF MOST-AT-RISK  
POPULATIONS**

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**REPORT**

## **The International Working Group on Policing Key Populations**

### **Participation in the Consultation:**

**Dr Giorgio Bignami**, President, Forum Droghe, Rome, Italy

**Professor Scott Burris**, Director, Centre for Public Health Law Research, Temple University, Philadelphia, U.S.

**Franco Corleone**, Forum Droghe, Florence, Italy

**Alison Crocket**, UNAIDS, Geneva, Switzerland

**Professor Nick Crofts**, School of Population Health, University of Melbourne; and Director, Law Enforcement and HIV Network, Melbourne, Australia

**Professor Ernie Drucker**, Columbia University and John Jay College of Criminology, CUNY, New York, U.S.;

**Mikhail Golichenko**, Senior Policy Analyst, Canadian HIV/AIDS Legal Network

**Dr Jean-Paul Grund**, Addiction Research Center, Utrecht, The Netherlands

**Geoff Monaghan**, Research Fellow, Semeion Research Center for the Science of Communication, Rome, Italy

**Sanjay Patil**, Program Officer, International Harm Reduction Development Program, Open Society Foundations, New York, U.S.

**David Patterson**, Head, Social Development Unit, International Development Law Organization, Rome, Italy

**Dr Diane Riley**, Psychotherapist/Consultant/Assistant Professor of Public Health, Canada

**Dr Nick Thomson**, Senior Research Fellow, Nossal Institute for Global Health, University of Melbourne, Australia

**Fariba Soltani**, Senior Expert, HIV/AIDS Unit, United Nations Office on Drugs and Crime, Vienna, Austria

**Nicole Turner**, Co-ordinator, Law Enforcement and HIV Network, Melbourne, Australia

**Daniel Wolfe**, Director, International Harm Reduction Development Program, Open Society Foundations, New York, U.S.

**Alex Zelitchenko**, Co-ordinator, Law Enforcement and HIV Network, Bishkek, Kyrgyzstan

**Grazia Zuffa**, Director, Fuoriluogo.it, Florence, Italy

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The meeting was chaired overall by Professor Nick Crofts, Director of LEAHN, with assistance in facilitation by Alison Crocket of UNAIDS and other participants; the primary rapporteur was Nicole Turner, LEAHN Co-ordinator, assisted by Fariba Soltani of UNODC and Nick Thomson. This report was prepared from their records by Nick Crofts and Geoff Monaghan with input from other participants in the Consultation.

The Consultation was organized by the Law Enforcement and HIV Network (LEAHN), in collaboration with the International Development Law Organization (IDLO) and Forum Droghe. IDLO also provided the venue and logistical support for the Consultation, and substantial in-kind support; Forum Droghe managed finances and accommodation for participants. The Consultation was co-sponsored by the Open Society Foundations (OSF), the Joint UN Programme on HIV/AIDS (UNAIDS), and the International Drug Policy Consortium (IDPC).



## Contents

List of Abbreviations	5
Executive Summary	6
1. Introduction and Background	8
Box I: The FCDS works against HIV prevention	9
Box II: Bangladesh – police work against condom distribution	9
2. Methods	11
2.1 Participants	11
2.2 Consultation	11
2.3 Consultation Process	11
3. Discussion	12
3.1 Characteristics of policing in relation to drug users and sex workers	12
3.2 <i>Why</i> do police behave in the way they do?	12
3.3 Need for Agreed Definitions	14
3.4 Policing for public health	15
3.4.1 Characteristics of policing for public health	16
3.4.2 Principles	17
Box III: Sex workers reform police practice in West Bengal	18
Box IV: The Nepal Police HIV Strategy and Civil Society Engagement with police: Two processes combining for a better HIV prevention environment	18
3.4.3 Operational Guidelines	19
3.4.4 What does policing for public health look like?	20
3.5 How do we move from here to there?	21
3.5.1 Elements of Change for Current Policing Cultures	21
3.5.2 Joining with wider police movements	24
4. Highlighted conclusions	24
References	26
Box V: Suggested Guidelines for production of SOPs for HR Policing	29

## List of Abbreviations

ARVs	Antiretrovirals
BDS	Blue Diamond Society
CJS	Criminal justice system
DATs	Drug Action Teams
DEA	Drug Enforcement Administration (United States of America)
FDCS	Federal Drug Control Service (Russia)
FSU	Former Soviet Union
HBV	Hepatitis B
HCV	Hepatitis C
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IDLO	International Development Law Organization (IDLO)
IDPC	International Drug Policy Consortium
IDU	Injecting Drug Users
KP	Key Populations
LEAHN	Law Enforcement and HIV Network
LGBTI	Lesbian, Gay, Bisexual, Transsexual, Transgender, Transvestite, and Intersex
MDGs	Millennium Development Goals
MoH	Ministry of Health
MOU	Memorandum of Understanding
MMT	Methadone Maintenance Therapy
MSM	Men who have Sex with Men
NGO	Non-Governmental Organization
NSP	National Strategic Plan
OSF	Open Society Foundations
OST	Opiate Substitution Therapy
PHC	Populations of Humanitarian Concern
PLHIV	People Living with HIV
PWIDs	Persons who Inject Drugs
SOCA	Serious and Organised Crime Agency (United Kingdom)
SOPs	Standard Operation Procedures
STIs	Sexually Transmitted Infections
SW	Sex Workers
TB	Pulmonary Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

## **Executive Summary**

In much of the world, marginalized and criminalized communities especially persons who inject drugs, sex workers and their clients, transgender persons and men who have sex with men, are among the groups most at risk of exposure to HIV and other infections substantial resultant morbidity and mortality. Efforts to prevent disease in these populations are often hampered by policing policies and practices, a key shaper of the risk environment. This has been extensively documented; less widely examined are the ways in which policing policies and practices can help decrease risk, of which a growing number of examples exist. The need for better understanding of how the police role in risk environments can be changed through engagement and partnership, rather than conflict and tension, led to this Consultation, which began identifying and defining principles underlying effective policing for HIV prevention, treatment, care and support among most-at-risk populations (MARPS) and marginalized communities.

## **Methods**

A group of people with widely differing experience in many parts of the world but a common interest in engaging with police came together for wide ranging discussion. The current situation, the ideal situation, and how to make progress from one to the other were all discussed. Participants came from policing, academic, NGO, multilateral and activist backgrounds and institutions from ten countries, as well as UNAIDS and UNODC were represented. This Report provides an edited and supplemented account of the discussions that took place, preceding, during and following the two days.

## **Discussion**

The Working Group discussed a wide range of issues related to policing for public health in these key populations, beginning from the way police behave at present to members of these groups and why this might be so, through to the characteristics of an ideal policing approach to public health and ways in which this agenda might be advanced.

### **Characteristics of policing in relation to drug users and sex workers**

Police cultures are often traditionally antagonistic to these populations; to improve advocacy and education, better understanding of why police behave in these ways is necessary. A wide range of reasons for hostile police behaviour in relation to HIV prevention has been advanced, but mixed messages - coming even from within the UN family - around control of drugs or sex work and control of HIV are a major problem,. This confusion extends to definitions of terms, common understandings of which are necessary to effective communication and partnership. When police are asked to assist in HIV prevention, the common response is *'but it's not really our job'*.

### **Policing for public health**

There is a need to define police policy and activities in relation to harm reduction programs with Standard Operation Procedures (SOPs) for police dealing with such programs. More broadly however there is little formulation as yet of what defines 'policing for public health' differently from more traditional policing; and how 'policing for public health' relates to other movements of innovation and reform within police cultures and agencies. The overriding feature of public health policing is that of partnerships - of police being active within the multi-sectoral decision-making processes of the community; a community that is inclusive of KPs and other marginalized communities equally as the mainstream. As well, accountability and prioritization are integrated into these processes. This needs consensus around goals (evidence informed, explicitly based on human rights) and a clarity about those goals. Policy and policing are often separated by a huge gulf. The fundamental goal is good cooperation between police on the street and public health actors. Solutions most often happen locally, so it is important to build up from frontline police - which raises the challenge of taking lessons learned upwards and integrating them into policy.

## **Principles**

Principles underlying policing for public health help direct development and monitor progress: they need to be precise, law enforcement-oriented and legally supported, and some potential principles are enunciated here. More work is needed, especially reviewing current good practice.

## **Operational Guidelines**

Police require SOPs to direct their activities and provide guidance for the exercise of discretion, and Operational Guidelines to underpin development and refinement and evaluation of SOPs

## **Characteristics of Policing for Public Health**

include that police recognise their impact on public and personal health, and there is institutional and professional responsibility; multi-sectoral partnerships and collaborations, with police as essential members of public health teams; principles of policing for public health are widely embedded in law enforcement policies and practices; police apply a full range of response options in terms of viable alternatives to arrest and prosecution for named offences.

## **How do we move to policing for public health?**

The role of police services in helping governments to realize the ambitions of Millennium Development Goal (MDG) 6 (combating HIV/AIDS, malaria and other diseases) and MDG Target 6A (halt by 2015 and begin to reverse the spread of HIV/AIDS) and the UNAIDS 2011-2015 Strategy *Getting to Zero* is one of the central issues for the next four years.

## **Elements of Change for Current Policing Cultures**

The discussion identified training, partnerships, empowerment of KPs, accountability, political commitment, tackling corruption, reforming police practice around arrest quotas and the like, use of instruction and orders, and practicability as key elements in the package of tools for bringing about change; and a need to use examples to assist scale-up.

## **Joining with wider police movements**

There are police reform conversations happening internationally, investigating how police can be more progressive and effective. Integrating harm reduction policing into policing for public health, and that into existing frameworks for police reform, provides better traction for harm reduction policing.

## **Conclusions**

This initial discussion covered an enormous amount of ground in relation to policing for public health in the context of HIV among key populations; it was impossible in the time available to look both comprehensively and in depth at all the issues of importance. Some conclusions are drawn, but overall the conclusion from this Consultation is that a good start has been made, but there is much work yet to do – and that this is a most important new frontier in the ongoing struggle against AIDS.

## 1. Introduction and Background

In much of the world, marginalized and criminalized communities are among the groups most at risk of exposure to HIV, tuberculosis (TB), hepatitis B (HBV) and C (HCV), and sexually transmitted infections (STIs). In many places, as a result, these groups have the highest prevalence of these diseases. These key populations (KPs) include to varying degrees depending on geography) persons who inject drug (PWIDs), sex workers (SWs) and their clients, transgender persons, men who have sex with men (MSM), refugees, populations of humanitarian concern (PHC) and those who are or have been incarcerated. PWIDs and some other drug users such as cocaine and methamphetamine smokers also run a high risk of overdose and other serious medical complications. Worldwide, HIV, HBV, HCV and TB cause substantial morbidity and mortality among these populations.

Much has been learnt over the last three decades about how to diminish the risk of HIV and other diseases among these populations, and much has been done globally. However, in most places at most times these efforts have been carried out *despite* policing policies and practices. Indeed, in many countries police services<sup>1</sup> have been considered, often rightly so, as barriers to public health efforts to reduce the transmission of HIV, HCV, TB and overdose deaths.

Drug use and/or possession and most forms of sex work are either punishable crimes or administrative violations in most countries. As such police services and their policies and practices form one of the most powerful shapers of the risk environment for these populations. Some tactics employed by police services can increase the risk of HIV, HBV and HCV among these populations. In many countries where HIV, HVB, HVC and TB prevalence rates remain high, PWIDs and SWs are frequently harassed, tormented, and persecuted by police officers. Many police officers routinely extort money from drug users and sex workers and exploit sex workers for their own sexual gratification. In some countries, police services go out of their way to thwart tried and tested HIV prevention, treatment and care policies and practices (see Boxes I and II for examples). Such draconian responses have served only to weaken public health responses to HIV, hepatitis and TB.<sup>2</sup>

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<sup>1</sup> We here use the term 'police services' to describe those statutory bodies empowered to enforce national laws within the confines of their country, a state, territory, or possession (or political subdivision) of their country, or within the borders of a host nation, and include also other law enforcement agencies entrusted with 'policing powers' (e.g. inspection, entry, search, arrest, detention and other investigative powers) such as prison and parole services, border guard, immigration, customs and coastguard services and specialist agencies such as the Drug Enforcement Administration (DEA) in the USA, the Federal Drug Control Service (FDCS) in Russia, and the Serious and Organised Crime Agency (SOCA) in Britain.

<sup>2</sup> There is a growing body of literature addressing these negative impacts of and barriers presented by law enforcement in relation to HIV risk among marginalized populations (Rhodes and Simic 2005). These include, for example, negative impacts of policing on HIV programs targeting PWIDs and police 'crackdowns' driving SWs away from areas where HIV programs can reach them (Strathdee et al 2008a; Strathdee et al 2008b; Friedman et al 2006; Rhodes et al 2002; Shannon et al 2008; McMillan and Worth 2010; Yi et al 2010), harassment or confiscation of injecting equipment leading to improper use and disposal and avoidance of harm reduction programs (Wood et al 2004; Burris and Strathdee 2006), the use of drug registries by police (Shields 2009 and Wolfe, Carrieri & Shepard 2010), lack of access to drugs and treatment during incarceration (Kerr et al 2005, Wolfe, Carrieri & Shepard 2010, and Krüsi et al 2010) and generally tension and conflict between public health strategies and law enforcement strategies towards PWIDs in many countries (Maher 2004; Rhodes et al 2006; Shannon et al 2008; Wolfe, Carrieri & Shepard 2010; Krusi et al 2010; Werb et al 2008; Wood et al 2005; Sarang et al 2010; Small et al 2006). In South Asia, for further examples, there is much evidence of the detrimental impacts of police practices on MSM and transgender people, and to services seeking to address their needs (e.g. Chatterjee 2006; Chakrapani et al 2007; Safren et al 2006; International Gay and Lesbian Human Rights Commission 2003).



## Box I: The FCDS works against HIV prevention

The Federal Drug Control Service (FDCS) in Russia epitomizes the stance of antagonism to evidence-based approaches to HIV prevention. Since its creation in 2003, the FDCS has repeatedly blocked all attempts by international and national organizations to set up opiate substitution therapy (OST) programs in Russia. In two documented cases, the FDCS forced the closure of websites which promote methadone maintenance therapy (MMT) for opiate users.<sup>i</sup> Similarly, it has done its utmost to counter all efforts to scale-up NSPs in Russia by threatening to prosecute non-governmental organizations (NGOs) for running NSPs or even suggesting that they be set up. More insidiously, since 2003 the FDCS has failed to meet its legal obligations to work with the Ministry of Health (MoH) in drafting guidelines which would place NSPs on a secure legal footing in Russia, which in turn would allow for their funding at federal, oblast and city levels.<sup>ii</sup>

<sup>i</sup>See *Russia Scorns Methadone for Heroin Addiction*, The New York times, 22 July 2008, which describes attempts by the FDCS to instigate proceedings against Professor Vladimir Mendelevich, a distinguished narcologist working in Kazan, Russia, after he posted reports on methadone treatment on his website in 2006 <http://www.nytimes.com/2008/07/22/health/22meth.html?pagewanted=all> Accessed 29 May 2012.

Also see *Russia's drug policy fuels infectious disease epidemics*, The Lancet Infectious Diseases, Volume 12, Issue 4, Pages 275 - 276, April 2012. Which describes how the FDCS blocked the website of the Andrey Rylkov Foundation for promotion of opioid substitution therapy in the Russian Federation <http://www.thelancet.com/journals/laninf/article/PIIS1473-3099%2812%2970072-5/fulltext> Accessed on 11 June 2012

<sup>ii</sup>See the Note to Article 230 ('inclining to consumption of narcotic drugs or psychoactive substances') of the 1996 Criminal Code of the Russian Federation. The Note allows for the distribution of sterile injecting equipment to PWIDs providing this done in accordance with joint instructions issued by the FDCS and MoHSD. To date, no such instructions have been issued.

## Box II: Bangladesh – police work against condom distribution

[From: Legal environments, human rights and HIV responses among men who have sex with men and transgender people in Asia and the Pacific: An agenda for action. Au: John Godwin. Regional HIV & Development Programme for Asia & the Pacific, UNDP Asia Pacific Regional Centre. July 2010. <http://regionalcentrebangkok.undp.or.th/practices/hivaids>]

The sodomy offence of the *Bangladesh Penal Code* is rarely enforced against MSM, but there have been incidents of harassment by vigilante groups. Local *fatwas* have been issued against MSM, which influence application of *Sharia* law by informal courts. Arrests of MSM have also occurred under public order offences of the *Code of Criminal Procedure*. Arrests are rarely followed by prosecutions. According to the NGO Bandhu Welfare Society, police frequently stop, harass and arrest MSM under suspicious behavior laws. Such laws have effectively prevented Bandhu Welfare Society's staff from handing out condoms in public places.<sup>i</sup>

A study of Bangladeshi *hijras* (male to female transsexuals) describes the vulnerability of sex workers to law enforcement abuses: The *hijra* sex workers were exploited by clients, mugged, and beaten by hooligans but never received any police support. They hardly reported any incidents to police because of fear of further harassments. The law enforcing agents either raped a *hijra* sex worker and/or burglarized earnings from sex trade.... *hijra* are not safe in sex trade. They are forced to have unprotected sex with clients, local influential persons, and police free of charge.<sup>ii</sup>

Human Rights Watch found that the police actively interfered with outreach work among MSM, including confiscation of condoms.<sup>iii</sup>

<sup>i</sup>Hussain D. (2009). Between invisible friends *Himal South Asian*. December 2009.

<sup>ii</sup>Khan, S, Hussain M, Parveen S., et al (2009) Living on the Extreme Margin: Social Exclusion of the Transgender Population (*Hijra*) in Bangladesh *Journal of Health Population and Nutrition* 27(4): pp. 441-451 at 446.

<sup>iii</sup>Human Rights Watch (2003). *Bangladesh : ravaging the vulnerable: abuses against persons at high risk of HIV infection in Bangladesh*. New York: Human Rights Watch

Currently, police attitudes as exemplified by racial bias of the 'Stop and Frisk' policy in the U.S., where the vast majority of those targeted are black and Hispanic men, creating mistrust and antagonism among the populations so policed. Police are often very reactive, chasing the "drug of the month" without understanding the complexities involved in the patterns or circumstances of use. There has been some progress with policing in relation to HIV but such advances are usually trumped with concerns about crime and violence.

A paramount example at the moment is the brutality of the Mexican drug cartels – as a victim of crime, one does not go to the police; they are as likely as not implicated in the crime itself. In an escalating spiral, the U.S. has promoted the use of the military to take on the cartels.

While this problem has been widely documented, there are also ways in which policing policies and practices can help decrease risk – and these positive approaches by police services have been less widely examined. Indeed, there are a growing number of police services which are prepared to rethink their policing strategies in relation to public health concerns and which have developed enforcement policies and practices based on harm reduction approaches. Therefore, against these concerns and general observations, there is a need to better understand ways in which the police play a role in creating and sustaining such risk environments and how this can be altered. With active participation, through engagement and partnership, rather than conflict and tension their role can be altered to ameliorate risk.

In terms of building supportive environments for HIV prevention, treatment, care and support, police services could be considered next logical step. More than this, however, police may be real partners in building public safety (which should include protection from HIV): police can be leaders. This has been demonstrated in other public health settings, such as the routine inspection of retail pharmacists and the products they sell and the devising and enforcement of multiple strategies to decrease death and injury from road trauma.

There are an increasing number of HIV programs serving marginalized communities, particularly SWs and PWIDs, which have found ways of working with rather than against their local police. In a number of developing as well as developed countries, some police services are consciously moving towards more collaborative approaches to policing of these communities.

The increasing number of collaborative experiences has highlighted that the meaning and principles behind police policy and practice – in regards to HIV prevention – must be made clear. A collected, codified and further disseminated set of policies must also be put into action much more systematically than they have been to date. There is a perceived need for shared definitions and principles, derived from experience of successful approaches, and then finding local expression that is adapted to the local context.

In a paper from the Harvard Kennedy School (Travis and Stone, 2011) entitled 'Toward a New Professionalism in Policing', the authors reflect on changing ideas, policies and practices of police in terms of four attributes and imperatives: accountability, legitimacy,

innovation, and national coherence. This analysis is especially in regard to the USA, where they note a wide diversity in attitudes of police and in populations policed. Travis and Stone however argue at the same time for the wider applicability of these principles which go a long way to framing how we might think about policing in relation to the broader issues of public health. In some ways it describes a current picture very similar to how we thought about health, medicine and drug use 30 years ago. For example, doctors were initially (and in many places still are) hostile to 'drug addicts' – and yet much of their work involved dealing with drug dependent people as patients. This reflects the present agenda about public health and policing, of which policing in relation to these populations is part. To achieve an effective partnership between the HIV prevention agenda and police approaches to these populations, we need a good understanding of what drives police behaviour in these areas, in order to provide a basis for how to move ahead. In simply characterising police as part of the problem an adequate understanding of why they act as they do is not provided.

This Consultation aimed to begin the process of identifying and defining the principles underlying effective policing for HIV prevention, treatment, care and support among marginalized communities (including in prison and other detention), and a process for going further.

## **2. Methods**

### **2.1 Participants**

To begin to build on scattered progress globally, a group of people with a common interest in engaging and working with police towards a common goal of creating supportive environments for HIV prevention came together in Rome over two days in May 2012. The group drew from people with widely differing experience in many parts of the world. Participants came from policing, academic, NGO, multilateral and activist backgrounds as well as institutions from ten countries and included representatives of UNAIDS and UNODC.

### **2.2 Consultation**

The Consultation was organized by the Law Enforcement and HIV Network (LEAHN), in collaboration with the International Development Law Organization (IDLO) and Forum Droghe. IDLO also provided the venue and logistical support for the Consultation, and substantial in-kind support; Forum Droghe managed finances and accommodation for participants. The Consultation was co-sponsored by the Open Society Foundations (OSF), the Joint UN Programme on HIV/AIDS (UNAIDS), and the International Drug Policy Consortium (IDPC).

### **2.3 Consultation Process**

Before the Consultation, a set of Discussion Points was circulated to the participants, and added to by each where they saw relevance; the final version of this was made available to all participants, and points made are included in this report. The Consultation itself was held over the afternoon of 10 May and the morning of 11 May with a final session on the afternoon of 11 May. The discussion largely followed the structure of this report, with discussion in each section stimulated by some initial thoughts from one of the

participants. This Report provides an edited and supplemented account of the discussion that took place, preceding, following and during the two days.

Following wide ranging discussion about the current situation, the ideal situation, and how to make progress from one to the other, next steps were discussed and planned. This Report documents the process and outcomes of the Consultation.

### **3. Discussion**

#### **3.1 Characteristics of policing in relation to drug users and sex workers**

As indicated by the multiple studies referenced above, police cultures are often traditionally antagonistic to those who constitute these populations. As well, difficulties are created for effective policing in relation to HIV prevention among these populations by the conflict with perceived police roles in drug policing and social order.<sup>2</sup> These perceptions are located within international bodies, national governments, police agencies and police education and training facilities – creating an environment in which it is difficult for police to prioritise health partnerships.

There is a need to better to understand why police behave in the ways they do towards such people in different contexts, so that this understanding can underpin advocacy and education. The common response, when police are asked to assist in HIV prevention approaches, is *'but it's not really our job'*. The Consultation identified this as a key question to be answered, and asked if there is currently enough information about why the police behave in the ways they do.

#### **3.2 Why do police behave in the way they do?**

A wide range of reasons for adverse police behaviour in relation to HIV prevention among KPs have been advanced.

On the one hand, police behaviour results from forces acting upon them over which they have no control: for instance, statutory, administrative and professional obligations (e.g. paraphernalia laws, performance targets)<sup>3</sup> to which they are subject; their hands are tied by law, regulation and tradition. Police will often say they are simply “doing the right things, just following orders” – and police prefer the language of order. To a very large degree, daily police activity is reactive – responses driven by pressures from the community, interest groups and politicians. A major determinant of police behaviour is governed by the need to meet the expectations and demands of the public – “we don’t want dirty heroin addicts hanging around outside our restaurants and shops – it is bad for trade”. Discretion is an enormous part of policing, so it is not simply a matter of enforcing the law, there is much judgment in how the law is enforced, and against whom, and when as well as what the pressures are on police to respond to particular sectional community interests.<sup>4</sup>

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<sup>3</sup> 'Law Enforcement and Harm Reduction in SE Asia': examining policing and harm reduction in Cambodia, Laos and Vietnam. Eds: Nick Crofts, Tim Moore, Brigitte Tenni, Nick Thomson. <http://www.harmreductionjournal.com/series/policing>

<sup>4</sup> This consideration has led some to advocate to street-based drug users not to make themselves too conspicuous, particularly to the public; if they can stay out of sight they will often stay 'out of the minds' of police also. This is an example of a covert adjustment to police needs, as judged by the community; it is pragmatic, but it does not tackle underlying structural issues, or attend to the needs for community strengthening.

On the other, police are active in creating their own culture, and, as people coming from within their particular community, share the characteristics of the community. Some police cultures, therefore, as with many other sectors of communities, do not promote the interests or rights of drug users or sex workers as human beings; again, in some places, there is a lack of interest in or education about the human rights of these populations. It can be argued that to some extent, police reticence or reluctance, or even outright hostility to support programs designed to help groups that they see as some of the most active, and in some cases dangerous, criminals in their communities is understandable. A facet of the creation of police cultural construction of the members of these populations is that police see them disproportionately more often in situations of crisis and danger, and their view is thereby biased.

Again, where views are partial or perspectives are narrowed, harm reduction can appear counterproductive or misguided. Police often do not know about the damage that can be caused through their policies, practices and behaviours. There is commonly a lack of training for police in the importance and means of policing key populations in relation to HIV; where there is training, it is often not integrated or sustained.

"The police are trained to fight the drug users, so it is necessary to change the education system, change the approach of government before we can change the approach to drug users. For example in Kyrgyzstan, there is a need for education of police at all levels of policing; a useful starting point has been to look at personal security and safety issues, especially around occupational exposure. NGO and police partnerships are ideal, but it can take a long time for police to understand the issues." *Former FSU police officer*

"Is this because many police officers are poorly educated or is it because many training programs are flawed (e.g. poorly formulated definitions of harm reduction, insufficient detail regarding the benefits of OST, NSPs, alternatives to arrest/incarceration, harm reduction approaches couched simply in terms of 'police support for OST and NSPs')? Or is it that the trainers don't have the requisite training skills, or are poorly equipped to deal with the more searching questions by police officers?" *Former police officer*

Police see first-hand what to them are the failures of harm reduction policies (e.g. the diversion of methadone, discarded used syringes and other drugs litter, corrupt doctors selling prescriptions, injudicious prescribing practices, and outreach workers using/selling drugs, and methadone patients 'topping up' with heroin). This is fostered by lack of or inadequate education of police about harm reduction, and confusing or conflicting guidance or advice. The notion of 'police discretion' in relation to policing of key populations and HIV prevention is not particularly well-articulated by many police services, and there is often a lack of accountability or oversight, or poor implementation of oversight by police or other agencies.

From the point of view of some police officers, their hands are often tied when it comes to HIV prevention among populations such as PWIDs and SWs. On the back of political imperatives to tackle drug-related crime and to send a clear and unambiguous message that 'drug addicts and prostitutes' are not wanted in certain areas or at all on the streets, police often resort to draconian tactics such as 'crackdowns' involving mass arrests for relatively petty offences. These are often driven performance targets such as

arrest quotas on which their career and livelihood often depend. More often than not such action is damaging to harm reduction programs – including ignoring policies related to not attending overdoses or patrolling near OST programs and NSPs. Police often say public health is not their objective; police and public health partnerships and collaborations are not adequately identified or promoted. Where they are promoted, especially by public health authorities (including especially the AIDS community), mixed messages can often be the problem, with health imperatives given priority over policing imperatives. For police, drug use is linked to crime and antisocial behaviour – ‘it’s not my role’. There can also be conflicting advice from lawyers acting for State institutions as to whether a particular practice is lawful. This confusion of messages is embodied even within the UN: mixed messages from UN agencies serve only to confuse police services, who often then will discount the health component.

Police often do not recognize that drug control is subject to human rights. For many officers human rights and drug laws are from different universes and there is no practical way to match them. Human rights laws are seen as an obstruction for drug enforcement; therefore appeals to human rights do not work because for police such appeals are theoretical and not practice oriented.

There are also structural reasons for adverse police behaviour in relation to key populations. Inadequate salaries and universal opportunities for profit through corruption, or for boosting income for subsistence, or simply for ‘recompense’, all can militate against police adopting more effective approaches. In some settings, high turnover rates of police in the community mitigate against sustainable relationships as basis for common approaches. There is commonly a lack of incentives to take on extra work, such as assuming new responsibilities when referring drug users to treatment services, or handing out sterile injecting equipment to arrestees as they leave the police station.

### **3.3 Need for Agreed Definitions**

It is clear that for effective partnerships between police and health in relation to HIV prevention, broader harm reduction, and policing generally among key populations, there needs to be a common language and common understanding of the meaning of key terms on the part of both parties. There are clearly outstanding issues about definitions of key terms and concepts, about achieving agreement around definitions of these terms, and about getting these agreed definitions operationalized at all levels – but most particularly in police policy and SOPs.

This absence of agreed definitions is a major problem in getting police services and other criminal justice agencies to be supportive of harm reduction, and such definitions are therefore not finding their way into training programs and policy documents. This is the case even and especially among the UN agencies, though not exclusively so. There are examples of disagreements and confusion over definitions within the UN family, and specifically in relation to coercion and compulsion vis-à-vis drug treatment programs.

Terms and concepts for which agreement over definitions is needed include:

- harm reduction,
- sex work,

- decriminalization,
- legalization and depenalization,
- drug use and misuse,
- zero tolerance ... but there are potentially many more.

### **3.4 Policing for public health**

Policing among marginalised or key populations, and policing in relation to HIV prevention, are clearly not separate aspects of police policy and practice, to be applied only to certain populations and at certain times: there is a need for a much broader, more all-embracing concept than this. At the most basic, there has been and is a need to define police policy and activities in relation to harm reduction programs: such definitions will then be contained and contextualised in SOPs for police when dealing with such programs. The historical starting point for this approach has been with harm reduction programs focussed on HIV prevention among IDU and SW communities.

But moving more broadly (than in police collaboration with specific programs), there is little formulation as yet of what defines 'policing for public health' differently from more traditional policing, especially when looking at the general police relationship with key populations and marginalised communities. There is also little on and how 'policing for public health' relates to other movements of innovation and reform within police cultures and agencies.

Harm Reduction is about prioritisation, about setting more important and urgent goals ahead of less pressing and less immediately achievable ones. There is a vast array of standards among policing organisations in different parts of the world – or even in the one place – between and within different police agencies. The degree of education, accountability, competence, corruption and management capacity and ability varies widely. The concept of 'policing for public health' brings the public health focus to the forefront of policing – on the basis that a human rights-based public health is at the heart of humane and effective drug control policies (as provided for by the UN Drug Conventions), and of the regulation of sex work. 'Policing for public health' should therefore aim to equally accommodate public health, individual, public and international security considerations on the balance of human rights.

There continues to be debate, however, about the need for trade-offs between different principles – for instance, between public health and public safety, where greater police emphasis on public health may lead to greater police intrusiveness (not itself necessarily iniquitous to human rights); and where considerations are driven by political imperatives that are in conflict with public health or human rights goals.

There is further discussion to be had about these issues, around

- (i) the achievement of common goals (expressed in common language) between public health and law enforcement, encapsulated in some phrasing such as "human-rights based public safety"; and
- (ii) what are the processes by which these prioritizations are brought about?

In relation to the former, there it was suggested that there was a need for a philosophical understanding of how a society achieves consensus, with inclusiveness as its watchword – so that protecting the health and security of marginalized populations, given their relative inability to protect themselves as a direct result of marginalization, becomes a key focus of law enforcement. In this sense there should be no conflict to be resolved; as was said at the Consultation: “what, after all, are the laws which are being enforced for, if not to protect health and security?”

In relation to the latter, there was unanimity that the overriding feature of such police approaches (as a subset of ‘public health policing’) is that of partnerships – of police being active within the multi-sectoral decision-making processes of the community; a community that is inclusive of KPs and other marginalized communities equally as the mainstream. As well, accountability and prioritization are integrated into these processes.

One definition of ‘policing for public health’ which was generated by the meeting was:

Police policy and practice which works to common goals with health and local community, to support community safety and security where the drug users and sex workers and other key populations are seen as part of the community, and problematic drug use is understood as the business of health and social interventions. It is policing with realistic evidence-based use of police resources to tackle serious crime parasitizing marginalized communities. It provides recognition and support of the major role of public health in crime prevention.

### **3.4.1 Characteristics of policing for public health**

The group raised a number of questions for further consideration about what ‘policing for public health’ should look like:

- What is the relationship of ‘policing for public health’ to ‘operational policing’?
- ‘Effective/cost-effective policing’: what does this mean in relation to ‘policing for public health’? What costs and for whom? How does this balance with human rights?
- Can we be recommending effective models of policing within bad policy and legislation?
- What are the common factors in successful collaborations? How do they work their way upwards to become national policy?

### **Considerations:**

Fundamentally, there is a need for a consensus around goals that are informed by evidence, and based on human rights principles, and a clarity about those goals, towards which policing for public health aspires. In relation to drugs, for instance, such a policing approach must be designed to be part of a comprehensive drug control system which effectively and equally accommodates public health, security and human rights considerations. In relation to HIV, this means police operating in a public health environment, with a shared language and common goals with health.

This implies functioning partnerships, constantly renewed and optimized. Such partnerships, which critically include civil society and government as well as police and public health, must be flexible, evolve and change as the nature of the groups being



dealt with, and the culture, varies. The police-public health partnership is then expressed in recognition of and respect for each other's role, and development of mechanisms to both foster and operationalize the partnership (e.g. diversion at the point of arrest to health services).

Policy and policing are often separated by a huge gulf. The fundamental goal is good cooperation between police on the street and public health. Solutions most often happen locally, so it is important to build up from frontline police – which raises the challenge of taking lessons learned upwards and integrating into policy.

How 'success' and outputs are measured depends in the first instance on clarity of goals. Prevention is difficult to measure, because it is long term and the issues being dealt with are complex. Operational issues such as rates of particular sorts of crime, rates of diversions, reduction in recidivist behaviour, referrals to partner organisations such as mental health, and hospital admissions for particular conditions become surrogate measures – but long term studies are needed.

Leadership in these partnerships is needed from police, as senior partners in the relationship in many societies, with the inclusion of proactive roles and liaison officers. This will happen when police themselves recognise the importance of this role for them, and when they are credited with its beneficial outcomes.

### **3.4.2 Principles**

It is worth enunciating principles underlying policing for public health so that they may be applied when developing or moving towards such policing, as guides and when monitoring and evaluating policing approaches in practice. The group began consideration of such principles, which need to be precise, law enforcement-oriented, legally supported and concise. Suggested principles included

- the accommodation of both health and security considerations
- respect of human rights and fundamental freedoms
- respect for the needs of affected groups of population
- prioritization of immediate harms
- basing policy and practice on evidence, cost effectiveness and transparency and
- public access to information about impact assessment and independent evaluation.

However, further work is needed before such principles can be finally asserted to universally underlie policing for public health. This work includes examination of elements derived from examples of best practice, which are transferable across contexts to find local expression – there is therefore a need for more exercises in gathering best practice examples (see Boxes III and IV).

### Box III: Sex workers reform police practice in West Bengal

DISHA Jana Kalyan Kendra is an Indian NGO that in 1995 began working with sex workers in a red light area in Bardhaman district in Asansol city, West Bengal. The area was a well known for its crime and corruption and also fostered an environment where HIV risk behaviours were common. Throughout a series of consultations between the police and the community, it became clear that the area was a breeding ground for police corruption. DISHA embarked on a series of activities that would address the police corruption issue and create a safer space for HIV prevention efforts with sex workers. Senior police officials began working in the area which led to the cessation of corrupt practices by junior officials, a health clinic and the opening of a bank to assist sex workers. In addition, self help groups of sex workers began to form, leading to a peer based behaviour change communication strategy being scaled up, and the initiation of alternative income generation projects. The Additional Superintendent of Police of Asansol automatically becomes the *ex-officio* President of DISHA meaning that the police are always connected and in communication with DISHA. The project was written up in a UNAIDS Best Practice Case Study in 2010 and continues to be an example where police have not only worked with the community towards increasing HIV prevention but have actively driven it.

Reducing Harm, Rebuilding Lives: HIV/AIDS and High Risk Populations. Law Enforcement Agencies as Agents of Change. UNAIDS Report 2010.

### Box IV: The Nepal Police HIV Strategy and Civil Society Engagement with police: Two processes combining for a better HIV prevention environment

The Blue Diamond Society (BDS) was formed in 2001 to address health and human rights needs of lesbian, gay, bi-sexual, transgender and inter-sex; rights violations, often at the hands of the police, were reported as common among these groups. BDS is now represented in 40 cities in Nepal. Its expansion has coincided with a drop in reports of rights violations against LGBTIs and an improved environment in which coverage of HIV prevention for LGBTIs has significantly increased. BDS has helped drive legal and policy reform in Nepal through targeted advocacy campaigns; at the same time it has actively sought partnerships with the Nepal Police that have helped change the way that police interact with LGBTI programs, services and people.<sup>i</sup>

The Nepal Police released their HIV/AIDS Strategy and Work Plan in 2005:<sup>ii</sup> this commits the Nepal Police to HIV prevention among uniformed officers and the population including sex workers, LGBTIs, PWIDs, prisoners and migrants. It stresses the importance of police partnerships with public health and with NGOs working with vulnerable groups; and training about HIV and sensitisation of high ranking police officers so that policy translates to operational guidelines and practice on the ground. The strategic objective is to create an enabling environment that facilitates HIV prevention and includes: involving representatives of key affected populations as resource speakers and trainers for the police, field visits to programs working on HIV prevention among KPs, investigating allegations of police harassment of members of KPs and supporting condom distribution in high risk areas.

The Human Rights Unit of the Nepal Police notes that the Strategy and Work Plan is becoming institutionalised and that implementation is progressing, citing an HIV Advisory Team at Nepal Police HQ, a program of awareness raising through Master Trainers of Training and police orientation programs, HIV training now integrated at all levels of police.<sup>iii</sup>

While the BDS and the police do not have an institutionalized relationship, the presence of a Nepal Police HIV Strategy that specifically promotes dialogue between police and KPs creates opportunities for regular meetings between BDS and the police. BDS reports that there are regular meetings between senior police and BDS and that police are willing to act on legitimate cases of police harassment.<sup>iv</sup> BDS continues to train and sensitize police, reaching over 500 police a year.

<sup>i</sup><http://www.leahn.org/wp-content/uploads/2011/09/pinkey-presentation.pdf>

<sup>ii</sup>Nepal Police HIV/AIDS Strategy and Workplan. Available at [http://www.policyproject.com/pubs/countryreports/NEP\\_PoliceStrategy.pdf](http://www.policyproject.com/pubs/countryreports/NEP_PoliceStrategy.pdf). Accessed on 17 December, 2011

<sup>iii</sup>[http://www.leahn.org/wp-content/uploads/2011/09/Bishwa\\_ICAAP.pdf](http://www.leahn.org/wp-content/uploads/2011/09/Bishwa_ICAAP.pdf)

<sup>iv</sup>Personal communication with staff member from BDS.

There is also a need for a vision of what policing for public health should look like, and a description of its elements (see below). Further to this, policing for public health is not just a principle, or a set of principles, it is a commitment to take the infrastructure that exists and on the basis of common objectives move toward the vision – best linked to the MDGs, and never losing sight of the fact that the common enemies are the spread of the HIV epidemic, hepatitis, TB, STIs, overdose and other health conditions on the one hand, and damaging criminal justice practices on the other.

The vision and the principles on which it is based should accord and connect with principles of multi-sectoral collaboration, agendas of professionalization of police, and the selection of partners, agents of change internally.

### **3.4.3 Operational Guidelines**

It is critical to get partnership agreements on paper, with a written commitment either through a local SOP or MOU with police so that when the new police come in there is a documented history and agreement to work from.

Police require SOPs to direct their activities and provide guidance for the exercise of discretion. There is a need for Operational Guidelines to underpin development and refinement and evaluation of SOPs; in some ways the Guidelines are more important than the Procedures, because in an analogous way to the Principles enunciated above, Guidelines are largely invariable across different settings, whereas SOPs must be tailored to local circumstance. Operational Guidelines therefore need to be drafted in a way that clearly describes the main features that should be included in any SOP the police adopt in relation to harm reduction.

A starting point for development of these Guidelines is presented in Box V. These points need to be converted into baseline generic SOPs that will be useful for police organizations around the world.

Two pertinent comments on this issue, which must be/should be practicality inherent in production of Guidelines and a generic SOP which will on the one hand fulfill policing for public health goals and on the other be grounded in police realities, are acceptable to police and relate to operational policing:

“It would be good to identify the drug and sex work related harms to be directly influenced by police activities and design the guidelines in a way to demonstrate to what extent certain tactics and activities can reduce or produce harms (HIV, shift to dangerous drugs, violence, death of overdose, corruption among police ranks, number of acquisitive crimes committed by people who use drugs etc).”

“But also accepting that police services/law enforcement agencies will, on occasions, need to engineer a range of harms (arrest, prosecution, incarceration, confiscation and forfeiture) against some key populations in order to reduce the range of harms these users inflict on communities when they are selling drugs, stealing, committing fraud, causing public disorder, selling sex, exploiting children and young persons and victims of human trafficking etc.”

### **3.4.4 What does policing for public health look like?**

Echoing the discussion around principles, a number of features common to policing for public health were identified.

**i. Police recognise their impact on public and personal health, and there is institutional and professional responsibility; and police are an essential part of public health committees/teams**

Police impact on public and personal health is universally recognized both by police and the health sectors, and they are seen as an essential part of a public health response. There is a need for a public health curriculum in police academies and in-service training; similarly, a need for law enforcement curriculum in public health training. There is routine access to essential health services in police detention (such as OST and ARVs – the comprehensive package of WHO, UNODC, and UNAIDS). It is equally imperative that the public health sector also assesses that evidenced based responses actually impact on crime prevention. There is a need for development of a common language, and integration of police performance indicators in public health approaches.

**ii. The principles of policing for public health are embedded in law enforcement –**

They are embedded in policies, education and training, and performance indicators, professional development opportunities, and standard operating procedures.

Health and social services within the CJS are in line with internationally recognised standards.

**iii. Police apply a full range of response options in terms of viable alternatives to arrest and prosecution for named offences**

This makes discretion meaningful in the public health context, and allows police to work within different legal frameworks, in responses to incidents involving key populations and in referral to services for those in need. It allows the avoidance of unnecessary arrest, as in cases of overdose, condom possession, and needle & syringe possession.

**iv. Multisectoral partnerships and collaborations**

Best practice examples of collaboration need to be identified and translated across horizontal and vertical levels; existing local collaborations between the community and police are integrated into national, regional policy and practice; innovation in partnerships is encouraged.

**v. Post arrest**

There is routine risk assessment in terms of health considerations prior to detention, and routine access to essential health services in police custody in line with the duty of care. This includes access to OST, ARV, mental health services

**vi. There is an accountability mechanism that assesses performance**

Impact assessment and evaluation strategies are mandatory, and are integrated into routine police practice, as part of accountability. Multiple variables are to be considered in such evaluation – for example, decreasing police violence, increasing referrals to health services, use of force decreased, increase in condom use and decreases in arrest for condoms. There is a need to understand the governance of various social issues in this context.

**vii. Policing for public health ties in with broader police professionalization agendas and strategies**

This can be achieved through accountability, legitimacy and innovation (Travis and Stone, 2011).

**viii. The observation of human rights is an integral part of policing for public health.**

**3.5 How do we move from here to there?**

Two major groups of themes emerged from the discussion about how to move from the current situation towards the ideals that have been identified: (1) how to bring about change in current policing cultures, environments and practices; and (2) how to join this agenda to wider movements of police cultural change. These are clearly inter-related, with each area of action influencing progress in the other. In the more immediate environment, linking harm reduction policing agendas with other UN initiatives can provide leverage; more broadly, linking these objectives with wider police reform and innovative movements can assist progress in culture change around policing marginalised populations.

The UNAIDS “three zeros” target includes zero stigma and discrimination. There is a need for a guide on how to shift the organizational culture of police forces from where they are now to the policing for public health paradigm envisaged here, and articulate the key components of what is required and how to achieve such a shift. The role of police services in helping governments to realize the ambitions of Millennium Development Goal (MDG) 6 (combating HIV/AIDS, malaria and other diseases) and MDG Target 6A (halt by 2015 and begin to reverse the spread of HIV/AIDS) and the UNAIDS 2011-2015 Strategy *Getting to Zero* is one of the central issues for the next four years. In many countries, the targets will only be achieved if police services wholeheartedly embrace harm reduction approaches and do their utmost to support the key nine interventions which make up the comprehensive package.

**3.5.1 Elements of Change for Current Policing Cultures**

The discussion identified key elements in the package of tools for bringing about change. These were: training, partnerships, empowerment of KPs, accountability, political commitment, use of instruction and orders, and practicability as well as a need to use examples to assist scale-up.

**Training**

There was absolute agreement about the necessity for universal introduction of training in harm reduction policing for all police, at basic level in Academies or other police training institutions, and continuing through the course of their careers. At the very minimum this should consist of sensitization to harm reduction issues and policies, and in support and protection of harm reduction programs.

Some police services provide very little training and guidance on creative thinking to tackle operational problems. UNODC and others have developed and are developing training resources – manuals, curriculums etc. – for training police in harm reduction and working with marginalized populations; these need completion and dissemination and capacity building in training.

Training is a necessary but not sufficient factor in changing the nature of policing in relation to HIV prevention and working with health in partnership. The issue is about culture change, not solely about training. However training has a large role in culture change: where training is mandatory, when for instance the majority of police officers are able to rattle off a definition of harm reduction along with 'theft', rape, burglary etc., and are required to be able to do so. Thus training programs and promotion examinations can assist the move to cultural change. The importance of peer education cannot be overstated in this process.

The nature of this training must also be broadened and integrated in two directions: linking the harm reduction training with other relevant and associated issues such as mental health; and linking to operational policing and demonstrating the operational usefulness of harm reduction approaches for police.

It is the design and application of the training that is important - definitions alone are not enough in terms of influencing attitudes, behaviour and cultural change. Training must be holistic and include a combination of theory and experiential learning tools such as role plays and site visits. Hearing stories from drug users and sex workers is critical to fostering empathy and understanding toward diverse communities. Harm reduction is part of a broader philosophy around policing for diverse and marginalized communities – so other modules would include cultural diversity, disability, mental health and so on. It is also worth emphasizing the importance of interagency and co-facilitated training, both in terms of building partnerships and trust but also a shared philosophy and approach

### **Partnerships**

There is a worthwhile strategy and approach in looking at drug control as a general issue, around the international conventions: there is a common framework for both law enforcement and harm reduction in the relationship between public health and security. Police in pursuing their goals around drug control should therefore work in partnership with other agencies to jointly achieve both goals.

The Dutch experience is of linking harm reduction into community policing promoting and using this as a vehicle to disseminate messages about health (e.g., alcohol). This was all on the basis of forming relationships and partnerships with health agencies. The Dutch recognized the need to look at the wider context, especially the economic situation, and link programs and their performance to funding levels – this approach forced groups, that were not already, to start talking to each other.

In Iran, the perception was that police do not know about the damage they cause – so, very deliberately, the police were made part of the Harm Reduction committee. In many instances at many times there is the opportunity for NGOs to educate police about the harms they are causing, and work together to overcome them. This is not always and everywhere the case.

Historically, police have been agents of public health as long as they have existed (similarly, public health has had a law enforcement role for the length of its existence). When the police are involved, they are usually more than happy to work on the joint agenda and in partnership. There is a need for education of everybody involved in the partnership – not just police: change needs to occur within public health agencies as well. Developing a common language is vitally important.

## **Empowerment**

There are powerful examples (e.g. the Durbar project in Sonagachi), but unfortunately few, of marginalised communities organising and pushing back against repressive and discriminatory action by police. In the case of the gay rights movement, one could say however that the experience is massive. There is not a lot of evidence as yet that empowerment on its own works, but marginalised communities need to find ways to counter their marginalisation.

## **Accountability**

Boosting police accountability, especially to the marginalised communities, can be a powerful mechanism for increasing police adherence to harm reduction principles. Police behaviour has to be more transparent because it is in the public eye. Police policing the police is no longer the norm in Canada, for instance.

## **Political Commitment**

Convincing police that public health is an important activity for their engagement depends very much on the political context, at local and national levels. Commitment from government, real and expressed, is an important determinant of police acceptance of harm reduction.

## **Command**

The structural dimension of police as a workforce is extremely useful if setting public health goals can become part of routine policing: operationalizing these then means they are concrete orders for police to follow. In Kyrgyzstan, an instruction has been developed for police – “Police prefer the language of order; Police may not value drug users as human beings, but, if they don’t follow orders, they will be punished”. For another example, English and Welsh police services support for and referral to MMT programs is part of their statutory obligation under section 17 of the Crime and Disorder Act 1988 (reduction of crime). Then there are the obligations imposed on police services as members of Drug Action Teams (DATs). Prevention, diagnosis and treatment of TB is certainly the role of police officers in those countries where the police service has responsibility for prisons, as is the case in Vietnam.

## **Practicability**

Perhaps one of the ways to persuade police to apply the harm reduction approach of the policy level is by linking the drug control provisions to “three zeros” through Article 38 of the Single Convention, 1961 as amended by the 1972 Protocol. Article 38 focuses on *practicable* measures against drug abuse. One of “three zeros” – discrimination (in case of drug policy it is different treatment of a person or a group of people based on health status or a habit) – is justified when it pursues the legitimate aim with the means which are proportionate to the results wished to be achieved. If pursuing the legitimate aims of drug control: security and public health, the Government (police included) uses the means which do not lead to the desired results, the policy is not justified and should be deemed as discriminative. In other words the term “practicable” is key to determining whether the policy employed as part of drug control is in line with the Single Convention and human rights obligations.

Practicability in achieving the goals of drug control will become a measurement for police performance by way of impact assessment and independent evaluation. When practicability becomes the measurement for police performance (perhaps because it is

included into SOP) the training on what is practicable (harm reduction for drug enforcement) will be naturally demanded and culturally adsorbed by police ranks.

### **3.5.2 Joining with wider police movements**

There are police reform conversations happening internationally, investigating how police can be more progressive and effective. Harm reduction can be a contentious language, so it is strategic often to link harm reduction policing to larger efforts e.g. community or “public friendly” policing. Integrating harm reduction policing into policing for public health, and that into existing frameworks of police reform, provides better traction for harm reduction policing.

For instance, donors are allocating significant funds to help reform police organizations in a number of lower or middle income countries. In these contexts it is important to illustrate to donors that harm reduction policing is an integral part of “public safety” and therefore consistent with their desire to help encourage democratic policing.

In higher income countries, austerity measures and cutbacks have forced law enforcement agencies to do more with less. In these countries, the zero tolerance approach towards drugs has proven to be a significant financial burden. It is important to demonstrate to the police and policymakers that harm reduction policing provides an opportunity to make police organizations more efficient and effective.

This provides enormous challenges but also opportunities for creative partnership approaches, as in the Dutch example.

## **4. Highlighted conclusions**

This initial discussion covered an enormous amount of ground in relation to policing for public health in the context of HIV among key populations; it was impossible in the time available to look both comprehensively and in depth at all the issues of importance. Therefore it is possible only to highlight some conclusions from the discussion that were felt to be key:

- There is a strong sense that we need better to understand why police behave in the ways they do towards members of key populations in different contexts, so that this understanding can underpin advocacy and education.
- It is clear that for effective partnerships between police and health in relation to HIV prevention, broader harm reduction, and policing generally among key populations, there needs to be a common language and common understanding of the meaning of key terms on the part of both parties.
- The concept of harm reduction brings a public health focus to the forefront of policing – on the basis that a human rights-based public health is at the heart of humane and effective drug control and sex work policies. Policing for public health should aim to equally accommodate public health, individual, public and international security considerations on the balance of human rights.



- It is worth enunciating principles underlying policing for public health so that they may be applied when developing or moving towards such policing approaches as guides, and when monitoring and evaluating policing approaches in practice.
- Historically, police have been agents of public health as long as they have existed (similarly, public health has had a law enforcement role for the length of its existence). When the police are involved, they are usually more than happy to work on the joint agenda and in partnership. There is a need for education of everybody involved in the partnership – not just police: change needs to occur within public health agencies as well. Developing a common language is vitally important

The Consultation in Rome was left with three main feelings:

1. Members of the affected communities and operational police were under-represented at the Consultation. Any follow up event should be more inclusive of these critically important groups.
2. It was equally clear that despite the contributions of members of this group and others, and the work of this group leading up to and at the Consultation, there is much work left to be done – this meeting and its output represents a small start on a major issue.
3. And lastly there was a generally shared feeling that this process embarked upon by this group in Rome should continue and grow; that this is a most important new frontier in the ongoing struggle against HIV and the other diseases and problems to which we refer.

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## Box V: Suggested Guidelines for production of SOPs for HR Policing

1. Encouraging entry of KPs into drug treatment programmes via drug referral and similar schemes. (In order to ensure sufficient numbers of arrestees take up the offer of referral, police services should allow drug referral workers (or specially trained outreach workers) to access arrestees whilst they are in police stations.)
2. Preventing the spread of HIV and hepatitis caused by injecting by supporting community-based and prison-based NSPs, and providing arrestees with sterile injecting equipment on their release from police stations.
3. Preventing drug overdose fatalities by allowing specially trained officers to carry and administer naloxone, treating all cases of drug swallowing as a medical emergency requiring immediate hospitalisation and ensuring that all drug using arrestees are examined by a doctor to determine their fitness to be detained at the police station.
4. Reducing drug-related crime, illicit drug consumption, HIV, hepatitis and drug overdose deaths in communities and prisons by promoting opioid substitution treatment programmes.
5. Helping to reduce incarceration rates by adopting or scaling-up warning, cautioning, and cautioning-plus programmes as alternatives to prosecuting offenders for minor drug use/possession/trafficking crimes and minor offences relating to adult prostitution.
6. Preventing sexually transmitted infections in prisons and other closed settings by making condoms and dental dams readily available and setting up mechanisms which allow for the voluntary referral of sex workers to local prevention, treatment and care services.
7. Tackling in-service stigma and discrimination by adopting and implementing liberal recruitment and retention policies for homosexuals and PLWH and ensuring they have the same career opportunities in terms of promotion and specialization as their colleagues.
8. The reduction of collateral harms (e.g. large-scale public disorder, allegations of evidence fabrication and cracked trials'), by focused intelligence-led tactics (e.g. test purchase and undercover buy operations and controlled deliveries), in conjunction with other prevention strategies and, where possible, in consultation with community leaders and community groups.
9. Making sure they focus on those drug and sex markets which are causing or are likely to cause, most harm to individuals and communities. The misuse of some drugs such as alcohol, cocaine, heroin and methamphetamine create far more harms than say, cannabis or ecstasy.
10. Ensuring that the principles of harm reduction are embedded in police service training curricula. In this respect, UNODC together with its consultants, is taking a global lead in developing training manuals and other materials.
11. Forging durable partnerships with health authorities, drug and HIV prevention, treatment and care services and PLWH support groups.
12. Regularly reviewing their policies, strategies, tactics and performance indicators/targets to ensure they support the broader agenda of public health imperatives and are underpinned by rights-based international treaties.

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