The Law Enforcement and HIV Network

Speech delivered at the Consultation on Police and HIV

Industrieele Groote Club (IGC), Dam 27, Amsterdam
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By
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Dear colleagues,

Ladies and gentlemen,

I would like to warmly welcome you to this consultation on Police and HIV.

I would like to thank you for your commitment to joining the fight against HIV and congratulate you, the organizers, and the drafters of the **"Amsterdam statement on police partnerships for harm reduction"** for your wisdom and your courage.

Because, it takes wisdom and courage to question and challenge, as you do, established ways of working.

It takes wisdom and courage to question whether policing practices with regard to socially-marginalized groups, as implemented in so many parts of the world, are the right course of action to take, from a public health perspective.

It takes wisdom and courage to "think differently" and to ask how best to "protect and serve" in legal and policy environments that in many parts of the world are discriminatory, aggressive to the most vulnerable, including people who use drugs and sex workers. Today, we will be hearing many examples of how police can do things differently and more effectively, even within adverse environments.

It takes wisdom and courage to base what you do on evidence, rather than on tradition.

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And the evidence when it comes to HIV, drugs, sex work, the legal and policy environment, and law enforcement is crystal clear:

1. Whereas remarkable progress has been achieved globally, the world has failed in dealing with so-called "concentrated" epidemics, including epidemics driven by unsafe drug injection.

2. The evidence that harm reduction works is comprehensive, compelling, and undisputable.

3. Repressive laws and policies based on prohibition increase the health risks of people who use drugs and their communities – and they fail to achieve their objectives of protecting citizens and reducing crime.

4. Although formal laws are an important component of the legal environment supporting harm reduction, it is the enforcement of the law that affects the behavior and attitudes of people who inject drugs most acutely.

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The world has failed in dealing with so-called "concentrated" epidemics. At least one out of five persons who inject drugs lives with HIV, and two out of three are infected with the Hepatitis C virus. HCV co-infection rates among HIV-positive people who inject drugs are particularly high, often ranging between 70 and 90 %. HIV-positive people who inject drugs have a two to six-fold higher risk of contracting tuberculosis.

The prevalence of both HIV and HCV is much higher among prison inmates than in the general population. For an HIV-positive person who injects drugs in prison, the risk of contracting tuberculosis is 23 –fold higher than that in the general population.

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Whereas the number of new infections and AIDS-related mortality have decreased globally by 25-30% in the last few years, these numbers continue to increase in Eastern Europe and Central Asia (EECA) where unsafe injection drug use remains the main driver of the HIV epidemic in EECA, as well as in most of Asia. Unsafe injection drug use is now an increasing mode of transmission in coastal regions of Africa where new routes of trafficking are also opening new routes for drug consumption.

At the same time and whereas coverage with antiretroviral treatment has reached 65 % of estimated needs among HIV-positive people globally, it is only 4 % of people who inject drugs living with HIV that access therapy.

Clearly, throughout the history of the AIDS epidemic, the investment to prevent and treat HIV among people who inject drugs, sex workers and other criminalized and marginalized populations has not met the need.

Harm reduction works. And yet there is compelling evidence that needle and syringe programs (NSP) and opioid substitution therapy (OST) are effective in reducing the sharing of injecting equipment and averting HIV infections. In combination with antiretroviral treatment, NSP and OST reduce HIV transmission, decrease mortality, reduce drug dependency, reduce crime and public disorder and improve quality of life. NSP and OST also reduce the risk of acquiring viral hepatitis.

Harm reduction interventions are very cost-effective. They are part of the WHO-UNAIDS and UNODC recommended package of services for people who inject drugs. A health-based approach to drug policies starts with the implementation and scaling up of harm reduction.
However, globally, only 8% of people who inject drugs have access to OST. And, in 2010, it was estimated that, worldwide, just two needles and syringes were distributed per person who inject drugs per month.

Repressive laws and policies increase the health risks of people who use drugs and their communities. There is ample evidence of the many direct and indirect harms that flow from punitive legal and drug policy frameworks: health –related harms, HIV/AIDS, hepatitis C and tuberculosis; mass incarceration, prisons, pretrial detention, administrative detainees; stigma against and marginalization of people who use drugs, and human rights being severely undermined in every region of the world.

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Laws and policies surround syringe purchase and possession, including over the counter sales and NSPs. Laws and policies also govern access to OST. Such laws vary by country, state or province and sometimes between and within cities. Because of these legal provisions, coverage of NSP and OST worldwide remains exceedingly low. Despite it being on the list of essential medicines, methadone remains illegal in a number countries, including in the Russian Federation where the epidemic remains largely driven by unsafe injection drug use.

Laws and policies can be critical but it is the practices of police and the enforcement of the law that affects the behavior and attitudes of people who inject drugs most acutely.
Syringe confiscation and arrests directly influence the risk of people who inject drugs of acquiring HIV or hepatitis as they often then resort loaning someone else's used syringe or using discarded syringes. Such arrests happen even in settings where syringe possession is not prohibited by law. Fear of police discourages people who inject drugs from carrying syringes even for the purpose of syringe exchange. The following words from a young woman in Moscow describe the fear cause by aggressive law enforcement, "Fear, fear. This is the very main reason. And not only fear of being caught, and you won't be able to get a fix. So on top of being pressured and robbed (by police), there is the risk you'll also end up being sick. And that's why you'll use whatever syringe is available right then and right there".

In Bangkok, a study has shown that people who inject drugs who had been subjected to random urine testing were more likely to report avoiding healthcare services and avoiding access to voluntary addiction treatment.

In addition, ample evidence documents that policing can also indirectly increase HIV risk by conducting surveillance, crackdowns and arresting people who attend harm reduction NSP or OST programs.

And most concerning, of course, are cases where police engage in misconduct extorting bribes, planting drugs, forced withdrawal, or physical and sexual abuse.

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This long list of issues – unfortunately so real in the life of people who inject drugs and communities in almost every part of the world - is familiar to you.

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Today's consultation is about seeking solutions, and ways of intervention.

The good news is that the debate on what the current international drug regime has achieved/ or – actually - not achieved and on the effectiveness, or rather, lack of effectiveness of drug policies primarily based on a prohibitionist paradigm is now open. The Special Session of the UNGA on drugs to be held in 2016 provides us with a unique opportunity to hold that debate at national, regional and international levels. The UN SG has called on a wide-ranging and open debate that considers "all options". The Global Commission on Drug Policy, of which I am part, has called again last month in its latest report, for reforms that promote public health over the criminalization of drug use and for alternative legal regulatory frameworks for drugs.

But shifting the emphasis of the international drug control systems, changing laws, and matching reform of law enforcement to reform of laws and policies is still a long way to go from where we are today.

And we are here because we all believe that a lot can be done on the ground, at the community and city levels, starting today, that may have a considerable positive impact on the health and life of people. This is the work in which you have engaged: training and harm reduction education, Law Enforcement Assisted Diversion programs, partnerships between police and health facilities (Safe Injection Facility in Vancouver), documenting and fighting violation of human rights and misconduct.

I look forward to listening to your experience and what you believe should be the priority pathways for intervention; also to listening to your views on which are the challenges you see in your diverse country contexts in re-aligning your practices with public health. Pathways of intervention that ensure that policing and law enforcement does not undermine prevention, and also actively promote harm reduction.

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Ladies and gentlemen,

Dear colleagues,

Ample evidence documents the ways that experiences of police harassment and abuse increase HIV risks. Less time has been spent on today's debate, documenting the positive counter-examples and the mix of practical incentives and police commitment that have shifted dynamics, improved HIV programming and led to better outcomes for both police and the communities they serve. As many of you have demonstrated, there is a lot that can be done within the existing legal and policy environments.

Improving law enforcement responses to drug-related harms requires building operational bridges between criminal justice and public health sectors. It requires, in parallel, initiatives seeking to improve police professionalism, accountability and transparency, and to boost the rule of the law.

Our common challenge is to promote a "smart law enforcement " where public health and law enforcement work synergistically to shift the environment from one that exacerbates HIV risks and crime to one that promotes safer and healthier communities.

Congratulations again on your wisdom and courage. Keep up the fight.

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