UNODC
United Nations Office on Drugs and Crime

Training manual for law enforcement officials on HIV service provision for people who inject drugs

Acknowledgements

This Manual was authored by Diane Riley (Centre for Law Enforcement and Public Health, Melbourne, Canadian Foundation for Drug Policy, and International Harm Reduction Unit, University of Swansea, UK), Nicholas Thomson (Johns Hopkins Bloomberg School of Public Health and the University of Melbourne's School of Population and Global Health), Geoffrey Monaghan (former UNODC HIV Advisor and career detective at New Scotland Yard, Metropolitan LE officials Service, UK) and Melissa Jardine (former police officer with Victoria Police, Australia).

The editorial team composed of: Monica Beg, ZhannatKosmukhamedova and FabienneHariga (HIV/AIDS Section, UNODC).

UNODC gratefully acknowledges the contributions of the following agencies and individual experts to various drafts of the Manual: The International Harm Reduction Association (IHRA), the Open Society Foundations (OSF), the Law Enforcement and HIV Network (LEAHN), the International Police Advisory Group (IPAG), Leo Beletsky (Northeastern University, Boston, USA), NadiyaProkopenko and MirzahidSultanov (UNODC, Ukraine), TofikMurshudlu, Ian Munro and Stephen Thurlow (Implementation Support Section, UNODC) and Anna GiudiceSaget (Justice Section, UNODC).

UNODC also wishes to acknowledge the support of USAID towards the development of this Manual.

TABLE OF CONTENTS

All power point presentations that are referred to in this manual can be found on the CD.

Preface

There is an increasing global recognition of the important role that law enforcement (LE) officials have in protecting and promoting individual and public health, especially the health of diverse and vulnerable communities. In the context of HIV prevention, treatment, care and support, LE officials have a significant role and responsibility to ensure uninterrupted access to essential HIV-related health and social services for vulnerable populations including people who inject drugs (PWID).

The success of any National HIV/AIDS programme is dependent on the strength of multi-sectoral partnerships and collaboration between all relevant agencies but especially between the LE officials, health sector, social services and non-government agencies. Functional and collaborative partnerships between these agencies can significantly enhance the enabling environment for the provision of key services that prevent, treat, care and support people who are vulnerable to HIV and other infections.

The Training Manual for Law Enforcement Officials on HIV Service Provision for People Who Inject Drugs has been developed to assist LE officials and other uniformed services in building their understanding of, and collaboration with, HIV prevention, treatment, care and support services for PWID. This can only be achieved if LE institutions have developed their own internal HIV related occupational health and safety protocols as standard operating protocols that outline the role of LE officials as part of a country's multi-sectoral national HIV response. The Training Manual is therefore built around a series of modules that together form a comprehensive HIV/AIDS related training programme for LE officials to enable them to respond more effectively to the challenges posed by HIV, specifically in regard to:

- The professional and personal risk of HIV among the members of the LE community and;
- The Prevention, Treatment Care and Support of HIV among the most vulnerable communities they serve.

By virtue of their role in upholding law and order, promoting community safety and protecting human rights, LE officials are often in frequent contact with PWID. The Training Manual aims to assist LE trainers with designing, tailoring and delivering a training package that will ensure that LE officials at all levels are better informed and equipped to exploit the unique opportunities their work presents for reaching out to the key populations they encounter, referring them to HIV prevention, treatment, and care services and for helping them to adhere to such services.

Enhancing the role of LE officials as significant partners in a multi-sectoral National HIV response is critical. The Training Manual provides the background, rationale and training tools to ensure that LE officials not only contribute to the National HIV response, but in doing so promote and protect the human rights and needs of the most vulnerable communities. The Training Manual also includes an Annex "Creating a Law Enforcement Institutional Environment that will Support an Enhanced Role of LE officials in the National HIV/AIDS Response",which has been designed in recognition of the role of senior officials in building the necessary institutional support for the implementation of the Training Manual.

The Training Manual focuses predominantly on the role of LE officials in supporting HIV/AIDS prevention, treatment, care and support among PWID, while many of the principles outlined in the

modules do also apply to other key populations for HIV such as men who have sex with men, sex workers, transgender populations and people incarcerated in closed settings.

While commonly referring to police, the term “law enforcement officials” in many countries includes officials from drug law enforcement, public security, military, prisons, correctional and other uniformed services. This Training Manual recognises that different countries may have a wide array of law enforcement institutes, agencies and departments but for the purposes of this Training Manual, the term law enforcement official (LE official) refers to all uniform personnel who in the course of their duty may interact with PWID and other key populations.

Introduction

The global community has made significant progress in responding to the HIV pandemic but concentrated epidemics amongst key populations still persist and present ongoing challenges. HIV transmission through unsafe injecting drug use is largely responsible for continued high rates of HIV transmission in Eastern Europe, Central Asia, many parts of West, South, South-East Asia as well as in some parts of Sub-Saharan Africa.HIV among certain groups of people who use crack cocaine and other stimulant drugs such as methamphetamine, is a public health problem in some parts of the world including Latin America and Caribbean and South-East Asia. (*1*).

These high rates have resulted from a combination of insufficient provision of evidence-based comprehensive HIV services and a persistent criminalisation of and discrimination against PWID (*2*).

UNODC, WHO, UNAIDS and the World Bank estimate that globally there are 12.7 (8.9-22) million people who inject drugs and of those 1.7 million are currently living with HIV (*3*). Preventing HIV and other infections from and among PWID and other vulnerable populations is a fundamental public health imperative for any country. In responding to HIV among PWID, a comprehensive package of nine interventions, also known as 'Harm Reduction' services, needs to be available at scale including the provision of needle syringe programmes (NSP), opiate substitution therapy (OST), HIV counselling and testing (HCT) and antiretroviral therapy (ART). This comprehensive package of nine interventions has been recommended by WHO, UNODC and UNAIDS, and endorsed at the highest political level including the UN Commission on Narcotic Drugs (CND), UNAIDS Programme Coordinating Board (PCB), and the UN Economic and Social Council (ECOSOC). It also helped to shape policy around HIV and harm reduction. Donor agencies such as the Global Fund and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) also adopted the guide. (*4*).

On their appointment, LE officials swear or affirm to uphold the laws of their countries including laws that directly or indirectly protect public health, fundamental human rights and promote health related programmes and interventions. By supporting programmes that work with the key populations to reduce their risk of HIV infection, LE officials can make a significant contribution to public health and public safety and ensure that the fundamental right to health of all citizens is protected.

There are many countries where the provision of a comprehensive range of harm reduction services for PWID is supported by the government. This results in an environment where HIV infection risk is dramatically lowered. There are also countries where PWID can face harsh penalties and are often at greater risk of negative interactions with LE officials. Resolving these political, legal, procedural and cultural tensions is critical to improving the coverage and impact of the National HIV programme. At the same time, counting on the support of LE officials in the National HIV programme by giving them the necessary knowledge and skills is fundamental in resolving these tensions.

Background and Rationale

While the role of the LE officials in many public health issues such as preventing and responding to road trauma is recognised and understood, the law enforcement agencies have not been sufficiently integrated into national plans and policies for HIV prevention, treatment, care and support. The culture, operational policies and practices of law enforcement agencies can influence the course of an HIV epidemic, either for good or ill, especially with regard to populations at particular risk for HIV infection (5). LE officials, like all professionals, should be aware of the health and welfare implications of their actions at the individual and community levels.

Individual LE officials can also be at risk of HIV acquisition due to their professional front line role in the community and also due to their personal behaviours. Despite these risks, evidence from many countries around the world indicates that LE officials do not always have an adequate knowledge about HIV and AIDS. This results in misconceptions about their own HIV risk as well as increasing levels of stigmatisation and discrimination towards people considered more at risk of HIV. Education and awareness raising trainings can address misconceptions, encourage attitudinal change and improve the ability of LE officials to collaboratively respond to HIV as part of a multi-sectoral approach (*6*).

The central emphasis of the Training Manual for LE officials on HIV service provision for PWID is to enhance and support the LE officials' role in the National HIV response by ensuring that LE officials are more knowledgeable and competent when working with each other and with the community in order to be able to contribute to:

- Prevent HIV among LE officials and their partners and families;
- Prevent and respond to HIV among key populations and the broader community;
- Eliminate stigmatisation and discrimination towards vulnerable populations;
- Ensure effective prevention, treatment, care and support for those infected or affected by HIV and AIDS;
- Reduce the impact of the epidemic on individuals and society as a whole;
- Enhance collaboration between law enforcement agencies and services providers, including civil society and community based organizations, in responding to HIV.

The Training Manual has been designed to provide a general background on HIV and AIDS related issues, highlight the correlation between LE agencies and HIV, describe priority areas of HIV training for LE officials, and suggest implementation and evaluation methods. The Training Manual has the following overall objectives:

- To assist trainers from law enforcement training institutions to justify, design and conduct training on HIV/ and AIDS related issues as part of the formal training curricula and to train future trainers;
- To provide LE officials with accurate facts and information about HIV and AIDS that will support better Occupational Health and Safety practices;
- To raise the awareness of LE officials about HIV and human rights in order to better

ensure that LE officials implement their duties without stigmatizing and discriminating against people at risk for HIV infection or those already infected;

- To enhance the ability of LE officials to improve their collaboration between their agency and other government and non-government health and social service providers and civil society and community based organizations in responding to HIV.

The training modules were developed in consultation with former and current LE officials and address the gaps in knowledge of LE officials as identified in interviews, meetings and surveys in a number of countries, grounded d in international laws and standards, scientific evidence and current good practices. It is recommended that all law enforcement personnel, cadets and experienced officers, receive training and that training is also incorporated into continued professionalization and education programmes. Law enforcement agencies will attain maximum benefit if the suggested training programme on HIV and AIDS is comprehensively implemented at the country level or, where needed, separate training modules are incorporated into existing training curricula.

Overview of the Training Manual

In order to reach the overall objectives, the Training Manual includes 8 practical training modules. Each module is introduced with a brief background to the topic and the purpose for its inclusion in the training. Modules also contain learning objectives, suggested readings, case studies and fact sheets. A series of slide by slide instructors' notes and accompanying Power Point slide presentations for each module will assist LE trainers deliver each of the modules. The 8 modules have been designed to deliver relevant training for LE officials to ensure adequate coverage across the following HIV and AIDS related areas:

1. An overview of HIV epidemiology and response
2. Occupational health and safety for LE officials in the context of HIV
3. An overview of the role of LE officials in public health and the importance of working with key populations
4. Risk and vulnerability: policing key affected populations and protecting human rights
5. An introduction into drugs, policing and harm reduction
6. Part A: An overview of the WHO, UNODC, UNAIDS Comprehensive Package

   Part B: An overview of the role of LE officials in drug overdose
7. Law enforcement and the use of discretion, drug diversion programmes and the role of an ethical framework
8. Creating multi-sectoral partnerships to more effectively work with key populations to enhance the National HIV/AIDS Response

Implementation Guidance

In order for the Training Manual to be implemented, senior LE leadership structures need to consider a range of structural issues that may need to be addressed to support the implementation of the Guidelines. **Annex 1 "Creating a Law Enforcement Institutional Environment that will Support an Enhanced Role of LE officials in the National HIV Response"** outlines specific components of the design of an overall National HIV Policy for LE officials. The creation of a National HIV Policy for LE officials will provide an overarching framework that this Training Manual can be implemented under. The development of such National HIV Policy for LE officials should include:

- Occupational health and safety protocols for HIV prevention, treatment, care and support for LE officials;
- Standard operation protocols for LE officials working with key populations;
- A clear articulation of the role of LE officials in the National HIV Programme Response;
- An integrated operational framework that highlights how LE officials work in collaboration with a range of other stakeholders including the Ministry of Health, public hospitals and primary care clinics as well as non-government and civil society and community based organizations.

Each module has been designed to be able to be delivered between 60 and 90 minutes. It is envisaged that the entire training package could be delivered in 12 to 16 hours; a proposed training workshop that incorporates the Training Manual across 5 days has been developed as a guide. Experiences from a variety of settings indicate that the training could be delivered in a shorter period of time or integrated over a longer period of time. Where required and relevant, individual modules can also be presented as part of other LE officials' training programmes.

A combination of training approaches is recommended including formal lectures, practical sessions, field visits and presentations from people working in HIV programmes and members of key population groups. The contribution into the training by non-government and community based organizations working with or representing key population groups is critical to building better collaboration between LE officials and the HIV programmes on the ground. Training must be integrated as part of recruit training as well as of continuing professional development training of field officers and senior LE officials and executives. Training must be for all LE personnel if it is to be truly effective and sustainable.

Annex 2 "Implementation and Evaluation of the UNODC Training Manual" contains more specific logistical considerations for actually implementing the Training Manual across various LE training institutes and to LE officials who are already working in the field. It suggests conducting a training of trainers for nominated LE officials from law enforcement training institutions and from provincial and/or district level operational policing units. Instructed over an intensive week, the trainers would then be able to implement the course in training institutes and in field offices.

Law enforcement institutions should constantly review the effectiveness of the Training Manual. The implementation of the Training Manual should be evaluated from a variety of perspectives. Annex 2 proposes a multilayered evaluation framework that will allow law enforcement

institutions to assess the impact of the Training Manual on enhancing the role of LE officials in the National HIV Programme as well as on a range of specific LE indicators of interest such as community perceptions of safety, trust in the LE service and the use of LE officials' time and resources. The evaluation framework also provides considerations for how other key sectors can evaluate the role of LE as part of a multi-sectoral response to HIV.

The Training Manual has been grounded in evidence and current good practices. The document provides references throughout the text to support particular approaches or strategies. Annex 3 "References, Additional Readings and Resources" contains the full text of each of the references as well as a list of potential additional readings and resources that may be useful when adapting and implementing the Training Manual at the country level.

Evaluation of the training

The pre/post questionnaire is a common form of evaluating training in terms of knowledge improvement of the participants. The following questionsmay be used for pre- and post-tests to compare scores before and after the training respectively.

Pre-test

Please answer the following using a scale from 1 = Strongly Agree to 5 = Strongly Disagree

Questions	1	2	3	4	5	na
LEAs have a key role to play in HIV prevention and related services						
I have good knowledge of how to work with CSOs to prevent HIV among drug users						
I have the skills to work with CSOs in preventing HIV among drug users						
I am comfortable working with CSOs that work with drug users, and know how to initiate and maintain cooperation						
I know domestic and global HIV statistics						
I know how the injected drug use affect spreading the HIV infection, Hepatitis and other blood-borne infections						
Training of LEAs on HIV prevention and equal access to related services is important						
Training of LEAs on how to better collaborate with CSOs is important						
LEAs should play an active and important role in public health promotion						
LEAs and CSOs should be partners in HIV prevention, and equal access to related services						

Post-test

Please answer the following using a scale from 1 = Strongly Agree to 5 = Strongly Disagree

Questions	**1**	**2**	**3**	**4**	**5**	**na**
LEAs have a key role to play in HIV prevention and related services						
I have good knowledge of how to work with CSOs to prevent HIV among drug users						
I have the skills to work with CSOs in preventing HIV among drug users						
I am comfortable working with CSOs that work with drug users,and know how to initiate and maintain cooperation						
I know domestic and global HIV statistics						

I know how the injected drug use affect spreading the HIV infection, Hepatitis and other blood-borne infections						
Training of LEAs on HIV prevention and equal access to related services is important						
Training of LEAs on how to better collaborate with CSOs is important						
LEAs should play an active and important role in public health promotion						
LEAs and CSOs should be partners in HIV prevention, and equal access to related services						

Proposed Workshop Schedule

Black: Modules and Lectures - Green : Practical Sessions

Day 1 Training for LE Officials including Recruits and Field Officers	**Day 2** Training for LE Officials including Recruits and Field Officers	**Day 3** Training for LE Officials including Recruits and Field Officers	**Day 4** Training for LE Officials including Recruits and Field Officers
MORNING SESSIONS			
Registration and opening ceremony Introduction of the trainers, trainees and the objectives of the course	Reflections from Day 1 Practical session Guest panel and discussion with HIV programme service providers and people representing key populations	Reflections from Day 3 Module 6b: What is the role of LE in the case of a drug overdose? Practical session The use of Nalaxone	Reflections from Day 3 Module 8: Creating partnerships to more effectively work with other sectors and key populations
Coffee/Tea Break			
Module 1: Overview of HIV and AIDS: Epidemiology, prevention, treatment and care	Module 4: Risk and vulnerability: policing key affected populations and protecting human rights	Module 7 LE and the use of discretion, drug diversion programmes and the role of an ethical framework	Practical Session Mapping out the next steps in implementing training skills into practice
Lunch Break			
Module 2: Occupational health and safety	Module 5: Introduction to drugs, policing and harm reduction	Practical Session Site visit to OST (methadone/buprenorphine) programme, needle and syringe programme	Closing ceremony Certificates of completion
AFTERNOON SESSIONS			
Module 3: Overview of the role of LE officials in public health and the importance of working with key populations	Module 6a: The Comprehensive Package for the prevention, treatment and care of HIV for people who inject drugs	Practical Session Knowing your community	

Module 1
Overview of HIV and AIDS: Epidemiology, Prevention, Treatment and Care

Module 1 – Overview of HIV and AIDS: Epidemiology, Prevention, Treatment and Care

Since being first clinically described in 1981, HIV has become an epidemic in many countries, posing a threat to public health, socioeconomic development, security and human rights. Globally, there were approximately 35.3 (32.8-38.8) million people living with HIV in 2012 (*7*). The incidence of HIV/AIDS is especially high in sub-Saharan Africa, the Caribbean, Eastern Europe and Central Asia (where 1% of the population were living with HIV in 2011). Although rates of HIV infection have now begun to decrease in many parts of the world, this is not the case for certain vulnerable population groups in many countries across Africa, Eastern Europe as well as South, South East Asia, Central and West Asia where concentrated epidemics persist among people who inject drugs, sex workers, men who have sex with men and prisoners (*7*).

In 2012, 1.6 (1.4-1.9) million people died from AIDS, down from 2.3 (2.1-2.6) million in 2005 (*7*). The provision and scale up of anti-retroviral therapy has significantly contributed to this decrease in morbidity and mortality associated with HIV/AIDS. In Eastern Europe and Central Asia, however, there was a 21% increase in mortality from 2005 to 2011. Most countries have devised national HIV programmes that include a variety of strategies and intervention programmes and several international bodies have dedicated extensive resources to HIV/AIDS prevention, treatment, care and support. The UN Millennium Development Goals (MDGs), established in 2000, pledged to halt and reverse the spread of HIV/AIDS by 2015 (*8*). The UN Declaration of Commitment on HIV/AIDS in 2001, and again in 2006 and 2011 further established HIV/AIDS as one of the most crucial development issues in the world (*9,10,11*). All UN member countries have drawn up comprehensive plans to fulfill the commitment.

"Universal access" refers to maximal coverage of HIV prevention, treatment, care, and support services for those who require them and should be the underlying principle in the design and delivery of a local, national, regional and international HIV programme. To achieve Universal Access, UN agencies and UN member states recognise the need for whole-of-government responses to HIV to improve the legal and programmatic environment for delivery of services. The Political Declarations and various UN Resolutions specifically mention the need for collaboration between the criminal justice, law enforcement, health and civil society organizations in pursuit of Universal Access (*12,13*).

With increasing awareness and acknowledgement of the important role of LE officials in the National HIV response, there is a crucial need to build the baseline knowledge of LE officials about the HIV epidemic at the local, national and global levels and its prevention, treatment and care. A law enforcement institution that is fundamentally aware how it can contribute to Universal Access is a significant premise of a successful national HIV response.

Purpose

The purpose of Module 1 is to give participants a sense of the global HIV epidemic and the political and programmatic contexts of the international response. It also specifically highlights and articulates how LE officials are considered a key partner in the HIV and AIDS response. It begins by examining the global epidemiology of HIV and how it is transmitted before examining current

good practices in HIV prevention, treatment, care and support and other blood-borne viruses, specifically Hepatitis C. The module is designed to orient LE officials to HIV and AIDS through also reviewing national level HIV data so participants can contextualise their own country's response to HIV and therefore begin to think about the role of LE officials in the national HIV response.

Learning Objectives

At the completion of Module 1, participants should have an:

- Increased knowledge and understanding of the global HIV epidemic and the political and programmatic contexts of the global efforts;
- Up to date knowledge of the epidemiology and policy and programmatic response to HIV and AIDS in the country in which they work;
- Improved understanding of what HIV and AIDS is and how HIV is transmitted, prevented, and treated and a basic understanding of transmission and prevention of viral Hepatitis B and Hepatitis C;
- An understanding of current good practices in preventing, treating, caring and supporting people vulnerable to or people living with HIV and AIDS;
- An understanding of their own professional and personal risk.

Useful Learning Materials and Readings

To support participant learning and adaptation to country specific contexts it is recommended that the following reading and learning materials be made available to trainers and participants:

- UNAIDS 2013 Global Report available at http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/unaids_global_report_2013_en.pdf
- UNAIDS 2013 Global Fact Sheet available at http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/20130923_FactSheet_Global_en.pdf
- Country specific information from the UNAIDS Asia Pacific Data Hub available at http://www.aidsdatahub.org/Country-Reviewscountry level UNAIDS Data Hubs
- UNODC World Drug Report 2014 available at http://www.unodc.org/documents/wdr2014/World_Drug_Report_2014_web.pdf
- Quiz on HIV/AIDS available athttp://www.avert.org/aids.htm

It is highly recommended that a senior public health officials figure familiar with national HIV and AIDS situation and response including the gaps, challenges and opportunities, be seconded to speak to participants during the delivery of Module 1. Experience in delivering training to LE officials on HIV suggests that when LE officials are taught about HIV prevention, treatment and care, HIV risk practices and the country situation, they can often have many pertinent questions

relating to their own perceived risks. An expert on HIV and AIDS is a useful addition to this session to be able to respond to participant inquiries.

Case Studies

(If relevant)

Practical Sessions

Activity One: *Testing Participant Knowledge*

Ask participants to divide into small groups for a discussion on the modes of transmission of HIV. Using the recommended quiz, ask participants to go through the range of true and false statements about HIV transmission. At the completion of the quiz, recap the main concepts relating to transmission and prevention and if time permits ask the group these two main questions about prevention: How can sexual transmission of HIV be prevented? How can transmission of HIV and viral hepatitis through blood be prevented?

Course Content and Instructors' Notes for Module 1

Overview of HIV and AIDS: Epidemiology, Prevention, Treatment and Care

Slide 1

Title Slide

Slide 2

Learning objectives of Module 1

Slide 3

An explanation of HIV and what the difference between HIV and AIDS and of the implications it can have for the human immune system. While the explanation is to be kept simple, depending on the level of participants, it might be possible to discuss that HIV is a descendant of simian (monkey) immunodeficiency virus (SIV), to describe in more detail how HIV targets specific cells in the body and how that results in a weakened immune system. Reminding participants that while HIV cannot currently be cured, the provision of anti-retroviral therapy significantly improves therapeutic outcomes and is also being used pre-emptively among some groups at high-risk to protect them from HIV acquisition.

Slide 4

The slide should show a map depicting the extent of the global epidemic of HIV and give an overview of prevalence and incidence of HIV regionally and globally. A good source of information is the power-point slide presentation from the WHO HIV Department updated every year and available at http://www.who.int/hiv/data/en/

Slides 5 – 9

HIV Prevention, Treatment and Care

These slides outline the basic information related to HIV prevention, treatment and care. Depending on the level of the group, the presenter can discuss in more details specific aspects of HIV prevention, treatment and care science. Slide 7 dispels common myths about HIV transmission.

Instructors should ask participants to outline how HIV could be prevented in the context of understanding the transmission pathways. Instructors should use the opportunity to highlight that correct and consistent use of condom prevents sexual transmission of HIV and sexually transmitted infections, while the use of sterile needles and syringes and other injecting equipment prevents the transmission of HIV, Hepatitis B and Hepatitis C.

This slide introduces more formally the role of anti-retroviral therapy (ART) in the treatment of people living with HIV (PLWHIV) and also notes that ART is also being used to help prevent transmission of HIV, including from mother to child (during pregnancy and breast feeding) and in the context of sexual relationships where one partner is HIV positive and the other partner is not (sero-discordant couples).

Slide 9 introduces the concept of Post Exposure Prophylaxis which is covered in more depth in Module 2.

Slide 10

Principle of Universal Access

"Universal access" refers to maximal coverage of HIV prevention, treatment, care, and support services for those who require them. UNAIDS recommends that when scaling up programmes towards universal access, such services must be equitable, accessible, affordable, comprehensive, and sustainable over the long term. Different settings often have distinctly different needs, and so targets for universal access are set nationally.

Participants may be keen to understand specific HIV risk behaviour as it may relate to either themselves or people they know. The instructor should feel confident in answering questions about HIV and therefore it is recommended to have a national level HIV/AIDS expert to deliver this opening module.

Slides 11-14

The Global Response to HIV

Why the concern about HIV/AIDS?

The instructor will provide an overview why the World Health Organisation (WHO), UNODC, UNAIDS and other UN Co-Sponsors, governments, other international organisations, and individuals are greatly concerned about the transmission of HIV and its impact on communities and countries. Essentially that HIV and AIDS can create a significant burden for individual and public health as well as having negative implications for economic and regional security. Instructors may want to describe burden of HIV co-infection with hepatitis B and C as well as tuberculosis.

Instructors should introduce the international political frameworks that shape the international response to HIV including the UN Political Declaration and various UN Resolutions that call for member states to achieve Universal Access. Particular emphasis should be put on the role of multi-sectoral partnerships across policing, criminal justice, health and civil society in the pursuit of Universal Access. Instructors should ask participants to think of what the role of LE officials in achieving Universal Access should be.

Slide 14-17

Highlighting the progress that is being made across the globe in addressing HIV but that concentrated epidemics of HIV persist among certain populations known as key populations. The instructor should introduce the term "key populations" (people who inject drugs, sex workers, men who have sex with men, transgender people and prisoners). The instructor should briefly describe why these population groups are considered at greater risk and highlight some specific global data around HIV and people who inject drugs.

The instructor should specifically describe why PWID are at greater risk to HIV and should outline that HIV among PWID can be prevented through the provision of and access to sterile needles and syringes (as part of a comprehensive package described in Module 6). Instructors should note the efficiency of HIV transmission through injecting contaminated blood directly into the bloodstream of an un-infected person, compared to sexual transmission.

Again, given the fact that these populations are at greater risk, the instructor should ask trainees what the role of LE officials should be in supporting HIV prevention, treatment, care and support for Key Populations and should conversely ask participants what the impact of no service provision, stigma, discrimination, punitive national drug policies and practices could be on HIV risk among PWID and other key populations.

Slide 18

Hepatitis C

Hepatitis C or HCV is a blood-borne viral infection which results in inflammation of the liver and compromised liver function. It is often highly prevalent in PWIDs as it is extremely virulent and easy to spread, through direct sharing of unsterile needle and syringe and indirect sharing behaviours, including sharing of cookers, cotton, rinse water and back/front loading. HCV is curable but the treatment regimens are expensive. Slide 18 highlights basic facts about HCV.

Slide 19-20

What is the situation of HIV in this country?

These next slides should outline information about the epidemiology of HIV in the country where the training is being conducted and it should include the prevalence and incidence of HIV among the general population and among key affected populations, including PWID.

What is the current political, legal, social and cultural response to HIV in this country?

These slides should examine the current national response to HIV and describe the national HIV programme including the key stakeholders, lines of authority and any specific instruction as to the role of LE officials in supporting the national response. It may be appropriate for a national expert in HIV epidemiology, policy and programme to give country specific details to participants. This can also help to facilitate partnerships and understanding across different sectors.

Slide 21-22

Group Discussion

In order to find out if the participants are picking up the information, this is a good opportunity to ask the group some questions and promote some thinking and analysis about how the HIV epidemic and national programme and policy response in their country may differ from other countries. The instructor could ask the following questions: Why is this epidemic of such concern? What is the epidemic like in your region and country and how does this differ from other parts of the world? Why do you think epidemics can differ so much?

Activity One

Quiz and Group Discussion on HIV Transmission

At the end of this activity, instructors should hand out a quiz on HIV and AIDS.

Participants form small groups and generate ideas for prevention of HIV transmission based on each of the modes of transmission.Ask one participant from each group to take notes and to read these when they regroup in the plenary. The instructor should also encourage review of the quiz and any questions or concerns that the participants might have.

Group Discussion on HIV and the LE community and their potential role

Encourage participants to outline how HIV/AIDS is impacting their community. Also ask them if they know of any organization that work with those most at risk of HIV or work with PLWHIV. Ask participants to begin then to think about how the LE officials can support HIV prevention, treatment and care and thereby contribute to the national HIV response.

Slide 23

Review of the module and main learnings

Ask participants what can they do at work and in personal life to prevent HIV transmission and viral hepatitis transmission. Ask if they have any questions or concerns. Also ask if their understanding of HIV and AIDS has changed and if they would like to know more.

Module 2
Occupational Health and Safety: HIV and Hepatitis

Module 2 - Occupational Health and Safety: HIV and Hepatitis

Information concerning HIV prevalence among LE officials and its impact on them is often not readily available, mainly because of the lack of systematic testing and recording of HIV data by LE agencies (*14,15*). The majority of research looking into the direct effect of HIV/AIDS on LE personnel has involved armed forces. Where there are numbers, these are often difficult to access because of concerns about the reaction to HIV/AIDS within and outside the LE institutions and agencies (*15,16*). Research that has been done on the relationship between HIV/AIDS and the LE officials indicates that:

- LE officials are as vulnerable to HIV and viral hepatitis as the civilian population; there is some additional risk of occupational infection related to exposure to blood and other body fluids.
- LE officials working in detention facilities are at risk of airborne infections such as TB.
- Patterns of vulnerability are dependent on a number of variables including rank, deployment patterns, culture and age.
- Civilian LE officials in peacekeeping operations need special consideration.
- The stigma associated with HIV and AIDS has given rise to a lack of openness on the issue and this appears to have been the greatest barrier in getting governments and LE officials sufficient forces to acknowledge and deal with HIV and its effects (*15,16,17*).

At a personal level, LE officials are at risk for HIV and viral hepatitis if they do not practice safe sex, if they inject drugs with unsterile injecting equipment or if they receive blood or organs that are infected. Access to voluntary confidential counselling and testing (VCCT) can ensure that staff are aware of their status and can begin ART if necessary. The best prevention approach to sexual transmission of HIV for LE officials is the provision of accurate information, raising awareness, increasing availability of condoms and lubricant, and education to ensure that LE officials know how to properly use condoms.

In the workplace, risk is relatively low, but with increased HIV prevalence among key populations with whom LE officials often interact there is some risk of infection, for example due to needle-stick injury when searching people who may have needles and syringes on them or due to exposure to contaminated body fluids at scenes of accidents where body fluids are spilt or sprayed (*15,18,19*), for example.

The risk depends on the type of work undertaken and the location of the work, yet occupational health risks can be greatly reduced by simple low cost measures and procedures such as universal precautions (*20*). Post-exposure prophylaxis (PEP) should be readily available to deal with possible infection due to needle-stick injury or contamination with infected body fluid (such as blood entering a wound or splashing into the eyes). PEP should also be made available regardless of occupational or non-occupational exposure to HIV. The prescription of PEP should be guided by medical professionals and based on reported type and risk of exposure (*21*). LE officials also need to be able to facilitate access to medical prescribers of PEP for the victim of crime such as rape, when the victim may have been exposed to HIV through the crime committed against her/him.

While occupational risk is low, it has been found that using the issue of occupational exposure to the HIV virus is a potential entry point for researchers and organizations wishing to work with LE officials (*6,15,19*). Senior LE officials need to ensure that standard operating protocols (SOPs) are developed to support occupational health and safety for reducing the risk of HIV to LE officials. The SOPs need to also include the provision of and access to the information about post-exposure prophylaxis.

Purpose

The purpose of this module is to develop the participants' understanding of HIV transmission methods and how they can protect themselves from HIV infection whilst at work and in their personal lives. The participants will be taught about the risk of HIV infection from a range of unsafe behaviours. Importantly, this module provides information about tools they can use to protect themselves at work, for example gloves and safety glasses, highlighting as well that they too can access harm reduction services for injecting drug use or condom provision. This module will teach participants what constitutes unsafe body searching practices. An assessment task is essential in this module so that participants can demonstrate and consolidate new knowledge about safe searching practices and safe disposal of needles and syringes.

Learning Objectives

After completion of Module 2, participants should be able to demonstrate that they have increased their knowledge and understanding:

- Of infection control procedures;
- Of HIV, hepatitis, and tuberculosis as occupational hazards for LE services;
- That all LE officials can make well informed decisions to protect themselves from HIV;
- That if they are infected or affected by HIV, LE officials know how to access prevention, treatment, care and support services;
- Of the necessary skills and techniques for searching and safely handling and disposing of needles and syringes and other injecting equipment.

Useful Learning Materials and Readings

- Background reading: Joint ILO/WHO guidelines on health services and HIV/AIDS 2005, http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_116240.pdf
- ILO Recommendation 200, 2010http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/normativeinstrument/wcms_194088.pdf
- Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection, 2007. http://whqlibdoc.who.int/publications/2007/9789241596374_eng.pdf?ua=
- Fact Sheet Handout - Health and Safety at Work (see instructor notes)

The Trainer will need to obtain:

- Examples of disposal containers of acceptable quality and of unacceptable quality. This will include containers made specifically for the purpose and ones that have been hand-made such as from plastic water bottles etc.
- Sterile/new needles and syringes and other injecting equipment such as swabs so that both the trainer and each Group will have at least one full set.
- Gloves and plastic bags that can be used as protective barriers by the LE officials while handling the injecting equipment.
- An example of SOPs in case of accidental puncture (including access to Post Exposure Prophylaxis – PEP)

Case Studies and Practical Sessions

Assessment Task - Guidelines for searching a person and disposal of needles and syringes

The following guidelines do not replace policies of the organization in which the LE participant works. These guidelines have been produced so that the participants will be aware of the problems of the traditional "pat down search" and will have an added skill in the repertoire that they can use when appropriate. The particular method employed by a LE officer to search any individual will depend on many factors including the number of other LE officials who are assisting with the search, the nature of the reason for the search, and the degree of cooperation provided by the person to be searched. However, the officer should remember that an officer can increase the level of cooperation shown by a person to be searched by being respectful and courteous.

Part 1 – Searching a person

1. Discarded items?	Observe the person to be searched to determine if any weapons, injecting equipment, or other items have been discarded. Any items that have been discarded should be dealt with in accordance with the current priorities and relevant guidelines.
2. Show respect	Speak to the person with respect. It is usually not necessary to intimidate a person. It is not helpful if you insult them or degrade them. You want the person to cooperate. A person who is about to be searched is more likely to assist you if treated with respect. Be diplomatic and tactful.
3. Advise of legal grounds	Advise the person of your intention to search, the reasons for the search, and the legal grounds to conduct a search.
4. In private?	Inform the person, if it is appropriate, that you are willing to conduct the search away from where other members of the public can see the search. Inform them that this is to avoid them being embarrassed and to

	gain their cooperation.
5. Instructions	Tell the person what they need to do. Tell them that they: ❖ Will be asked to show what is in their pockets and may be asked to tip whatever is in their pockets onto the ground ❖ Might be asked to take off their shoes and empty the contents. ❖ Will be expected to cooperate and help with the search. In return you will conduct the search in a way so that they will not be harmed.
6. Understand?	Ensure that they understand so that there will be no confusion leading to confrontation.
7. Right-handed?	Ask them which hand they mainly use for writing, catching, etc. In other words ask them if they are right-handed or left-handed. This is important because you will want them to use the hand that they are least familiar with using if they are required to hand you weapons etc.
8. Anything dangerous?	Ask the person if they are in possession of any weapons, drug injecting equipment, or anything that might be harmful to you when they are being searched. Explain the consequences of non-disclosure and your discretion on disclosure. If they do have anything dangerous etc., ask them to: ❖ Use the opposite hand that they normally use to write with, catch a ball, etc., and slowly remove the item(s). ❖ Place the item(s) slowly on the ground (or into a "disposal container" or other place you designate). ❖ Step away from the item(s) to a position that you designate.
9. Any other items?	Ask the person if they are in possession of any other items such as: wallets, coins, mobile phones, etc. Explain the consequences of non-disclosure and your discretion on disclosure. If they do have any other items ask them to: ❖ Use the opposite hand that they normally use to write with, catch a ball, etc., and slowly remove the item(s). ❖ Place the item(s) slowly on the ground or wherever you designate. ❖ Step away from the item(s) to a position that you designate.
10. Turn out pockets	Request the person turn out their pockets. Depending on what is found, take whatever action you feel necessary.
11. Take off jacket, etc.	Request the person to remove any outer garments such as jackets.
12. Take off shoes	Request the person to remove any shoes. Examine the shoes as you need to.

13. Take off other clothing?	Request the person to remove any other items that you feel they need to remove.
14. "Roller technique"	Place the removed items on a solid flat base, such as a wall, road or concrete path, and use the "roller" technique to detect needles and syringes.
15. "pinch and pull" technique	Remove any detected items by using the "pinch and pull" method
16. Special gloves?	It should be noted that in some countries special gloves and other items are being supplied to some LE officials to help them reduce the risk of a needle-stick injury when searching. The gloves are not latex gloves but are specially made gloves which are unlikely to be penetrated by needles and syringes and similar items. This information has been added because it is important for LE officials to be aware of recent developments.
17. Dispose	Follow the guidelines for handling and disposing of needles and syringes and other bio-hazardous material. Never try to write on or label the needle or syringe.
18. Allow the person to keep new needles and syringes?	Depending on the circumstances it would be worthwhile considering not disposing of any sterile/new needles and syringes that are still in their packet and capped that the person has. These items show that the person is "doing the right thing from a harm reduction point of view" as they are not using previously used needles and syringes. It would be worthwhile considering allowing the person to keep such items.
19. Search the actual person - advise them	Now advise that you are going to conduct a search of the person themselves and any remaining clothing. As before, explain the reasons for the search and the need for safety. Ask if the person is in possession of any equipment or items for injecting drugs, any weapons, or any items which could harm you. If they answer "yes", have the person remove them. Follow previous steps.
20. Search the person	Conduct a search of person using the "roller technique". At any stage of the search if an item is detected, request the person being searched to explain what it is.
21. Remove items	If any items are detected you should assess the situation. It may be appropriate to ask the person to remove it or to remove it yourself using an appropriate technique.
22. Dispose	If any needles and syringes or related equipment is found, handle and dispose of them as per other guidelines on the handling and disposing of needles and syringes.
23. Usual procedures	Depending on the nature of why the person was stopped and searched, use appropriate procedures to take notes, etc.
24. Engage the person in conversation	Whilst conducting the search engage the person in conversation to discover their knowledge of HIV.

25. Provide information	As appropriate, provide information on HIV, unsafe injecting drug use, and where to obtain help.
26. Get dressed	Allow the person to replace their clothing after the search.
27. Wash hands	As soon as practicable wash hands with soap and water.

Part 2 – Handling needles and syringes

Key term	What to do
1. Assess	Assess the environment where the needle and syringe is located. Take note of any other needles or injecting equipment nearby that could injure you.
2. Needle and Syringe Programme	If feasible, ask the local needle syringe programme to collect and dispose of any injecting equipment. They are usually very helpful once a good relationship has been established with them.
3. Shoes	Wear shoes.
4. Disposal container	Obtain a suitable disposal container. If you do not have a proper disposal container manufactured in a factory then you will have to use some other container.
5. Move the disposal container	Take the disposal container to the needle and syringe. Do not pick up a needle and syringe and carry it to the disposal container. You should limit the amount of movement you make with the needle and syringe. The longer you carry a needle and syringe the more likely it is that you will have a needle-stick injury because: 1. All of us from time to time stumble or trip over something. 2. Someone could bump into you. 3. A loud noise such as a car backfiring could make you flinch or make you lose concentration.
6. Stable surface	Place the container on the ground and place it where it will not move. You could hold it still by placing it under your shoe. The disposal container should be on a stable surface on the ground and not held by your hand when placing the needle and syringe in it.
7. Use Universal Precautions - use a barrier	That is, use a barrier. Wear gloves for protection. If you do not have a proper pair of latex gloves use a plastic bag. Plastic gloves are acceptable or a plastic bag may have to be used when in the field. A supply of plastic gloves and plastic bags should be kept in LE officials cars and other LE officials vehicles. Thick gloves that can reduce your dexterity should be avoided. Ensure that any open cut or wound is adequately covered with a water proof cover.
8. Do not re-cap	Do not try to place the cap back on the needle. Never attempt to recap a needle and syringe, even if the cap is also discarded. Treat the cap as carefully as any other item of injecting equipment
9. Pick it up by the	Do not pick up the needle and syringe by the needle. Pick it up by the

Key term	What to do
barrel	barrel.
10. Use tongs if appropriate	If appropriate use tongs. If you are going to use tongs, practice with them first. Many tongs that are used by cleaners and rubbish collectors have been specifically designed to pick up particular items of rubbish such as paper and similar items. They have not been designed to pick up something small and smooth like a needle and syringe. On some occasions with tongs, the needle and syringe can slip and be propelled some distance away. In some cases, Officers have used pieces of split bamboo. Tongs may also assist you to remove the injecting equipment if it is difficult to access.
11. Separate needles and syringes	If there is more than one needle and syringe, it may be useful to separate them using an appropriate instrument. Do this carefully. Each item can then be picked up separately.
12. Point it away from you	Always make sure that the needle is pointed away from you and everyone else. It is preferable to point the needle towards the ground.
13. Needle end first	Place the needle end of the needle and syringe into the disposal container first.
14. Do not touch	Do not place your hand on the container where it could be stabbed as you put the needle and syringe into the container.
15. Swabs	Other material such as swabs and bandages can be placed in a plastic bag and the end of the plastic bag can be tied. These items should also be treated as bio-hazardous.
16. Lid	After the needle and syringe has been placed inside the container, put a lid on the container. This can present a problem as sometimes the container does not have a lid. If the container is a plastic bottle and you do not have the lid, you could burn the top of the bottle so that it closes over.
17. Do not over-fill	Make sure that the container is of adequate size and is not overfilled. Overfilling the container can increase the risk of injury.
18. Dispose	Dispose of the container appropriately so that someone such as a child will not find it and play with it.
19. Dispose of gloves etc.	If using rubber gloves, or something similar, remove them and place them in a plastic bag. Tie the bag closed and place it in a rubbish bin where someone will not take it out and open it up.
20. Wash hands	As soon as is practicable, wash your hands thoroughly using soap and water as the local conditions allow.
21. Contact the local Needle and Syringe Programme	Contact your local needle and syringe programme, or local disposal site. Sometimes, arrangements can be made with hospitals and other health facilities that have proper systems and processes for disposing of bio-hazardous material such as high intensity incinerators.

Infection Control Procedures

The guidelines in this Training Manual do not replace the guidelines that are provided by your government, employer, and other relevant organisations in your country. They are examples only but are based on international good practice that all law enforcement agencies should aspire to replicate. You should follow the guidelines that are provided by the relevant agencies in your country. Post-Exposure Prophylaxis (PEP) must be available as part of an occupational and non-occupation health and safety approach to HIV prevention within every LE agency.

Handling injecting equipment

Assumption of risk

The basis of good infection control is to assume that everyone could have an infection which can be passed on to you.

- You should never assume that just because a person looks healthy or attractive they could not have an infection that could be passed onto you.

Dealing with spills of body fluids

Examples of body fluids include blood, saliva, semen, urine and faeces. You should always:

1. Isolate the area.
2. Wear gloves, a plastic apron and eye protection, such as goggles.
3. Soak up the fluid with disposable paper towels, or cover the spill with a granular chlorine-releasing agent for a minimum of 10 minutes. Scoop up granules and waste using a piece of cardboard (or similar), place in a plastic bag and dispose of appropriately.
4. Mix 1 part bleach to 10 parts water and apply to the area for 10 minutes.
5. Wash with hot water and detergent.
6. Dry the area.
7. Dispose of paper towels and gloves appropriately.
8. Wash your hands.
9. Rinse any contaminated clothing in cold running water, soak in bleach solution for half an hour, then wash separately from other clothing or linen with hot water and detergent.

Universal Precautions

Universal Precautions is the international term used by the health sector to describe the set of measures used to safely handle body fluids. The main principles of universal precautions are:

1. Presume that the blood and body fluids of all persons could potentially be a source of infection, while additional precautions may be required in areas of high risk.
2. Washing hands.
3. Care of intact skin.
4. Protection of damaged skin.
5. Proper handling and disposal of sharp objects.
6. Good hygiene practices.
7. Careful handling of all blood and other body fluids.
8. Personal protection must be provided and available in all areas where blood and body fluids may come into contact with personnel. Gloves, waterproof aprons or gowns, and masks or protective eyewear must be worn where appropriate.
9. Workers with cuts or abrasions on exposed body parts must cover these with waterproof dressings.

Exposure to body fluids

If you come in contact with blood or other body fluids, you should:

1. Flush the area with running water.
2. Wash the area with plenty of warm water and soap.
3. Report the incident to the appropriate staff member.
4. Record the incident via an appropriate reporting procedure.
5. Seek medical advice.

Employers (and occupational health and safety representatives if they exist) should investigate all incidents involving contact with blood or other body fluids, and take action to prevent a similar incident from happening again.

What to do if you have a needle-stick injury

Needle-stick injuries are wounds caused by needles that puncture the skin. It usually refers to only those cases where the skin is punctured by a 'used' needle.

Immediately after the injury, suggested steps include:

1. Wash the wound with soap and water.
2. DO NOT force or encourage the wound to bleed.
3. DO NOT lick or suck the wound.
4. If soap and water aren't available, use alcohol-based hand rubs or solutions.
5. If you are at work, notify your supervisor or other appropriate officer. You may need to fill out a special form.
6. Go straight to your doctor, or to the nearest hospital emergency department, or follow the guidelines developed by your department.
7. In case PEP is indicated , in order to be effective, it has to be initiated as soon as possible and not later than 72 hours after the accident.

Ways of reducing the risk of needle-stick injuries include:

1. Health workers who may come in contact with blood or other body fluids should receive hepatitis B vaccinations.
2. Follow all safety procedures in the workplace.
3. Regularly undertake safety refresher courses.
4. Minimise your use of needles.
5. Remember that latex gloves don't protect you against needle-stick injuries.
6. Don't bend or snap used needles.
7. Never re-cap a used needle.
8. Place used needles into an approved sharps disposable container – they must be rigid, puncture resistant, unbreakable, leak resistant with a tightly sealed lid and labelled "Sharps Waste" or with the International Biohazard label. No glass jars, soda bottles, or milk jugs are accepted since these containers are not puncture proof.

Course Content and Instructors' Notes for Module 2

Occupational Health and Safety: HIV and Hepatitis

Slide 1

Title Slide

Slide 2

Learning objectives of the module

Slide 3-4

Protecting yourself from HIV

Modes of HIV transmission

Slide 5-7

Risk of HIV transmission

Risk of HIV transmission through needle stick injury is actually quite low and important to remind LE officials of this. For more information see:

> Baggaley, RF; Boily, MC; White, RG; Alary, M (2006-04-04). "Risk of HIV-1 transmission for parenteral exposure and blood transfusion: a systematic review and meta-analysis". *AIDS (London, England)***20** (6): 805–12. doi:10.1097/01.aids.0000218543.46963.6d. PMID 16549963. *(22)*

Risk of HIV transmission through sexual transmission is also quite low but correct and consistent use of condom is essential for LE officials engaging in risky sexual activities. Therefore, condoms should be readily available. For more information see:

> Boily MC, Baggaley RF, Wang L, Masse B, White RG, Hayes RJ, Alary M (February 2009). "Heterosexual risk of HIV-1 infection per sexual act: systematic review and meta-analysis of observational studies". *The Lancet Infectious Diseases***9** (2): 118–129. doi:10.1016/S1473-3099(09)70021-0. PMID 19179227. *(23)*
>
> Beyrer, C; Baral, SD; van Griensven, F; Goodreau, SM; Chariyalertsak, S; Wirtz, AL; Brookmeyer, R (2012 Jul 28). "Global epidemiology of HIV infection in men who have sex with men.". *Lancet***380** (9839): 367–77. doi:10.1016/S0140-6736(12)60821-6. PMID 22819660. *(24)*

Risk of HIV transmission from oral sex is very low as well. For more information see:

http://www.cdc.gov/hiv/resources/factsheets/oralsex.htm

Slide 8

Other workplace risk

Risks to patrolling officers rendering first aid to victims and traffic LE officials attending accidents. Risks to officers attending bloody crime scenes.

Describe and discuss the risks attached to certain covert duties (e.g. following a test purchase transaction, undercover officers are sometimes told to conceal the package containing the drug inside their mouth).

Slide 9

Hepatitis B (HBV)

This slide discusses HBV which is a viral infection that attacks the liver. It is commonly spread through the use of contaminated needles and syringes. Therefore, HBV can be transmitted in a needle-stick injury. The risk of transmission can be reduced by 95% by administering a vaccine. This vaccine should be available through every LE institution.

Slide 10

Post-Exposure Prophylaxis (PEP)

If you think you have been exposed to HIV through a needle-stick injury (assuming that every needle-stick injury is a potential risk factor for acquiring HIV) or through unsafe sexual practices, you need to be seen by a medical professional as soon as possible to be assessed for PEP. Post-exposure prophylaxis is an antiretroviral therapy that is started immediately after someone is exposed to HIV. The aim is to allow a person's immune system a chance to provide protection against the virus and to prevent HIV from becoming established in someone's body. It usually consists of a month long course of two or three different types of the antiretroviral drugs. In order for PEP to have a chance of working, the medication needs to be taken as soon as possible, and within 72 hours of exposure to HIV. Guidelines for accessing PEP should be stated in LE institutional SOPs.

Slide 11

Work place HIV Safety

Items to use for protection from HIV when working in the field include the use of gloves when conducting searches and eye masks when confronted by people who may be affected by substances in a closed setting.

Slide 12

Personal HIV Risk Reduction

Items to use for self-protection from HIV – sterile needles and condoms.

Slide 13-17

Safe searching techniques

These series of slides show images of what is considered safe searching techniques to protect LE officials; the photos range from incorrect to correct technique.

The first picture shows a LE officer searching a man's body. The LE officer is not wearing gloves. He is also in a vulnerable position in the event that the man being searched wanted to attack or assault the LE officer.

The second picture shows a LE officer searching a man's pants pocket. The LE officer is not wearing gloves. It is also very risky to put your hands in someone's pocket as you risk needle stick injury.

This picture of a LE official searching a dog is basically to amuse the participants.

Slide 18

Safe Disposal

Safe disposal of needles/syringes requires the presence of or access to sharps disposable containers which should be easily available. Instructors should ensure that sharps disposable containers are used in the demonstration of safe disposal of needles, syringes and other injecting equipment.

Slide 19-20

Steps for safe searching of a person

This section requires a visual demonstration followed by an assessment of participants' techniques using the Practical Case Study.

Slide 21

A National Law Enforcement Policy for Occupational HIV Risk Reduction

A national law enforcement policy for occupational HIV risk reduction needs to be developed and taught to all law enforcement officials. The development of SOPs for guiding how law enforcement officials can reduce their risk is critical. It should promote and ensure access to condoms, PEP, voluntary counselling and testing and ART for all law enforcement officials and their families in a workplace culture that is free of discrimination and stigma.

Module 3
Overview of the role of law enforcement officials in public health and the importance of working with key populations

Module 3 – Overview of the role of law enforcement officials in public health and the importance of working with key populations

LE officials and other uniformed services have historically been critical partners in public health response generally and with vulnerable communities specifically. During their careers, most LE officials will work across a range of public health issues including but not limited to responding to road traffic and trauma, natural or manmade disasters and domestic violence. LE officials are often the first responders to people who may also have issues with alcohol or other drugs. In addition, LE officials' work intersects with people or behaviours that are often criminalised, discriminated against or considered illegal such as drug use and sex work. Balancing out their role in the enforcement of the law as well as protecting the rights and health of individuals and the community can provide constant challenge. In the context of preventing HIV among key affected populations, LE officials need to be able to find the appropriate balance between public health and law enforcement. This often calls for the use of discretion as well as a developed understanding of how their role can negatively or positively impact on key affected populations *(25)*.

There is a need to work with LE officials at an academy and at the field level to ensure that they are aware of their important role in public health generally and in HIV more specifically. LE officials, like all professionals, should be aware of the health and welfare implications of their actions and take a responsibility for these. Despite the vital role of the LE officials in public health, LE services and institutions have often not been sufficiently integrated into national plans and policies for HIV/AIDS prevention, treatment, care and support. Law enforcement institutions can and should play a role in shaping national policies on issues in which they play a central role *(5).* In order for this role to be an effective one, partnerships between the LE officials, other uniformed services, health services and community representatives are required. Inspiring LE officials to actively embrace their role as public health actors will result not only in better community health for diverse and vulnerable populations, but also result in better policing outcomes such as crime reduction.

Purpose

Having reviewed in Module 1 the relevant literature on global and national HIV/AIDS epidemic and response and how to decrease the occupational risk of HIV in Module 2, Module 3 then begins to explore the notion of significant role of LE officials as frontline partners in public health. The purpose of Module 3 is to orientate LE officials to their role as public health actors.

The Module begins by highlighting to LE officials their role as they are often the first officials to respond to a whole range of public health issues. The Module then uses this fact to frame how important the role of the LE officials is with key affected populations including people who inject drugs. The Module then examines in more details the role of LE officials in HIV prevention, treatment and care among people who inject drugs and other key populations.

Learning Objectives

At completion of Module 3, participants should have a greater appreciation of the following topics:

- The historical role of LE officials in supporting public health policies and practices
- In particular, the role of LE officials in public health extends to key affected populations, especially people who inject drugs and prisoners.
- A growing understanding of how exactly the role of LE officials impacts HIV prevention, treatment, care and support.

Useful Learning Materials and Readings

To support the learning of key concepts in Module 3, it is recommended that the following documents be made available to participants

> Monaghan, G, and Bewley-Taylor, D. Police support for harm reduction policies and practices towards people who inject drugs. IDPC 2013. Available at: http://idpc.net/publications/2013/02/LE officials-support-for-harm-reduction-policies-and-practices-towards-people-who-inject-drugs

Case Studies

Practical Sessions

Course Content and Instructors' Notes for Module 3

Overview of the role of law enforcement in public health and the importance of working with key populations

Slide 1

Title Slide

Slide 2

Learning objectives

Slide 3

This slide basically sets the scene. The trainers should be firm and strong on this theory that LE officials are an incredibly important component of a public health response and they need to understand this. Trainers can even ask participants if they consider themselves public health actors. If the participants do not respond, then move on to Slide 4 and 5.

Slide 4-5

These slides highlight specific examples of LE officials responding to particular issues and are designed to highlight that LE officials are absolutely involved in a wide range of public health activities starting from being the first responders to road trauma to being called upon to manage natural disasters. After talking through these examples, participants should be under no illusions as to the importance of their role in public health and also that public safety is public health. The difference is that there are so many more LE officials than public health officials so we must expect our LE officials to help out with a variety of public health duties.

Slide 6-7

The images in Slide 6 and 7 are designed to explain the two different perceptions of policing as either pro public health in the case of slide 6 or against public health and human rights in the case of slide 7. Slide 6 shows the perfect vision of LE officials being mobilized and resourced to be involved in many aspects of public health and to suggest to participants that "imagine what we could achieve for the community if all the LE officials were aware of their role in public health." Slide 7 is clearly a perception of LE officials as perpetrators of violence, which we do not want to promote.

Slide 8-9

Building on the fact that participants should now be aware of their role in public health, the trainers should suggest to participants that their role is even more important when working with vulnerable populations including the key populations – specifically people who inject drugs and prisoners. The slide 9 outlines an image of policing that is much more caring and understanding of HIV and how it affects vulnerable groups.

Slide 10

The trainers should basically have already convinced the participants of the need to work with key populations but this slide essentially says that the most important thing we can do in responding to HIV is to enlist the support of the LE officials.

Slide 11

With the participants on board, the trainers now need to outline how we are going to support the LE officials to become better at engaging with key populations such as people who inject drugs and therefore contribute to the national HIV response.

Slide 12

Group Discussion

Working in small groups, the participants will be asked to devise ways to get LE officials' involved in supporting public health in their own communities and in communities at higher risk of HIV including people who inject drugs and prisoners.

Module 4
Risk and Vulnerability: Policing Key Populations and Protecting Human Rights

Module 4 – Risk and Vulnerability: Policing Key Populations and Protecting Human Rights

LE officials are often involved in responding to complex social situations involving vulnerable groups such as people who use drugs, sex workers and people affected by mental illness. How LE officials interact with these populations can have wide ranging implications for broader societal values of inclusiveness and human rights. The way that LE officials interact in the community with various groups can either promote individual and public health or negatively impact on it *(26).* By respecting the rights of all members of the community, LE officials can contribute to reducing widespread stigma and discrimination often faced by certain groups. Understanding the impact of criminalisation, stigmatisation and discrimination often faced by vulnerable groups is a critical component of being able to work with all groups in a community and uphold the values that should be inherent in all states.

LE officials are often the most visible arm of the State and as such they need to be seen to promote and protect fundamental rights. Through addressing stigma and discrimination toward vulnerable groups using a human rights and community policing/crime prevention framework, LE officials can promote tolerance and understanding in society. Through partnerships with other sectors and visibly supporting the work of sectors and organisations that work with key populations, LE officials can significantly contribute to the goal of scaling up comprehensive HIV prevention, treatment, care and support for all members of the community. Evidence also suggests a host of positive benefits appear for the law enforcement agencies and institutions including improvements in community relations and crime reduction, when LE officials protect the rights of vulnerable populations, there are.

The role of LE officials in the national HIV response is shaped by the nature of the epidemic in the country and the social, legal, cultural and political context in which a response takes place. In a generalized HIV epidemic, LE officials are engaged in managing the social issues relating to drivers and consequences of infection such as through their interactions with people who live in abject poverty, street children, victims of trauma including gender based violence, rape and war and displaced populations resulting from war or disaster.In a concentrated epidemic which is primarily among key populations including people who inject drugs, prisoners, sex workers and men who have sex with men, LE officials should be primary partners in the response by supporting access of the key populations to evidence based HIV prevention, treatment, care and support services.

In both types of epidemics, an enhanced LE officials' response can be negatively impacted if their role is not well understood and if tensions between policing and public health objectives, such as through contradicting laws and policies, are not addressed. Operational culture and practice of the policing institution can also negatively impact an enhanced LE officials response to HIV for example when low LE officials salaries result in a culture of bribery and corruption and potential involvement of LE officials in controlling sex work or illicit drug trafficking.

Violence against women is a critical issue that deserves special attention when considering barriers and obstacles to adequate services and support. Women who inject drugs experience high rates of intimate partner violence *(27),*which negatively affects their ability to practise safe sex *(28)* and safer drug use *(27).* Punitive policies are frequently associated with police abuses,

including physical and sexual violence against women who inject drugs *(29,30).* Gender-related violence of such sorts makes women reluctant to access harm reduction services even if they are available, often because they fear being harassed or abused simply by trying to enter facilities *(31).*

The role of LE officials within a society and its communities is complex; although their primary role is to deal with crime, there are many other complementary roles within crime-prevention *(32).* These include helping people who are at risk, diverting potential offenders away from criminal justice and talking to young people about drugs. LE officials often have daily contact with people who use drugs, sex workers, street children and migrants and so can act as a link to education and services that these groups may not have heard of or have access to.

Studies on policing and drug enforcement have helped to identify alternatives to traditional enforcement approaches that can have substantially improved effects on both individual and public health as well as reduce crime and improve public safety *(25).* These include modifying policing practices to an approach better suited to community policing approaches involving fostering partnerships between policing and public health agencies, education and access to programmes aimed at making drug use safer and providing voluntary evidence-based drug dependence treatment programmes in the community and education aimed at the LE officials themselves to help deal with their attitudes and any possible discrimination on their part towards these communities (Pearce 2007). Effective HIV prevention and policing vulnerable populations are not separate aspects of law enforcement agencies' policy and practice, but a fundamental component of good policing *(19).*

LE officials need to understand the profound effect that policing practices can have on the effectiveness of HIV prevention initiatives, and in perpetuating HIV/AIDS related stigma and discrimination *(32).* Harassment and intimidation of people vulnerable to HIV infection or already infected with HIV can impede the effectiveness of HIV prevention and treatmentprogrammes by driving people underground, and making them more difficult to reach with HIV prevention and treatment messages. Stigma and discrimination also discourage people from accessing HIV testing facilities, with the result that less people will know their HIV status, and therefore won't take action to avoid transmitting HIV to other people. Even where a person is aware of their HIV positive status, stigma and discrimination can discourage them from accessing information, treatment, care and support services. Personal opinions involving disapproval of drug use, of commercial sex or of sex between men should not interfere with HIV prevention, treatment, care and support programmes that save lives.

Purpose

Building on from the topics covered in Module 3, the purpose of Module 4 is to give LE officials a deeper understanding of the notion of risk and vulnerability of various population groups. The module explains the concept of key populations and why certain populations of people are more "at-risk" or vulnerable to HIV infection. It is designed to also begin to ask LE officials to examine the impact of stigma and discrimination on key populations. By highlighting the various characteristics of human rights based policing models, this module then highlights specific actions of LE officials that may be considered to violate human rights, increase stigma and discrimination and have negative impacts for a national HIV response.

The secondary purpose of Module 4 is to encourage LE officials to envisage how a change in their attitudes and operational practice could have widespread positive implications for key populations and community safety more broadly. The Module then focuses on the benefits of working proactively with diverse groups and overcoming the challenges faced by law enforcement officials in terms of building trust and creating sustainable partnerships.

Learning Objectives

At the end of this module, participants should have been able to:

- Increase their knowledge and understanding of concept of risk and vulnerability for HIV infection;
- Increase their knowledge and understanding of people most at risk for, and/or vulnerable to, HIV infection;
- Understand the fundamental concepts of human rights based policing models;
- Articulate approaches to their work that can help LE officials reduce the risk and vulnerability of certain key populations;
- Identify and engage key populations in HIV programmes.

Useful learning materials and readings

Trainers should make themselves familiar with the principles of community policing and human rights policing. These concepts are explained clearly in the following document produced on Community Policing by LE officials researchers from the Australian Governmenthttp://www.aic.gov.au/publications/current%20series/rpp/100-120/rpp111.html

Key ingredients of human rights policing include:

- Dignity
- Respect
- Serving the community
- Protecting the community
- High standards professionalism and ethical conduct
- Free from corruption
- Free from discrimination

Source: OHCHR, International Human Rights Standards for Law Enforcement
http://www.ohchr.org/Documents/Publications/training5Add1en.pdf

Case Studies

It is important that the trainer is able to adapt the case study according to the target audience and the country where the training is being implemented. Recruits will have very little prior knowledge about policing practices whereas more experienced officers will be able to apply existing knowledge to more complex scenarios.
A case study example for recruits follows:'You have been assigned duties at a busy provincial LE station in a low socio-economic area. Your supervisor tells you he/she is trying to improve public perception of the LE officials and you are to spend your first shift conducting foot patrol duties.
During your shift, you notice a large group of young people milling around the local market. Your colleague tells you that some of the group are known drug users. They are not known to be violent, but they are very mistrustful of LE officials. What action might you take in relation to the young people? What biases and attitudes might shape your interaction with them? Why might they have a mistrust of LE officials?'

Practical Sessions

Activity 1: *Community Encounters Role Play*

Using the case study described above, ask LE officials to divide into groups of both LE officials and the young people suspected of using drugs around the local market. Ask the LE officials role-playing group to act how they would normally act when they are on duty. This role play session often generally highlights the typical response from LE officials to people suspected of using drugs and is characterised by much shouting and commotion as well as potential for rights violations. Ask LE officials to then review the concepts of human rights policy and community policing and to approach the group a second time, this time utilising the fundamental human rights and community policing concepts.

Activity 2: *Group exercise*

In small groups, participants put together a list of groups in their communities that are at most risk for or vulnerable to HIV infection. They then put together a list of factors that account for this risk and/or vulnerability. What are some strategies that could reduce HIV transmission in these groups?

Activity 3: *Panel Discussion "Community Encounters"*

This Module can be expanded to include a 'Community Encounters' panel involving representatives from key community groups, such as a former or current drug user, someone living with HIV, a sex worker and people working for non-government organizations who work in HIV programmes with key populations. This practical session is designed as a 'meet and greet' and would directly follow the lecture from Module 2. It aims to provide recruits with an opportunity to communicate informally with people from diverse backgrounds, providing a 'human face' to policing and reducing stigma and discrimination. It also provides an opportunity for LE officials to hear directly about the impact of policing on risk and vulnerability and opportunities to address these issues.

Course Content and Instructors' Notes for Module 4

Risk and Vulnerability: Policing Key Populations and Protecting Human Rights

Slide 1

Title Slide

Slide 2

Objectives of the Module

Slide 3-5

Overview and Definition of the concepts of risk and vulnerability and drivers of the epidemics

Risk is the probability that a person may acquire HIV infection; certain behaviours create, enhance and perpetuate risk. Examples of such behaviour include unprotected sex with a partner whose HIV status is unknown, multiple unprotected sexual partnerships, and injecting drug use with contaminated needles and syringes.
The term "driver" relates to structural and social factors, such as poverty, gender inequality and human rights violations, that are not easily measured and which increase people's vulnerability to HIV infection. Vulnerability to HIV results from a range of factors that reduce the ability of individuals and communities to avoid HIV infection. These include personal factors such as the lack of knowledge and skills required to protect oneself and others, factors pertaining to the availability, quality and coverage of services, and societal factors such as social and cultural norms, practices, beliefs and laws that stigmatize and disempower certain populations, and act as barriers to HIV prevention, treatment, care and support services. The definitions of risk, driver and vulnerability in the context of HIV are taken from the following document: UNAIDS (1998): Expanding the global response to HIV/AIDS through focused action: Reducing risk and vulnerability: definitions, rationale and pathway (*33*).

Slide 6

Overview of people most affected by HIV, people who are most at risk or vulnerable and why. The participants should be able to have a greater understanding of the concept of key populations now that they have gone through Module Two and the early part of Module Three. The instructor may want to go further into the issue through a discussion of the relationship between HIV infection and factors such as socioeconomic status, sexual orientation and access to methods of prevention and to treatment and care.

Slide 7

Women who inject drugs

Women who inject drugs are at greater risk for HIV than men. This is due to a number of reasons including exposure to gender-based violence, the trading of sex for drugs and a decreased ability to negotiate safe sex and high stigmatization. Law enforcement officers need to be acutely aware of the heightened risk for women who inject drugs and be able to protect the rights of women who inject drugs as well as be able to support service provision for women who inject drugs. More information can be found at:

> El-Bassel N, Wechsberg WM, Shaw SA. Dual HIV risk and vulnerabilities among women who use or inject drugs: no single prevention strategy is the answer. *CurrOpinHIV AIDS.* 2012 Jul;7(4):326-31. doi: 10.1097/COH.0b013e3283536ab2. *(34)*

Slide 8

HIV Risk Environments

The space where policing intersects with key populations is often where social networks of key populations are engaged in activities that challenges the boundaries of how LE officials are meant to respond. The idea of this slide is for LE officials to actually consider what an HIV risk environment may look like. Instructors should ask LE officials to describe how certain geographical locations or day-to-day circumstances of policing communities can increase the HIV risk environment

Slide 9-13

Decreasing the Risk Environment

What can LE officials do to decrease the HIV risk environment? What can be done to change risk levels? What are some of the negative policing strategies that affect HIV risk? What are the positive strategies that can decrease risk? We want the participants to think about their roles in working with key populations and to further think about what sort of support they need to provide to play a more enhanced role in reducing the risk and vulnerability of people to HIV. What do they need from their LE agency leaders? What do they need from their law enforcement institutions? What about the concept of knowing their communities – the community policing concept?

Slide 14-15

Human Rights Policing and understanding Diversity

It is important that participants have an understanding of international good practice policing philosophy and frameworks. This sets baseline knowledge and understanding for the entire training. Trainers should make themselves familiar with the principles of community policing and human rights policing. These concepts are explained clearly in the following document produced

on community policing by LE officials from the Australian Government http://www.aic.gov.au/publications/current%20series/rpp/100-120/rpp111.html

Key ingredients of human rights policing:

- Dignity
- Respect
- Serving the community
- Protecting the community
- High standards professionalism and ethical conduct
- Free from corruption

Source: OHCHR, International Human Rights Standards for Law Enforcement http://www.ohchr.org/Documents/Publications/training5Add1en.pdf

Slide 16-17

Community Policing

Introduce community-policing principles to participants. Explain that 'community policing' is an internationally recognised policing philosophy that fits well within a human rights framework. Acknowledge that many LE institutions around the world are based on a 'command and control' or para-military model, however the principles of community policing can be easily applied to any context.

- High visibility policing
- Engagement with the community
- Focus on vulnerable populations & recognition of special needs
- Embrace diversity
- Problem-solving
- Active involvement of community members
- Other terms associated with community policing include community engagement, problem-oriented policing, and crime prevention. It emphasizes a proactive, collaborative approach to solving complex social problems.

Slide 18

Panel Discussion: Community Encounters

This Module should include a practical session that is based on a 'Community Encounters' panel involving representatives from key community groups, such as a former or current drug user, someone living with HIV, a sex worker and people working for non-government organizations who work in HIV programmes with key populations. This practical session is designed as a 'meet and greet' and would directly follow the lecture from Module 3. It aims to provide recruits with an opportunity to communicate informally with people from diverse backgrounds, providing a 'human face' to policing and reducing stigma and discrimination. It also provides an opportunity for LE officials to hear directly about the impact of policing practices on risk and vulnerability and opportunities to address these issues.

Slide 19

How does the community experience policing?

This slide asks participants to think about how the community experiences policing and examines a number of different scenarios for LE officials to consider. The ultimate aim of LE officials is to consider how they are perceived in different circumstances which follows on from the group panel discussion.

Slide 20-22

Over represented populations, bias and discrimination

Why are certain populations over represented in the criminal justice system? Is it a result of profiling or tactics? When LE officials work, a certain amount of bias might be introduced to the work when interacting with some population groups . Does that lead to discrimination and over arrest of some populations at a greater rate than other people? What influences these decisions? Is it community wide bias and discrimination? What can the LE officials do to ensure that they are not discriminating against certain populations?

Slide 23-24

Benefits and Challenges of Community Policing

When community policing is done well, it results in significant benefits for both the community and the LE officials. These slides examine what those benefits are and highlight that community policing can result in significant advantages for LE officials in terms of crime reduction, improved community trust in policing and indeed better outcomes for populations at greater risk of HV. There are a range of threats to growing a culture of community policing and these can be related to legislation, community norms and expectations and the support for community policing within the leadership of law enforcement institutions.

Slide 25

Case Study and Activity (20 minutes)

'You have been assigned duties at a busy provincial LE station in a low socio-economic area. Your supervisor tells you he/she is trying to improve public perception of the LE officials and you are to spend your first shift conducting foot patrol duties.

During your shift, you notice a large group of young people milling around the local market. Your colleague tells you that some of the group are known drug users. They are not known to be violent, but they are very mistrustful of LE officials. What action might you take in relation to the young people? What biases and attitudes might shape your interaction with them? Why might they have a mistrust of LE officials?'

Slide 26

Summary and Discussion

What have we learnt from the case study about how to engage in community policing in circumstances where people may or may not be using drugs?

Key ingredients for effective community engagement:

- Proactive policing vs reactive
- Open communication style
- Empathy and understanding
- Role modeling
- Leadership

Module 5
Introduction to drugs, policing and harm reduction

HIV can be spread through sharing of unsterile needles and syringes and other equipment used in preparing and injecting drugs. Worldwide, unsafe injecting drug use is second only to unprotected heterosexual intercourse as a cause of HIV transmission. In 2013, there are an estimated 12.7 (8.9-22.4) million people who inject drugs (PWID) worldwide, with highest prevalence rates in Eastern/South Eastern Europe and Central Asia and Transcaucasia. Globally, 1.7 million (13.1%) PWID are living with HIV with highest HIV prevalence rates of 28.8% and 23.0% in South West Asia and Eastern/South Eastern Europe respectively(*3*).

WHO, UNODC and UNAIDS recommend a **comprehensive package of nine interventions, also known as 'Harm Reduction' services**, for people who inject drugs to stop the spread of HIV among this population group (35). These are: Needle and syringe programmes (NSPs); Opioid substitution therapy (OST) and other evidence-based drug dependence treatment; HIV testing and counselling (HTC); Antiretroviral therapy (ART); Prevention and treatment of sexually transmitted infections (STIs); Condom programmes for people who inject drugs and their sexual partners; Targeted information, education and communication (IEC) for people who inject drugs and their sexual partners; Prevention, vaccination, diagnosis and treatment for viral hepatitis; and Prevention diagnosis and treatment of tuberculosis (TB). The Commission on Narcotic Drugs (CND), the UNAIDS Programme Coordinating Board (PCB) and the United Nations Economic and Social Council endorsed the comprehensive package for people who inject drugs. The need for a comprehensive HIV response among people who use drugs was also reflected in the commitments made by the Member States at the United Nations General Assembly in 2001, 2006, 2008 and in 2011.

Based on the World Drug Report 2014, in 16 high prevalence countries — which account for 45% of the global number of people who inject drugs and 66% of the global number of people who inject drugs living with HIV —a generally low level of harm reduction service provision can be noted, particularly with regard to the needle and syringe programmes and opioid substitution therapy.

Evidence from around the world suggests that harm reduction strategies can be mounted given the political will to do so *(32).* Based on experience in numerous communities and governments, an effective harm reduction policy must be developed using the best available epidemiological information and evidence of effectiveness and with the participation and support of as many stakeholders as possible. It is characterized by flexibility, a health promotion approach, non-repressive legislation (such as laws that allow for distribution of needle-syringe), and law enforcement based on community policing and de-stigmatization. It also ensures adequate coverage of the population and sustainability of efforts. To implement the policy, countries need to provide education for law enforcement personnel on the harms associated with punitive responses and on health-promoting alternatives.

Purpose

Having orientated LE officials in Module 4 to the concepts of human rights policing and community policing with key populations, Module 5 is designed to provide participants with a more in depth understanding of drug use. The Module sets out to enhance participants understanding of different types of drugs, the varying level of psychoactive effects of certain drugs and that people use drugs for a range of reasons. Furthermore, the trainer will be able to explain how drug use influences some behaviour that can increase risk of HIV and other blood borne viruses (BBVs) such as HCV and HBV. One of the purposes of this course is to acknowledge that there are different levels of drug use. Some people use some types of drugs recreationally with minimal disruption to their health or social lives. Other people use drugs more frequently and there can be harmful effects but drug dependence is treatable. The main premise is that drug use needs to be considered through a health lens rather than through a criminal lens.

Learning Objectives

After taking Module 5, participants will have a greater understanding of drug use in the community, including which drugs they are more likely to encounter in the community and why people use both licit and illicit drugs. Module 5 explains the concept of harm reduction as an approach to HIV and other BBV prevention. In particular, participants will understand the concept of harm reduction and what constitutes a 'comprehensive package' of interventions for HIV prevention, treatment and care among people who inject drugs. Importantly, participants will be able to identify the benefits of harm reduction approaches for crime prevention and public order whilst developing an awareness of how law enforcement practices influence the success or failure of harm reduction interventions. Finally, participants will be introduced to a range of micro and macro challenges facing successful operation of harm reduction programmes including a lack of knowledge about HIV transmission and prevention among LE officials and the community, the social status of drug users, the use of discretion by LE officials and the political environment in which the LE officials work.

Specifically this module is designed to:

- Increase their knowledge and understanding of injecting and non-injecting drug use, the drugs PWID commonly use including the effects, techniques and preparation of drugs and patterns of use
- Understand drug use in the community:
  - Drugs can be both licit (tobacco, alcohol) and illicit
  - The most frequently used drugs in their community
  - Why people use drugs
  - Understand how drug use impacts on HIV risk
  - The difference between drug use and drug dependence
  - The impact of law enforcement practices

Learning Materials and Recommended Readings

Case Studies

Practical Sessions

Course conveners may wish to work with partners and have a guest lecture from a medical expert on clinical signs and symptoms of illicit drug use, increasing dependent drug use and overdose.

Course Content and Instructors Notes for Module 5

Introduction to drugs, policing and harm reduction

Module 5 provides a basic overview of types of drugs, their effects, why people use drugs and HIV risk associated with drug use. The level of detail and duration of Module 5 can be adapted to the audience. Some LE officials may be more familiar than others regarding types of drugs, their effects and reasons why they are used. This Manual recommends a simpler delivery of the Module for junior to mid rank officers and a more technically detailed delivery for more senior LE officials. The lectures in Module 5 are capable of being delivered to large audiences as part of broad LE training or to much smaller audiences at the provincial or local level, although the activities may need to be adapted to suit participant numbers.

Slide 1

Title Slide

Slide 2

Learning Objectives

Slide 3

What is a drug?

It is important to note that drugs include both licit and illicit substances. Drugs are substances that affect mood, cognition and perception because they interact with our central nervous system. Different drugs have different effects on both the body and the brain. Some drugs make everything speed up (such as stimulants); some drugs are depressants and make things slow down (such as heroin and alcohol).

Slide 4

Categories of drugs

Stimulants:	Enhance activity in the central nervous system (the brain and spinal cord).
Depressants:	Slow down the functioning and activity of the central nervous system.
Hallucinogens:	Distort messages to the central nervous system – causing disturbances in thought and perception.

Slide 5

Group Work (20 minutes)

This small group activity is designed to ask participants to explore their own knowledge about drugs in their country or community and asks participants "What are the most frequently used drugs in your country/region or your community?" Participants should have picked up this information from earlier modules.

Slide 6

Group work (20 minutes)

The aim of this activity is to highlight the range of reasons as to why people might start taking drugs or become drug dependent.
Ask participants to turn to the person sitting next to them. Ask the participants to compile a list of reasons why people use drugs with the aim of listing as many reasons as they can think of. Allow the group to have five minutes to compile their lists. Explain to the participants that each pair will have to report back to the class two reasons why people use drugs without repeating a reason already given by a previous pair. This will encourage people to think broadly so they can avoid repeating responses of the previous pairs. After five minutes, write responses on large butcher's paper, checking that responses aren't repeated. If participants exhaust ideas, show the slide containing the list of reasons why people use drugs. Check if all reasons were covered whilst noting that there are likely to be many more reasons than those listed.
Refer to the range of reasons why people use drugs and reflect that many of the reasons, such as grief, curiosity or ill mental health can affect all of us regardless of age, gender, sexual orientation, upbringing, social status, employment status etc.

Slide 7

Why do people use drugs?

This list highlights the broad range of reasons why people might use drugs.

Slide 8

Different drugs have different risks, particularly for HIV and these next series of slides begin to articulate the different risks associated with different drugs and begin by describing how the use of opiates can pose risks for the users.

Slide 9

Risk and harms of alcohol

Information for trainers- Some evidence suggest a correlation between heavy and harmful drinking patterns and an increased likelihood of sexual risk-taking behaviours, including engaging in unprotected sex. Excessive drinking patterns may influence sexual risk-taking by affecting

judgment and reducing inhibitions, thereby diminishing perceived risk or excusing behaviours otherwise considered socially unacceptable. Heavy drinking has been linked to decreased inclination to use condoms.

For further information:

http://www.icap.org/policytools/icapbluebook/bluebookmodules/24hivaidsrisksanddrinkingpatterns/tabid/182/default.aspx

Slide 10

Risk and harms of amphetamines

Slide 11

Activity 1: When is drug use a risk?

Slide 12

Positive approaches to addressing drug use

- There are many different approaches to addressing drug related issues.
- What is most important to acknowledge here is the importance of a holistic package when dealing with drug use. These interventions should not be seen as stand-alone solutions(Some of these approaches are explained in more detail in following slides.)
- Next we will look at harm reduction approaches

Slide 13-14

What is harm reduction?

WHO, UNODC and UNAIDS recommend **a comprehensive package of nine interventions**, also known as **'Harm Reduction'** services, for people who inject drugs to stop the spread of HIV among this population group (*35*). These are: Needle and syringe programmes (NSPs); Opioid substitution therapy (OST) and other evidence-based drug dependence treatment; HIV testing and counselling (HTC); Antiretroviral therapy (ART); Prevention and treatment of sexually transmitted infections (STIs); Condom programmes for people who inject drugs and their sexual partners; Targeted information, education and communication (IEC) for people who inject drugs and their sexual partners; Prevention, vaccination, diagnosis and treatment for viral hepatitis; and Prevention diagnosis and treatment of tuberculosis (TB).

Module 5 – Activity 2

Risk Assessment

a. Give each group one of the activity cards (see handouts). Each cardIncludes information about: a drug; a person; method of drug use; reasonsfor drug use and the context of drug use.

b. Ask one person in each group to facilitate discussion on what the situationis and what is risky about this situation.

c. During the feedback emphasize that the risks associated with the drug usedo not lie only in the drug itself but in the combination of the drug,user, context, amount, reasons and method and route of use.

Drug	Method	Reasons	Context	Person/s	Risks?
Heroin	Injecting	To escape the pain of everyday life	Sharing with a friend who also injects drugs on pay day	Young people on the corner of street	

Drug	Method	Reasons	Context	Person/s	Risks?
Alcohol	Drinking	Celebrating a marriage ceremony	In the back of the house	Young men who are friends of bridegroom	

Drug	Method	Reasons	Context	Person/s	Risks?
Heroin	chasing the dragon	To escape feelings of depression	With other people including fellow workers, friends or people who hang out on the street together	Men and women	

Drug	Method	Reasons	Context	Person/s	Risks?
Ampheta-mines	Oral or smoking	Seeking excitement	Dance party	Teenagers in the house of one wealthy friend	

Drug	Method	Reasons	Context	Person/s	Risks?
Heroin	Injecting	To have pleasure and take pain away. To make living on the street more tolerable	Using alone	25 year old street based addict	

Module 6a
The Comprehensive Package for Prevention of HIV, Hepatitis and TB among People who Inject Drugs

Module 6a – The Comprehensive Package for Prevention of HIV, Hepatitis and TB among People who Inject Drugs

WHO, UNODC and UNAIDS recommend a comprehensive package of nine interventions, also known as 'Harm Reduction' services, for people who inject drugs to stop the spread of HIV among this population group (35). These are: Needle and syringe programmes (NSPs); Opioid substitution therapy (OST) and other evidence-based drug dependence treatment; HIV testing and counselling (HTC); Antiretroviral therapy (ART); Prevention and treatment of sexually transmitted infections (STIs); Condom programmes for people who inject drugs and their sexual partners; Targeted information, education and communication (IEC) for people who inject drugs and their sexual partners; Prevention, vaccination, diagnosis and treatment for viral hepatitis; and Prevention diagnosis and treatment of tuberculosis (TB). The Commission on Narcotic Drugs (CND), the UNAIDS Programme Coordinating Board (PCB) and the United Nations Economic and Social Council endorsed the comprehensive package for people who inject drugs. The need for a comprehensive HIV response among people who use drugs was also reflected in the commitments made by the Member States at the United Nations General Assembly in 2001, 2006, 2008 and in 2011.

This UN Comprehensive Package was put together in order of priority and evidence, with NSPs and OST being the most important and having the best evidence base of the nine interventions. Over the past three decades, law enforcement agencies in many parts of the world have recognised that these harm reduction measures also reduce crime, save money and improve health. This has meant increasing support for components of the Comprehensive Package. Cities where these strategies have proved successful in avoiding an HIV epidemic among people who inject drugs have four features in common: the use of community outreach or peer education to reach and educate drug users; cheap and easy access to sterile syringes; early action on prevention, before HIV prevalence reached a critical point and the availability of OST and ARV. In many of these settings, LE operation and practice works towards enhancing access to these services.

Purpose

Having introduced the participants to the concept of harm reduction in Module 5, it is time now to give them a much more in depth review of what harm reduction actually looks like in practice. Module 6a is specifically designed to orient the participants to the components of what is regarded as the 'comprehensive package' for HIV prevention among people who inject drugs. The slides in Module 6a not only review the comprehensive package but also examine the role of LE officials in each of the components. Module 6a also highlights the benefits to the LE officials and the wider community of supporting the comprehensive package. Research shows that LE officials are generally more receptive to interventions which benefit the wider community, rather than focusing only on the benefits to individuals at risk of HIV.

Learning Objectives

By the end of Module 6a, participants should have a much higher level of awareness about public health oriented responses to drug use outlined in the Comprehensive Package and specifically should have:

- Increased knowledge and understanding of a comprehensive approach to the prevention, treatment and care of HIV, Hepatitis and TB through increasing familiarity with components of the Comprehensive Package;
- Understood the relationship between components of the Comprehensive Package and HIV prevention, treatment and care policies;
- Examined the role of LE officials for each intervention in the Comprehensive Package;
- Understood the benefits of the Comprehensive Package for policing, people who inject drugs and their sexual partners as well as for the wider community.

Useful Learning Materials and Readings

- WHO, UNODC and UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, 2012
- http://www.unodc.org/documents/hiv-aids/publications/People_who_use_drugs/Target_setting_guide2012_eng.pdf

Case Studies and Practical Sessions

Course Content and Instructors' Notes for Module 6a

Comprehensive Package for Prevention of HIV, Hepatitis and TB among People who Inject Drugs

Slide 1

Title Slide

Slide 2

Learning objectives

The slides in this module are designed to highlight to the participants the recommended available interventions to reduce the harm associated with drug use. Specifically the central premise of the Module and the main point to make to participants is to highlight that:

- Implementing a core package of interventions can very well reduce HIV transmission and the impact of HIV/AIDS associated with unsafe injecting drug use.
- There is strong and consistent evidence that this package of harm reduction interventions significantly reduces unsafe injecting drug use and associated risk behaviours and hence prevents, halts and reverses HIV epidemics associated with unsafe injecting drug use.
- Conversely, there is no convincing evidence of major negative consequences of these interventions, such as initiation of injecting among people who have previously not injected or an increase in the duration or frequency of illicit drug use or drug injection.

For further information:

WHO, UNODC and UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, 2012, http://www.unodc.org/documents/hiv-aids/publications/People_who_use_drugs/Target_setting_guide2012_eng.pdf

Slides regarding 'Considerations' for each intervention can be used by the trainer to pre-empt participant concerns or questions about their role. Some interventions, such as needle and syringe programmes at police stations may not be implemented in a certain country context. These interventions are included here as part of a good practice model and aim to raise awareness that LE officials in other countries can support these models without compromising their law enforcement role. The power point slides are presented in a way to give equal weight to individual and community level benefits of opioid substitution therapy, needle and syringe programmes and outreach work.

Slide 3-4

The comprehensive package for HIV prevention, treatment and care among people who inject drugs

Slide 5-9

Needle and syringe programmes

NSP is the most effective programme to prevent HIV among people who inject drugs.
NSPs are essentially the provision of free or very cheap new needles and syringes to PWID. The NSPs can be mobile, at fixed sites or delivered by outreach teams. The operating hours of NSPs are generally designed to adapt to the organization of the lives of PWID. The most effective programmes are the NSPs that do not require exact exchange of used needles for new needles but instead provide the number of new needles and syringes required by a person for a period of time defined by the PWID.

Needle and syringe programmes: considerations for LE officials

Punitive approaches also tend to push drug use further underground, where needle sharing becomes more common, with related increased transmission risk of other blood borne viruses. The proximate agent of this influence is the law enforcement sector, in particular, for the drug user on the street, the LE officials. It is important to consider how the daily practices of LE officials impact on programmes which might be funded by the government also. In addition, when PWID are under pressure from LE officials it can also result in abandoning of used needles in public space which creates a health and public security concern for the community.

Slide 10-15

Opioid substitution therapy (OST)

OST is a long term medical treatment (methadone and buprenorphine are medicines) that can be taken under medical supervision and is based on the principle that a drug user will be able to regain a normal life while being treated with a substance that prevents withdrawal symptoms but does not provide euphoria. Opioid substitution therapy (OST), with methadone or buprenorphine, is highly effective in reducing injecting episodes, which in turn reduces the risk of HIV transmission.

These next series of slides explore the benefits of OST for both the community of PWIDs and for LE officials.

For further information:

Vorma H, Sokero P, Aaltonen M, Turtiainen S, Hughes LA, Savolainen J. (2013), Participation in opioid substitution treatment reduces the rate of criminal convictions: evidence from a community study. Addict Behav. Jul;38(7):2313-6. doi: 10.1016/j.addbeh.2013.03.009. Epub 2013 Mar 22. (*40*)

Coid, J., Carvell, A., Kittler, Z., Healey, A. & Henderson, J. (2000), The impact of methadone treatment, drug misuse and crime, Research Findings, No. 120; Home Office Research Development and Statistics Directorate, London, National Criminal Justice reference Service NCJ 187821 https://www.ncjrs.gov/App/Publications/ abstract.aspx?ID=187821(*41*)

Cost effectiveness reference:

National Institute of Drug Abuse, NIDA International Programme, Methadone research, http://www.drugabuse.gov/international/methadone-research-web-guide-tutorial

Slide 16-20

Peer outreach benefits and considerations for LE officials

Drug use is a highly stigmatised activity; drug users and their sexual partners may find it difficult to access medical and social services through traditional agencies.

Peer outreach workers can access hard-to-reach PWID and advocate protective behaviours such as using sterile syringes, disinfecting injection equipment, and using condoms or getting tested for HIV. The distribution of materials that facilitate risk reduction (condoms, lubricant, cottons, cookers, alcohol swabs, etc.) is an important function of community outreach workers in initiating behaviour change. Likewise, providing information about the availability of sterile syringes, drug dependence treatment, HIV/AIDS treatment, and other medical and social services within the local community is also important.

Peer outreach does not necessarily emphasise reaching out to HIV-positive drug users. This is because people who are unaware of their serostatus may engage in risky behaviours not knowing they or others may be put at risk. Studies show that PWID who are aware of their HIV positive status are able to make major behaviour changes to protect their injecting and sexual partners. To this end, the present intervention model can be adapted to help people living with HIV to access HIV medicines and adhere to ARV treatments that can prevent progression of HIV disease, inform their drug and sex partners about potential risk of infection and the importance of getting tested and counselled for HIV and other blood-borne infections, and initiate behaviour change that may prevent transmission of the virus to others.

For more information see:

http://archives.drugabuse.gov/pdf/CBOM/Manual.pdf

Slide 21

Challenges for the LE officials when thinking harm reduction programmes

Slide 22

Discussion (30 minutes)

Discussion on first 2 components of the comprehensive package:

1. Needle and syringe programmes
2. Opioid substitution treatment and other drug dependence treatment

- What do you understand to be the activities of needle and syringe programmes?
- What strategies and programmes need to be in place to help people use safer injecting practices?
- How can concerns of citizens be addressed about NSPs in their community?
- Why are NSPs alone not enough to prevent the spread of HIV and hepatitis?
- What do you understand by the term opioid substitution treatment?
- What are some of the harms reduced by OST?
- Why is OST cost-effective? How is it similar to other forms of long-term medication-based treatment?
- How could these programmes be applied in your community?

How can LE officials be involved in the delivery of the Comprehensive Package?
How can LE officials support the harm reduction interventions?
What type of LE behaviour could compromise the delivery and effectiveness of the harm reduction interventions?

Module 6b
What can law enforcement officials do in a drug overdose situation?

Module 6b – What can law enforcement officials do in a drug overdose situation?

In many countries, LE officials are taking a more active role in responding to overdose including through the provision of naloxone to someone who has overdosed with opioid *(42).* There is growing evidence that law enforcement officials in various settings believe that LE officials should be able to administer naloxone as part of an overdose prevention policy and practice in the context of good community policing principles *(43).* Module 6b is designed to provide trainers with detailed guidance for the delivery of a lecture about what LE officials should do in a situation where a drug user has overdosed. Whilst some LE officials may have first aid training, it is important for the LE officials to recognize that a person who is exhibiting signs of potential overdose requires urgent medical attention. This Module highlights the importance of first responders – often LE officials – in immediately contacting ambulance and medical services or providing naloxone in the case of an opioid overdose.

Protecting lives is a law enforcement priority. Importantly this Module gives an overview of what LE officials should do in the event they are called to attend a non-fatal overdose and a fatal overdose. LE officials' actions at these scenes can either encourage or deter friends, family and witnesses of the event from contacting medical help in future overdose situations. Law enforcement institutions should ensure that there is an updated policy and standard operating protocol that allows LE officials the best possible opportunity to prevent opioid overdose.

Purpose

The purpose of this Module is to inform LE officials that they have a duty of care to intoxicated persons by way of keeping them safe from further harm e.g. taking them to a safe place, and contacting medical services immediately for a rapid response. This module also explains that even though drug use is illegal, through non-prosecution of self-administered non-fatal overdoses, people's lives are saved because people can call for help without the fear of arrest for using drugs. The participants will be taught what their role is at the scene of an overdose, fatal or non-fatal.

Learning Objectives

After taking Module 6b, participants will be aware of and understand the following concepts and vision of the course:

- Understand that it is important to seek medical attention as soon as someone appears to be having a drug overdose
- Identify organizational policies regarding the management of:
  - Intoxicated people
  - Intoxicated people in custody
- Understand that fatal drug overdoses should be investigated by LE officials in order to detect the exact cause of death;

- Understand that LE officials' behavior at a fatal or non-fatal overdose will influence whether the overdosed person or their friends and family are likely to call for help in future emergencies.

Case Studies

An intoxicated drug user was brought to a police station. He was conscious but not well oriented. The person was creating a law and order situation but clearly had individual health implications and considerations associated with his drug use. Discuss the best possible way of managing this situation that prioritises the health of the individual and ameliorates any law and order considerations in the case.

Practical Sessions

Discuss the experience LE officials have had in managing people affected by heroin and other drugs and discuss how their approach may change as a result of the training. A demonstration of the use of naloxone should also be considered where possible.

Course Content for Module 6b

What can law enforcement officials do in a drug overdose situation?

Slide 23 (slide numbers follow from Module 6a)

Title Slide

Slide 24

Intoxicated people in LE officials' custody

Slide 25

Activity 1

- Divide the participants in to 5-7 groups
- Nominate a person to make notes and a person to report responses back to the group
- What policies, procedures, and guidelines, does your organisation have in place to ensure the safety of people who are:

    - Intoxicated
    - In custody
    - Intoxicated and in custody
    - Overdosing in a public area

This exercise will reveal the extent to which policies exist and, indeed, if participants are aware of them. If policies do not exist, senior managers need to be informed so that policies can be designed. If there are policies but no one is aware of them, then senior managers must improve channels of communication within the organization.

Slide 26

Overdose in the custody of law enforcement

Research has shown that a significant proportion of people detained in law enforcement stations tend to be intoxicated or affected by drugs. People who are intoxicated can be at increased risk of engaging in various other offences, harming others, being a victim of crime, or suffering self-inflicted injury (deliberate or accidental).

Slide 27

LE officials' role in non-fatal overdose

LE officials have a duty of care to people in their custody, either in a public place or when held in custody at police station. In the event that drugs are located at the scene of the overdose, LE officials should deal with it as per normal procedures when dealing with exhibits. It is recommended that LE officials do not prosecute people who suffer a non-fatal overdose because it may discourage them from seeking help in the future for themselves or their friends.

Slide 28

The use of naloxone

Naloxone is a life-saving medicine that reverses respiratory depression from opioid overdose. There is an increasing push around the world to expand access to naloxone and also to increase the number of people who can use naloxone especially among people who are often first on the scene in an overdose situation. People often in a position to use naloxone and reverse an opioid drug overdose include first responders such as police and also PWIDs. Naloxone is easy to be administered by sub cutaneous, intramuscular or intravenous injection, there are also intranasal forms are available now.

For more information:

Davis CS, Ruiz S, Glynn P, Picariello G, Walley AY. Expanded Access to Naloxone Among Firefighters, Police Officers, and Emergency Medical Technicians in Massachusetts. Am J Public Health. 2014 Jun 12:e1-e3. [Epub ahead of print](*43*)

Green TC, Zaller N, Palacios WR, Bowman SE, Ray M, Heimer R, Case P
Law enforcement attitudes toward overdose prevention and response. Drug Alcohol Depend. 2013 Dec 1;133(2):677-84. (*44*)

Slide 29

LE officials' role in fatal overdose is as it should be in any other case of death where the cause of death is investigated thoroughly.

Module 7
Law enforcement and the use of discretion, drug diversion programmes and the role of ethical frameworks

Module 7 – Law enforcement and the use of discretion, drug diversion programmes and the role of ethical frameworks

It is common practice among the LE officials to enforce the law with some discretion in many areas. Exercising consistent and wise use of discretion within the law, based on professional policing competence, does much to retain the confidence of the public. Although it can often be difficult to choose between conflicting courses of action, it is important to remember that a timely word of advice rather than arrest, which may be correct in appropriate circumstances, can be a more effective means of achieving a desired end.

For example, the LE officials may often determine whether to enforce laws more or less vigorously. They may decide on which areas to focus their resources and on what crimes they will concentrate. The use of discretion can also assist the diversion of people away from criminal justice systems and into health and social sectors. The use of discretion can save precious law enforcement resources and also result in significant individual and public health benefits for key populations. The use of drug diversion programmes can offer LE officials the opportunities to use their discretion and assist people to avoid arrest and prosecution and refer people away from criminal justice systems (including diverting away from prisons) and into health orientated assistance.

In contexts where drug use is illegal, the use of discretion by LE officials is integral to supporting the major investments governments and local and international agencies make in harm reduction programmes. The Module introduces the important but under-examined use of discretion by LE officials in supporting harm reduction approaches. Officers of all levels of policing from junior and mid rank to more senior policing officials need to understand how decisions that avoid arrest or prosecution of drug users can also be ethical and just.

In many cases, LE officials may rigidly enforce illicit drug laws to resolve situations in a way that does not question their accountability to the law or their superiors. It is also widely known that LE officials use discretion to not arrest or prosecute in a range of circumstances e.g. giving a warning to a speeding motorist. LE officials are often criticized for enforcing the law when others believe that a warning or similar would suffice; however, LE officials are also criticized in some circumstances where they do not enforce the law for 'taking the law into their own hands'. This can be a sensitive issue for LE officials at any level and create ethical and professional dilemmas.

This module is designed to provide a framework for LE officials to make ethical decisions that support harm reduction in an environment with punitive illicit drug legislation. Evidence shows that LE officials who are trained in the ethical use of discretion are more likely to feel confident in using it.

Purpose

Module 7 provides trainers with detailed guidance for the delivery of a lecture focusing on LE officials' decision-making in line with harm reduction approaches. It explores the LE officials' use of discretion, and provides an ethical framework for utilising discretion and diversion.

The purpose of the first part of the module is to discuss the use of discretion openly and recognize that it is an important feature of day-to-day policing. The second half of the Module explores the use of diversion mechanisms and aims to demonstrate to LE officials how alternatives to prosecution can be more effective than arrest and criminal justice approaches at achieving community safety objectives.

The drug diversion programmes addressed in this Module benefit people who use drugs by enabling them to gain access to treatment services and other health and social services to improve their own wellbeing. Importantly, this Module also focuses on the LE officials' benefits of having options of diversion in order to encourage LE officials' support, such as the resultant reduction in illicit drug use, drug-related crime and decreasing amounts of law enforcement paperwork requirements.

Learning Objectives

After taking Module 7, participants will have a greater understanding of and capacity to use and justify using discretion whilst being held accountable for their decisions. Participants will recognize that often the day-to-day decisions cause them the most anxiety rather than such issues as corruption and LE officials' brutality. Participants will be introduced to the concept of an 'ethical dilemma', and how to identify when they are required to make a decision in these circumstances. Participants will develop awareness of a number of ethical frameworks that they can use to help them make ethical decisions.

Specifically, exploring the Module 7 the participants will be aware of and understand the following concepts:

- LE officials' use of discretion and ethical frameworks:
  - Understanding of the definition of 'discretion'
  - Understand the factors which make up an ethical dilemma
  - Develop awareness of specific ethical frameworks to justify decision making in relation to drug use and harm reduction
  - Decision making and accountability to superiors and the community

- Drug diversion programmes:
  - Understanding what diversion from criminal justice prosecution means
  - Develop an awareness of a range of programmes which can divert people who use drugs from criminal prosecution
  - Develop an appreciation of the benefits of drug diversion programmes for the individual, community and LE officials
  - Have a general overview of the evidence base supporting drug diversion programmes

Case Studies

Practical Sessions

Discussion on the concept of discretion and its practical application to policing

In an open and honest discussion, participants will gain practical experience, through a role-play, as to how to justify their decisions around the use of discretion and diversion to superiors based on evidence and an ethical framework.

(If relevant)

Course Content for Module 7

Law enforcement and the use of discretion, diversion and ethical frameworks

Participants should feel comfortable sharing their views about how they or their colleagues enforce the law or not. The purpose of this module is to enhance participants' capacity to use discretion with confidence and with an ethical foundation. Given that there may not be clear delineation as to when discretion is appropriate or acceptable for any organization or individual manager, this session aims to generate discussion in the workplace.

Slide 1

Title Slide

Slide 2

Lesson objectives

Slide 3

What is discretion?

This slide is aimed at promoting discussion on the prevalence and use of discretion by LE officials. For a broader review of the use of discretion in policing see "Discretion, Functionalism and Conflict" (Saunders, 1992). The review offers definitions of police discretion but notes that there is no legal definition of the term, but the most widely quoted definition is that of Kenneth Culp Davis: "A public officer has discretion whenever the effective limits on his power leave him free to make a choice among possible courses of action or inaction." A review of the law and discretion notes that the law recognizes that discretion is a necessary and crucial part of police work, but also recognizes that there are limits to this discretion that are defined by the courts. The concluding section explores the effects of the police organization on discretion in terms of both providing a framework for individuals to operate and a structure designed to both limit and control the use of police discretion.
The article is available at: https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=169300

Slide 4

What is an ethical dilemma?

Slide 5-6

Discretion and ethical dilemmas

Some research indicates that LE officials are much more concerned with smaller day-to-day decisions than the major themes (listed on the slide).

Slide 7

Ethical frameworks

A discussion of ethical systems provides a procedural framework but also demonstrates that there often is more than one "correct" resolution to a dilemma and more than one way to arrive at the same resolution. Likewise, a person may use the same ethical system to resolve different moral dilemmas or use multiple ethical systems to resolve a single dilemma.

Religious Ethics: What is good conforms to a deity's will. Religious ethics borrows moral concepts from religious teachings and draws on the participants' various religious beliefs. Discussions lead participants to recognize that religious philosophies are ethical systems based on absolute concepts of good, evil, right, and wrong.

Natural Law: What is good is what conforms to nature. If what is natural is good, then participants easily can appreciate the constraints of a natural law ethical system within the artificial constructs of modern society. It becomes clear that natural law theory offers only limited assistance when participants compare peoples' most basic, natural inclinations with their motivations in resolving complex dilemmas?

Ethical Formalism:What is good is what is pure in motive. When discussing ethical formalism, participants are asked to resolve a specific dilemma by selecting a resolution that is pure or unblemished in motive, regardless of the consequences. Discussions within this framework present almost absolute answers to ethical dilemmas and show that some actions have little or no ethical support.

Utilitarianism: What is good is what results in the greatest good for the greatest number. Participants who find the consequences of resolving a dilemma more ethically significant than the motive behind the decision making process will resolve a dilemma with what they perceive to be an acceptable consequence. Yet, in most instances, predicting the consequences is virtually impossible. This results in discussions that become simply a means to project the most likely effects of choices.

Ethics of Care:What is good is what meets the needs of those involved and does not hurt relationships. *Law enforcement* agency mottoes often reflect a philosophy based on the ethics of care, such as "To protect and serve." The ethics of care is founded in the natural human response to provide for the needs of children, the sick, and the injured. Many *LE* officials operate under the ethics of care when they attempt to solve problems rather than rigidly enforce the law.

Ethics training. By: Pollock, Joycelyn M., Becker, Ronald F., FBI Law Enforcement Bulletin, 00145688, Nov96, Vol. 65, Issue 11

Slide 8

Group work

Scenario – Stage 1

Slide 9

Group work

Scenario – Stage 2

Slide 10

Role-play

The role-play is designed to encourage LE officials to think about the range of alternatives available to them and how they would justify them in being held accountable by his/her superiors. This practice is essential to preparing for ethical decision making in relation to drug use and harm reduction programmes.

Slide 11

Drug diversion programmes

The following slides are designed to provide trainers and participants with detailed guidance for the delivery of a lecture about programmes which divert people who use drugs from the criminal justice system. The lecture provides examples of diversion programmes used in different countries. The trainer will be able to explain how diversion programmes benefit the individual, the community and the LE officials.

Slide 12-13

Diversion from criminal prosecution

Diversion from the criminal justice system has a long history. In the late nineteenth century, a children's court was established to divert children suspected of committing crimes away from the punitive adult approach to criminal justice. In its purest form, the term 'diversion' applies to those processes that are at the very front end of the criminal justice system – that is, at the pre-apprehension stage before any formal charges are laid – and are focused on diverting individuals from that system to an alternative form of processing. The obvious example here is informal LE officials' cautioning whereby individuals, instead of being apprehended and charged by LE

officials, are simply given a verbal warning with no further obligations placed on the offender and no official record kept of the contact. However, over the decades, the term has acquired a broader application. It is now commonly used to refer to any processing option that offers what is perceived to be a different and less punitive response to what would otherwise have applied. In addition, there is now a much greater emphasis on diverting individuals to an alternative programme rather than simply diverting them from the system.

Diversion from criminal prosecution

Drug diversion: the evidence

Although there is significant cost associated with LE officials diversion programmes in Australia, the Australian Institute of Criminology argues that, if the programmes are achieving their objectives the costs should be more than offset by the benefits accruing to the community through a reduction in illicit drug use and related offending, improved health and wellbeing for drug-dependent offenders, and reduced caseloads for the criminal justice system.

For more information on diversion see reference 45:

> Spooner, McPherson and Hall. (2004). The role of police in minimising illicit drug use and its harms. Available at: http://www.ndlerf.gov.au/sites/default/files/publication-documents/summaries/mono-02-summary.pdf

Module 8
Creating multi-sectoral partnerships to more effectively work with key populations to enhance the national HIV/AIDS response

Module 8 – Creating multi-sectoral partnerships to more effectively work with key populations to enhance the national HIV/AIDS response

Globally and regionally there are already successful examples of LE officials assuming a key role as collaborative partners in HIV prevention, treatment and care. There are also growing examples demonstrating how LE officials, criminal justice, public health and civil society sectors can effectively complement each other, share information and identify issues, offering a cost-effective way to reduce crime and prevent HIV. In the context of HIV prevention, treatment and care among PWID, LE officials need to work alongside other sectors and communities including PWID and make decisions collaboratively *(45, 46).*To be truly effective all sectors need to work in partnership to develop and support legislation, policy and practice that facilitate the common goals of HIV prevention, treatment and care enhancing community safety and reducing crime.

Module 8 is designed to bring all the learning from the previous modules together. At this stage in the course, participants should have a sound understanding that they have an important role to play in protecting and promoting public health outcomes for key populations, including for people who inject drugs. Participants should by now be much more aware of particular issues to be considered when attempting to engage and communicate with key populations. This module examines the basic key ingredients for partnership formation between LE officials, other government agencies and civil society and community based organizations. Consideration of these key ingredients will support multi-sectoral approaches to protecting and improving public health outcomes for key populations.

Purpose

This Module is designed to highlight the key ingredients in partnership formation at the local level. The Module examines not only the role of LE officials but also the role of other sectors. Participants should be able to draw on the previous modules from the course as well as their community knowledge in order to begin to see how they can form and sustain the necessary multi-sectoral partnerships. This module informs the final practical session of the course and should have participants enthusiastic and eager to develop community partnerships.

Learning Objectives

By the end of Module 8, participants should be ready to begin to formulate partnership plans with multiple stakeholders in the community. They should be aware of the responsibilities of LE officials to the partnership and be aware of some of the options that they can implement to form partnerships with key populations.

Specifically participants should be able to:

- Identify and recall the six main components of partnership formation
- Understand the specific role of the LE officials in the partnership
- Understand the need for a supportive environment within the law enforcement institutions to enable partnership formation
- Be aware of who the other partners in the community should be and how they work collaboratively with those partners

Case Studies

This module highlights several case studies around partnership formation that can be used as examples of how partnerships between the LE officials and other key stakeholders, including key populations, have resulted in better policing outcomes and better public health outcomes.

Practical Sessions

The module finishes with a practical session around planning for the next steps.

Partnership Issues: Panel Discussion with representatives from potential partner groups (a cross-section of interested parties).

Next steps and plans for further contact and partnership efforts

How can such a panel be replicated in the community?

Course Content for Module 8

Creating and sustaining multi-sectoral partnerships at the community level

Slide 1

Title Slide

Slide 2

Learning objectives

Slide 3

Participants need to understand their professional responsibility in protecting and working with key populations. These responsibilities are actually the hallmark of professional policing: respect, no stigma or discrimination, public service, public safety, community orientated policing. Many of the principles have already been covered in the Training Manual. Trainers should remind participants that they have an incredibly important role in determining if the environment for vulnerable groups is "risky" or "enabling". Ask participants to recall what makes an "enabling environment".

Slide 4

Overarching principles of partnership formation and the role of LE officials – respect the community; understand your role and know your community.

Slide 5-9

This series of slides highlights examples from around the world that shows that LE officials and communities can work together and the results are better policing and better public health. Some of these slides have been shown earlier in the training but it is important to highlight the win - win principle.

Slide 10

Group discussion

After looking at the case studies, ask the group to discuss the key ingredients in forming better partnerships with the community, especially in the context of key populations.

Slide 11

The next series of slides describe the key ingredients of partnerships between the LE officials and the community and have been based on an extensive review and analysis of partnership formation across the Asia Pacific. This slide examines the role of leadership and reminds participants on their role as collaborative leaders in public health.

Slide 12

This slide reminds participants about the incredibly valuable role that civil society organizations (CSO) and community based organizations (CBO) and other service providers can play in helping the LE officials with key populations. This relationship with CSOs and CBOs can be enhanced through joint meetings, trainings, MOUs, SOPs, shared vision, mission and objectives.

Slide 13

Law enforcement sector reform

This slide indicates that partnerships with the community may require some changes in the way the LE officials are used to do business. Ask participants to remind themselves about creating positive policing images with the community. This means no corruption, no arbitrary arrest and detention, no harassment of key populations etc. LE officials need to meaningfully want to become engaged with the community. And they need a supportive law enforcement institutional environment and culture in order to do that.

Slide 14

This slide highlights that ongoing communication between LE officials and key populations is critical in ensuring the success of partnership building. Communication can be informal or formal through regular meetings. LE officials should know how to connect with key stakeholders from different communities at all times. Through these informal and formal links many problems can be solved before they escalate. It's about respect and trust for all partners in the partnership even though people often have different backgrounds and objectives. Communication can help inspire solutions and shared visions.

Slide 15

Addressing structural drivers related to tension between LE officials and community is key here. It also refers to the need for governments to help creating and sustaining the "enabling" environments through the provision of services and policies that can help LE officials divert people away from the criminal justice system into social and public health services.

Slide 16

All partnerships need ongoing monitoring and evaluation to ensure they remain healthy partnerships. This can be done by jointly selecting certain variables of interest to different stakeholders in the partnership, for example, people who inject drugs might want to measure that there is less intimidation by LE officials. LE officials might want to measure that there is less crime committed by people who inject drugs. Whatever the variables are, they can form a good basis for monitoring the strength of the partnership.

Slide 17

This slide just reiterates a few key messages and considerations and is designed for participants to remember to look for common goals with the community and to support those common goals with meaningful outputs such as shared terms of reference and operating protocols between LE officials and community, regular meetings etc.

Practical session

This last session of the Training Manual asks participants to discuss what are the next practical steps that they can take to form better partnerships with the community, especially with people who inject drugs and other key populations. The trainers need to have worked closely with the senior LE officials and have an idea of what is feasible in this session and look towards short, medium and long-term goals. Senior officials should co-facilitate this session so that participants feel that what they are suggesting as next steps and plans can actually be implemented.

Trainers and UNODC should work closely with organizers and senior LE officials to design the logistics of this last session.

Annex 1: Creating a Law Enforcement Institutional Environment that will Support an Enhanced Role of Law Enforcement Officials in the National HIV Response

Annex 1 – Creating a Law Enforcement Institutional Environment that will Support an Enhanced Role of Law Enforcement Officials in the National HIV Response

This section examines the background, rationale, required knowledge and the political and institutional context to support the implementation of the Training Manual for Law Enforcement Officials on HIV Service Provision for People Who Inject Drugs. While the focus of this Training guide is on how law enforcement officials can support service provision for PWIDs, there is a broader need to create a law enforcement institutional environment that supports an enhanced role of law enforcement officials in responding to HIV among themselves, their families and the community at large including other key affected populations.

Annex 1 provides the framework for senior law enforcement leadership structures and institutions to justify, approve, contextualize and implement a national LE officials HIV training programme. Such training programmes will result in increased knowledge of LE officials about HIV, enhance the ability of LE officials to contribute to the national HIV response, as well as contribute to improved community safety and crime reduction and increase the level of community trust for the policing institutions.

Senior LE officials are responsible for providing an institutional environment that will support an enhanced role of LE officials in the national HIV response. Senior LE officials need to ensure the development and implementation of LE official's policies and instruction orders, standard operating protocols and guidance for their officers to be able to work more effectively and indeed as collaborative partners in the HIV response. Senior LE officials should endorse and introduce the Training Guide during the opening session and outline the internal law enforcement institutional policy framework that will help guide junior and mid rank LE officials in working directly with key populations and as partners with other sectors to support the HIV response.

In order to ensure that the LE official's institution can support broader national HIV response, senior LE officials will need to examine how current LE officials practice can either hinder or support the response. Negative policing practices such as "crackdowns", mass arrests and arrests for petty crime are often driven by performance targets such as arrest quotas on which career and livelihood may depend (LEAHN, 2012a; Monaghan, 2012). It is important that senior LE officials have discussions about the current performance indicators and examine how adjusting certain indicators could result in more effective policing as well as enhancing the overall environment for implementation of the HIV response.

Building a Supportive Policing Institutional Environment for Policing Key Populations

The role of LE officials within a society and its communities is complex; although their primary role is to deal with crime, there are many other complementary roles within crime-prevention *(25).* These include helping people who are at risk, diverting potential offenders away from criminal justice and talking to young people about drugs. LE officials often have daily contact with key populations such as people who use drugs, sex workers, transgender, men who have sex with

men and so can act as a link to education, health and social services that these groups may not heard of or have access to.

There are structural reasons for negative LE officials' attitudes and behaviours toward key populations. Salaries may be inadequate and/or there might be numerous opportunities for profit through corruption or borderline activities that can stand in the way of effective approaches. In some communities, the high turnover rates of LE officials undermine sustainable relationships. There is often no incentive to take on extra work, such as referring drug users to community-based treatment services (*25*).

At a policy and institutional level, linking policing with larger global initiatives can provide key support for HIV strategy. For example, the role of LE officials services in helping governments to meet the international developmental goals are clear points of alignment for policing *(4, 16, 25).* Additional key components of a LE official's strategy to enhance their role in the national HIV response are: adequate training, forming of multi-sectoral partnerships, empowerment of key populations, accountability, political and legal commitment, use of LE official's instruction and protocols, and practicability *(16).*

Key Principals and Guiding Recommendations

Globally, policing institutions need to be constantly evolving and professionalising in response to emerging political, socioeconomic, health and environmental challenges.
The following key principles and recommendations are designed to guide senior policing leadership executives and strategists in how to create and build a supportive policing environment for an enhanced role of LE officials in the national HIV response. Law enforcement institutional leadership needs to set the example and the tone and create the authorising environment for developing an institution and operational culture that can play a more sophisticated role in the HIV response.

The consideration and implementation of the following principals and recommendations will support professionalization of law enforcement institutions as well as make a significantly enhanced contribution to the national HIV response.

1. Design and implement Standard Operating Protocols to direct LE officials activities that support HIV prevention, treatment, care and support;
2. Recognize the LE officials role and professional responsibility in protecting and promoting public health and public safety;
3. Provide guidance for the exercise of discretion especially as it relates to the provision of a full range of options in terms of viable alternatives to arrest and prosecution for named offences;
4. Accommodate both health and security considerations;
5. Respect of human rights and fundamental freedom;
6. Respect for the needs of key populations;

7. Prioritize immediate harms;
8. Base policy and practice on evidence, cost effectiveness and transparency;
9. Ensure public access to information about impact assessment and independent evaluation;
10. Support interventions for HIV prevention, treatment and care among key populations (people who inject drugs, sex workers, men who have sex with men, transgender and prisoners);
11. Support all services oriented at reducing the harms associated with illicit drug use (e.g. prevention of drug overdose deaths);
12. Support a health based approach to sex work, and all services oriented at reducing the harms experienced by sex workers such as violence and the transmission of sexually transmitted infections;
13. Support the appropriate use of administrative or criminal laws in ways that do not undermine HIV prevention programmes among key populations;
14. Facilitate access to HIV/drug/sexually transmitted infection prevention, treatment and care services, including by adult and juvenile referral mechanisms;
15. Identify and apply alternatives to arrest and prosecution in appropriate cases, and reduce costs to LE agencies and other criminal justice agencies, reduce incarceration rates and divert vulnerable individuals from other unintended harmful consequences of the criminal justice system;
16. Support comprehensive law enforcement training and education strategies, policy development and realistic performance indicators to ensure all individuals have access to essential HIV services.

Key stakeholders

Senior managers attached to government and non-government agencies, especially those who work in partnership with policing agencies, such as;

- Department of Health
- Department of Education
- Department of Social Welfare
- Civil society organization service providers
- Community based organizations
- CSO legal and para legal support agencies
- UN agencies

Purpose

Annex 1 provides essential information for senior LE officials to build an internal institutional environment and structure that supports junior, mid ranked and senior officials in their efforts to create an environment where LE officials can enhance the national HIV response, promote and sustain multi-sectoral partnerships with key populations as well as with other key stakeholders working with these populations.

Learning Objectives

At the end of this session, senior LE officials should be able to:

- Acknowledge the important role that LE officials play as collaborative leaders in public health;
- Understand the international context and political framework that supports the role of LE officials as key partners in HIV prevention among key populations;
- Understand the impact of current law enforcement institutional indicators on law enforcement practice and HIV prevention efforts among key populations;
- Understand the critical components required to support an enhanced role of LE officials in engaging with key populations including reform of LE officials policy and practice, design and implementation of standard operating protocols and the need for institutionalised LE officials training;
- Understand the essential ingredients in forming and sustaining multi-sectoral partnerships;
- Endorse the implementation of the Training Manual to enhance the role of LE officials in the national HIV response and have initial implementation discussions;
- Begin to plan discussions with other key stakeholders in provincial and national government around collaborative approaches to working with key populations including people who inject drugs.

Useful Learning Materials and Readings

Senior LE officials should be encouraged to read and familiarise themselves with the Training Manual for Law Enforcement Officials on HIV Service Provision for People Who Inject Drugs.

Practical Sessions

Discussion about the role of Performance Indicators (PIs) in:

- Increasing LE officials' support for public health;
- The prevention, treatment, care and support among people at greater risk of acquiring HIV.

Course Content for Annex 1

Creating a Policing Institutional Environment that will Support an Enhanced Role of LE officials in the National HIV Response

Slide 1

Title Slide

Slide 2-3

Objectives of the session

Slide 4

Rationale for developing and implementing training for law enforcement officials on HIV

HIV is a global pandemic that has caused significant damage to individual and public health and socioeconomic development of countries around the globe. Responding to HIV is one of the Millennium Development Goals and a challenge requiring the collective efforts of UN and national governments as well as of the civil society and the community at large.

Slide 5

Introduction to the Training Manual for Law Enforcement Officials on HIV Service Provision for People Who Inject Drugs

The Training Manual has been developed to improve the role of LE in responding to HIV prevention, treatment and care needs of PWIDs and in the national response more generally. In order to do that we need a law enforcement institution that supports the role of LE officials in the national HIV response.

Slide 6

Role of LE officials in public health and HIV both in generalised and concentrated epidemics

LE officials have always had a significant role in the protection and promotion of public health yet this has not always been made clear to LE officials through their training and culture which is often framed through a law and order lens. As outlined in Module 3, LE officials have a significant role in many areas of public health and need to be recognised internally by the policing institution as well as through external recognition from other sectors, such as the ministry of health. Senior LE officials therefore need to advocate to other sectors about the importance of LE officials in

public health and also be able to produce tangible examples of that importance, for example, through the developments of standard operating protocol (SOP) for working with key populations.

Slide 7

Negative impact of some law enforcement strategies

It is important to understand the negative impacts of some law enforcement strategies on HIV risk among key populations. There is a great need to examine how criminalisation of certain populations or behaviours actually increases HIV in the community and therefore works against the role of police as increasing public safety.

Slide 8

A description of the main international political frameworks and rationale to support LE officials training in HIV and AIDS, including the United Nations General Assembly's Political Declaration on HIV/AIDS as well as UN Economic and Social Council (*ECOSOC*)resolutions. Further information is available in Module 1.

Slide 9

This slide articulates the importance of the support of senior law enforcement leadership for training implementation and for its effectiveness in the field.

Slides 10-13

Creating a supportive law enforcement institution for HIV/AIDS training and enhanced role in the national HIV response

LE officials are responsive to direction and orders. It is imperative that LE officials have an institutional framework that guides how they can support the national HIV response. This may include a Law Enforcement Institutional Instruction or Standard Operating Protocol that outlines what LE officials are expected to do in the context of their interactions with people who for a variety of reasons may have increased vulnerability to HIV infection. Law enforcement institutional instructions for working with key populations have been developed in many settings and provide LE officials with a clear course of action to follow that prioritises individual and public health. Law enforcement institutions must also have their own policy to support universal access and universal precaution for their own officers.

In supporting these endeavours the following components are considered important:

- Education about HIV and AIDS and overcoming denial, stigma and discrimination;
- Adopting equal opportunity and human-rights based principles of employment;
- Addressing operational exposure to HIV, including education, safety precautions and post exposure prophylaxis;
- Provision of voluntary counseling and testing, access to means of prevention such as condoms and access to HIV treatment;
- Provision of Hepatitis A and B vaccinations and education on Hepatitis C and TB to minimise risk of co-infections;
- Provision of flexible working conditions to help sustain the health and wellbeing of officers living with HIV;
- Provision of flexible working conditions for those officers supporting family living with HIV;
- Special measures to protect officers and support staff who are subject to gender discrimination;

A range of other considerations are outlined in the slides and in the introduction to this Annex 1.

Slide 14-19

Case Studies

A range of case studies presented in Module 8 highlight that when law enforcement institutions and officials support HIV prevention for key populations that they actually result in a host of benefits for policing as well as for public health. This is called the win-win affect and should be promoted when institutions are grappling with how to enhance the role of law enforcement in HIV prevention, treatment, care and support.

Slide 20

Key Ingredients

Slides in Module 8 also highlight the main key ingredients that can forge more effective partnerships between law enforcement and HIV programmes. It is suggested that law enforcement officials familiarise themselves with all 8 modules of the Training Manual.

Slide 21

The use of discretion

The use of discretion in policing is common across the majority of law enforcement institutions in the world. It is however rarely articulated or taught during LE officials training. The use of discretion when working with vulnerable populations can result in significant benefit for both the LE officials and the people that may avoid sanction or arrest because of the LE officials' discretion. Being confident to use discretion when contemplating the best course of action in a particular case is often a result of policing culture and expectations of senior LE officials' leadership. When the leadership is such that discretion is actively encouraged, junior and mid ranked officers can greatly assist people from key populations to access HIV prevention, treatment and care services whilst at the same time building rapport between LE officials and the community they work with.

Slide 22

Performance indicators discussion

Slide 23

Practical next steps

- Discuss an implementation plan for delivery of the Training Manual and then implement the training.
- Discuss the development of a National Policy for the Role of Law Enforcement in Response to HIV.
- Arrange field visits to organizations working with the key populations including interactions with them.
- Form a joint monitoring mechanism between the LE officials, civil societies and key populations to monitor the behavior of the LE officials.
- Attach trainees to agencies working with the key populations as a part of their training programme.
- Establish a network of designated LE officials liaison officers covering all policing districts, with responsibility for receiving and investigating complaints of human rights violations or other activities alleged to impede HIV prevention, treatment and other health promotion activities.
- Ensure that LE officials investigate all allegations of crimes or other human rights violations against people living with or vulnerable to HIV infection, and that legal proceedings are taken against perpetrators, whether the perpetrators are members of the LE officials force or other citizens.
- Support comprehensive harm reduction services, in deed and not just word, in all areas where they are needed.

Annex 2: Implementation and Evaluation of the Training Manual

Annex 2 – Implementation and Evaluation of the Training Manual

The Training Manual has been designed in order for law enforcement institutions to implement at scale across an entire policing service and thereby significantly enhance the ability of national LE agencies and institutions to contribute to the national HIV/ response. The Manual should be implemented across policing education at all levels; from basic recruit training through to LE officials working in the field and indeed with LE officials in senior leadership positions.

While the simultaneous implementation across the entire LE institution is unlikely, senior LE leadership structures should work with LE training and education institutes to design an implementation plan that ultimately leads to HIV training becoming a standard component of recruit level and operational level policing. The planning should include a strategy that builds a sufficient number of LE official trainers who can be responsible for delivering the training at both the LE training academies and to field officers working across the country.

Planning the implementation of the training should happen simultaneously with the work that needs to be done in "Creating a Law Enforcement Institutional Environment that will Support an Enhanced Role of LE officials in the National HIV Response" as outlined in Annex 1. Prior to the implementation of training there needs to be a clear National HIV Policy for LE officials that includes:

- Standard operation protocols for le officials working with key populations;
- Occupational health and safety protocols for HIV prevention, treatment, care and support for LE officials;
- A clear articulation of the role of LE officials in the national HIV/AIDS response;
- An integrated operational framework that highlights how LE officials should work in collaboration with a range of other stakeholders including the ministry of health, public hospitals and primary care clinics as well as civil society and community based organisations providing health and social services to key populations.

Implementation of the Training Manual

The overall goal when considering how to implement the Training Manual must be to ensure that all LE officials are trained and aware of their role in the national HIV response. To scale up training to all LE officials the implementation of the Manual should occur in three distinct phases.

Phase oneconsists of preparing and adapting the Training Manual according to the country specific situation. For example, different countries will have varying patterns and trends of drug use and sex work and therefore varying epidemiological profiles of the HIV epidemic. Different countries will also have different LE officials training structures that may include longer or shorter periods of recruit training and varying levels of ongoing professionalization training for operational policing divisions. These aspects need to be considered as part of the implementation strategy.

Phase twoof the implementation strategy should include the training of trainers who will be able to deliver the training across the national law enforcement training institutes and field offices. For this to occur at scale, it is recommended that several LE officials trainers from the LE officials training academy as well as suitably qualified LE officials from each of the policing jurisdictions be brought together for a week long intensive training to familiarise themselves with the content of the Training Manual. Depending on the size of the country, it may be appropriate to have more than one LE official per provincial or district level setting.

Phase threeshould include the mobilisation of trainers to implement the training at an appropriate juncture of LE officials' training at the academy and through a well-managed training exercise in each province or district. Depending on the political or institutional environment for implementing the Training Manual, specific countries may decide to implement the training at a demonstration site. Demonstration sites should be specific geographical areas where there is an immediate need to respond to an emerging or concentrated epidemic of HIV as well as the agreement of key stakeholders that the implementation can occur across the demonstration site. Ultimately the training needs to be taken to scale across all provinces and also embedded as a mandatory component of the core LE officials training conducted in the National LE Training academy.

Evaluation

Prior to implementation, it is also necessary to design an evaluation framework for evaluating the implementation and effectiveness of the Training Manual. Given both the theoretical and logistical components of the Manual, it is necessary to consider a range of different angles when designing the evaluation framework. The introduction to the Training Manual articulates several key emphases and objectives. These emphases and objectives are necessarily broad but do allow for a range of evaluation opportunities. The presence of an evaluation framework is also a central component of mobilising resources for the training from either international donors or from national law enforcement institutional budgets. All modules should be evaluated from the perspective of knowledge gained in relation to the objectives as well as an overall evaluation by participants of the training and the instructors.

In order to evaluate impact in the field, it is recommended that a multilayered evaluation framework be incorporated that will allow the impact of implementing the Training Manual to be assessed from a variety of both health and LE variables of interest. It should be evaluated for its ability to be implemented, create behaviour and attitude change among LE officials, lead to the formation of multi-sectoral partnerships and contribute to improved use of LE officials' time and resources. A multilayered evaluation framework is proposed below.

Evaluation Layer One: Preparedness Checklist

A preparedness checklist can be used to establish the institutional preparedness for the implementation of the Training Manual. While technical assistance may be required to develop a National HIV LE officials Policy, its presence or absence can form the part of the baseline evaluation. Assuming that the policy is developed, a checklist can ensure that the basic components of the policy are included as described above. The second part of evaluation layer one relates to the implementation of the policy and assessing the awareness of the existence and content of the policy among all LE officials. The third component of layer one is to assess the logistics and scale up of implementation across LE officials training including the number of trainers who are trained to deliver the Training Manual.

Evaluation Layer Two: Knowledge, Attitudes, Behaviours and Practices Survey

The Training Manual is premised on several central tenets and specific objectives. To assess the impact of the training on responding to these tenets and objectives, large-scale pre/post knowledge, attitudes, behaviours and practices survey should be designed and implemented across the national law enforcement institution. A sampling framework should be designed to ensure representation in the survey of LE officials from across law enforcement training institutes, field offices and other relevant departments and units.

The survey questions should be designed with the central tenets and objectives of the Training Manual in mind as articulated in the introduction section. The survey should be implemented prior to the training and then again at 6 and 18 months after the training has been implemented. The survey should include questions relating to the knowledge, attitudes, behaviours and practices of the LE officials in relation to:

- Knowledge of the prevention and treatment of HIV and AIDS among LE officials and their partners and families;
- Knowledge of the prevention of and response to HIV and AIDS among key populations and the broader community;
- Indicators of the level of stigmatization and discrimination towards key populations;
- The level of collaboration between LE officials forces and services providers in responding to HIV

Evaluation Layer Three: External Evaluation

While internal evaluation of the effectiveness of the Training Manual for the LE officials is important, it is equally important that the impact is evaluated externally by the community including government public health service providers, civil society organisations providing services to key populations as well as community representatives themselves.

The implementation guidance suggests that the Training Manual be implemented in strategic geographic locations where both the HIV epidemic demands action and the enabling environment for an enhanced role of LE officials is supported. The External Evaluation should draw on the opinions and understanding of key experts and key stakeholders who work to provide services to

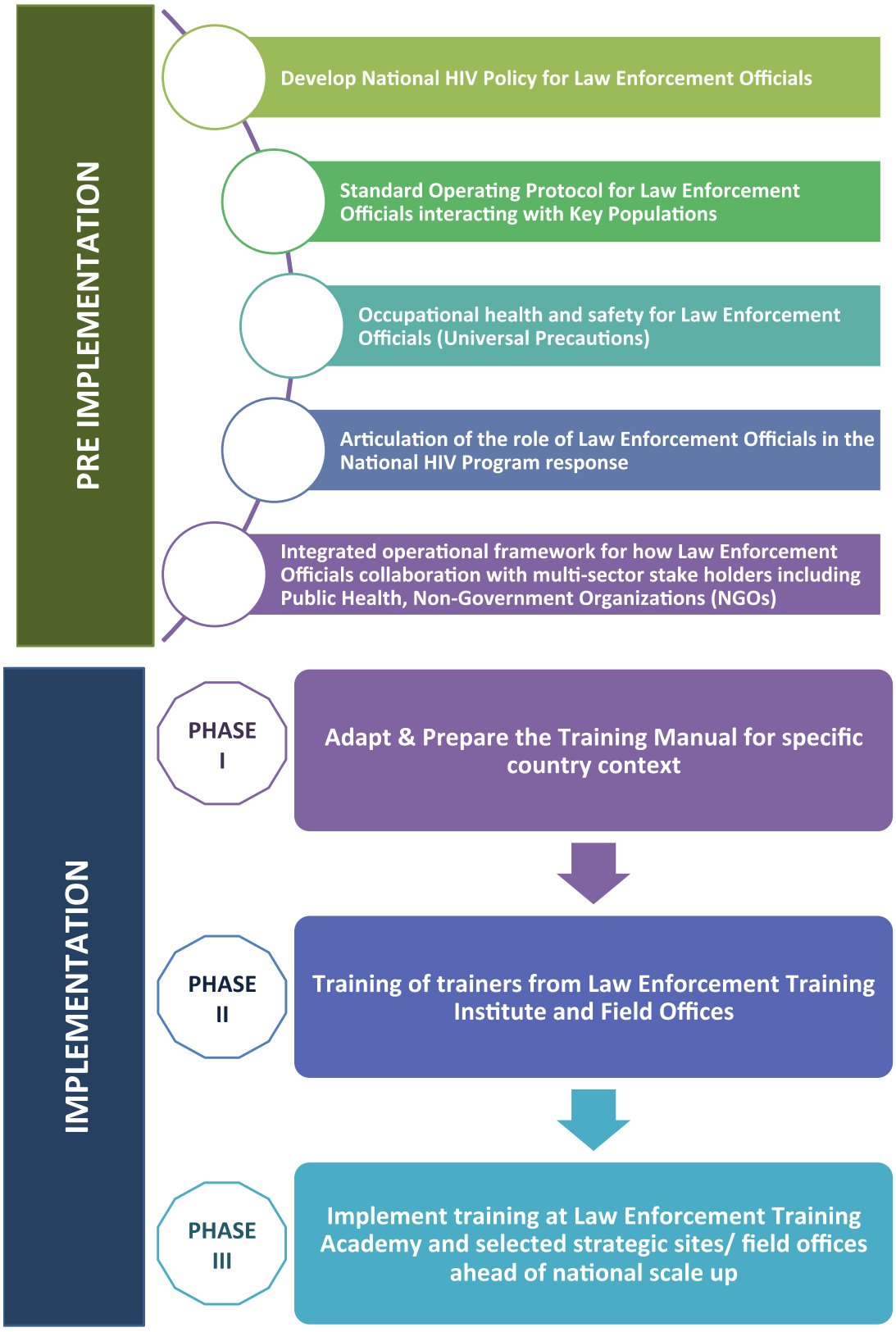
key populations and will be in a position to understand the impact of an enhanced LE official's response to HIV on the following topics:

- Improved service access of key population to effective HIV prevention, treatment, care and support;
- Decreased HIV risk behaviour and HIV incidence as a result of an improved enabling environment
- Improved levels and growing examples of LE officials as collaborators in the national HIV response
- Decreasing examples of negative interactions between LE officials and people from key populations and human rights violations.

Evaluation Layer Four: Impact on other variables of interest to the LE officials

While the international and national health and human rights stakeholders will have ongoing interest in an enhanced LE officials' response to HIV and its impact on reducing the epidemic, LE officials themselves will also be interested in other variables of interest. It is therefore important to examine how the implementation and scale up of the Training Manual can impact a range of other law enforcement variables such as the perceptions of community safety, perceptions of community trust in policing, impact on crime and the impact on the use of LE officials time and resources. The hypothesis of this layer of the evaluation is that the Training Manual should also result in an improvement in all of these variables

Figure 1: Flowchart for Implementation and Evaluation of the Training Manual




EVALUATION
Layer 1
Pre-Implementation Preparedness Checklist
Layer 2
Pre-Implementation Baseline Survey on Knowledge/ Attitudes/ Behaviors and Practices of Law Enforcement Officials around HIV and AIDS
0 Months
IMPLEMENTATION PROCESS
6
Layer 3 Part A
External Evaluation; Key Information Interviews with other stakeholders from Health Service Sector, Communities and NGOs working with KAPs to assess Impact of Law Enforcement Officials in Enhancing Services provision for PWIDS and other key populations
Layer 3 Part B
Post-Implementation Baseline Survey on Knowledge/ Attitudes/ Behaviors and Practices of Law Enforcement Officials around HIV/AIDS
POST 12 MONTHS
12
Layer 4
Evaluation of Law Enforcement specific variables of interest including: a) perceptions of community safety b) crime rates c) use of police time and resources

Annex 3: References, Additional Readings and Resources

Annex 3 – References / Additional Readings and Resources

References

1. Peterson Z, Myers B, van Hout MC, Plüddemann A, Parry C (2013). Availability of HIV prevention and treatment services for people who inject drugs: findings from 21 countries. *Harm Reduction Journal, 10*(13). http://www.harmreductionjournal.com/content/10/1/13

2. Ti L and Kerr T (2013). Task shifting redefined: removing social and structural barriers to improve delivery of HIV services for people who inject drugs. *Harm Reduction Journal*, *10*(20).http://www.harmreductionjournal.com/content/10/1/20

3. United Nations Office of Drugs and Crime. World Drug Report 2014. http://www.unodc.org/documents/wdr2014/World_Drug_Report_2014_web.pdf

4. World Health Organization, United Nations Office on Drugs and Crime & Joint United Nations Programme on HIV and AIDS , WHO, UNODC and UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, 2013, https://www.unodc.org/documents/hiv-aids/idu_target_setting_guide.pdf

5. Law Enforcement and Harm Reduction at the Nossal Institute. Sleeping with the enemy? Engaging with law enforcement in prevention of HIV among and from injecting drug users in Asia' (2010). *HIV Matters*, *2*(1): 14-16.

6. Beletsky L, Agrawal A, Moreau B, Kumar P, Weiss-Laxer N, Heimer R(2011). Police Training to Align Law Enforcement and HIV Prevention: Preliminary Evidence from the Field. *Am J Public Health*, 300254.

7. Joint United Nations Programme on HIV/AIDS. Global report: UNAIDS report on the global AIDS epidemic 2013. http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/unaids_global_report_2013_en.pdf

8. United Nations Millennium Development Goals. http://www.un.org/millenniumgoals/bkgd.shtml

9. United Nations. Declaration of Commitment on HIV/AIDS-United Nations special session on HIV/AIDS. Adopted by the UN General Assembly Twenty-sixth special session: June 25-27, 2001. New York, United Nations, 2001. Resolution A/RES/S-26/2.

10. United Nations. 60/262. Political Declaration on HIV/AIDS. Resolution adopted by the UN General Assembly, 60th session, June 2, 2006. New York, United Nations, 2006 Contract No.: Resolution A/RES/60/262.

11. United Nations General Assembly. General Assembly Resolution 65/277 - Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS. New York, United Nations, 2011.

12. UNESCAP, 2010. ESCAP Resolution 66/10: Regional call for action to achieve universal access to HIV prevention, treatment, care and support in Asia and the Pacific. Available at: http://www.unescap.org/sdd/issues/hiv_aids/Resolution-66-10-on-HIV.pdf.

13. UNESCAP, 2011. ESCAP Resolution 67/9: Asia-Pacific regional review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS. Available at: http://www.unescap.org/sdd/meetings/hiv/hlm/English/HIV_IGM1_INF5.pdf.

14. ASCI, Global Consultation on the Police and HIV/AIDS (2007) AIDS, Security and Conflict Initiative, London, 2007.

15. Pearce, H (2007). The Police and HIV/AIDS: A Literature Review. ASCI Research Report No. 1

16. Law Enforcement and HIV Network (LEAHN), International Consultation on Policing of Most-at-Risk Populations, Report, Rome May 2012.

17. Crofts N, Moore T, Tenni B and Thomson N (2012). Law Enforcement and Harm Reduction in SE Asia: examining policing and harm reduction in Cambodia, Laos and Vietnam. *Harm reduction Journal*, http://www.harmreductionjournal.com/series/policing

18. International Labour Organization. An ILO Code of Practice on HIV/AIDS and the World of Work, International Labour Office, Geneva, 2001. http://www.unplus.org/downloads/wcms_113783.pdf

19. Law Enforcement and HIV Network (LEAHN), The International Police Advisory Group (IPAG) of the Law Enforcement and HIV Network, Statement of Support by Law Enforcement Agents for Harm Reduction and Related Policies for HIV Prevention, Melbourne, 2012. http://www.leahn.org

20. World Health Organisation. Aide Memoire. For a strategy to protect health care workers from infection with blood-borne viruses. http://www.who.int/injection_safety/toolbox/docs/AM_HCW_Safety.pdf

21. Australian Society for HIV Medicine (ASHM). National Guidelines for Post-Exposure Prophylaxis after Non-Occupational and Occupational Exposure to HIV, 2013. http://www.ashm.org.au/pep-guidelines/NPEPPEPGuidelinesDec2013.pdf

22. Baggaley RF, Boily MC, White, RG, Alary, M (2006). Risk of HIV-1 transmission for parenteral exposure and blood transfusion: a systematic review and meta-analysis". *AIDS, 20* (6): 805–12. doi:10.1097/01.aids.0000218543.46963.6d. PMID 16549963.

23. Boily MC, Baggaley RF, Wang L, Masse B, White RG, Hayes RJ, Alary M (2009). Heterosexual risk of HIV-1 infection per sexual act: systematic review and meta-analysis of observational studies. *The Lancet Infectious Diseases*, *9* (2): 118–129. doi:10.1016/S1473-3099(09)70021-0. PMID 19179227.

24. Beyrer C, Baral SD, van Griensven F, Goodreau SM, Chariyalertsak S, Wirtz AL, Brookmeyer R (2012). Global epidemiology of HIV infection in men who have sex with men. *Lancet,380*(9839): 367–77. doi:10.1016/S0140-6736(12)60821-6. PMID 22819660.

25. Monaghan G and Bewley-Taylor, D. Police support for harm reduction policies and practices towards people who inject drugs. IDPC 2013. Available at: http://idpc.net/publications/2013/02/LE officials-support-for-harm-reduction-policies-and-practices-towards-people-who-inject-drugs

26. United Nations. Office of the High Commissioner for Human Rights, 2013. http://www.ohchr.org/EN/Issues/SRHRDefenders/Pages/Defender.aspx

27. Roberts A, Mathers BM, Degenhardt L (2010). Women who inject drugs: A review of their risks, experiences and needs. Independent Reference Group to the United Nations on HIV and Injecting Drug Use, 2010. Available at www.unodc.org/documents/hiv-aids/Women_who_inject_drugs.pdf

28. Dunkle KL, Jewkes RK, Brown HC, Gray GE, McIntryre JA, Harlow SD (2004). Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *The Lancet*, 363:1415–142.1.

29. The Global Coalition on Women and AIDS. Women who use drugs, harm reduction and HIV. 2011. Available at www.womenandaids.net/news-and-media-centre/latest-news/women-who-use-drugs--harm-reduction-and-hiv.aspx

30. Eurasian Harm Reduction Network. Halting HIV by reducing violence against women: The case for reforming drug policies in Eastern Europe and Central Asia. 2012. Available at www.igpn.net/ehrn-file/violance-brief_final-ENG.pdf

31. Ataiants J, Merkinaite S, Ocheret D. International Drug Policy Consortium (IDPC) Briefing Paper. Policing people who inject drugs: Evidence from Eurasia. 2012. Available at http:// dl.dropbox.com/u/64663568/library/IDPC-briefing-paper_ Policing-people-who-inject-drugs-evidence-from-Eurasia.pdf

32. Monaghan, G. Harm Reduction and the Role of Police Services, in R. Pates and D. Riley (eds) Harm Reduction in Substance Use and High-Risk Behaviour, Oxford, Wiley-Blackwell, 2012, 59-76

33. Joint United Nations Programme on HIV/AIDS, 1998. Expanding the global response to HIV/AIDS through focused action: Reducing risk and vulnerability: definitions, rationale and pathway. http://data.unaids.org/publications/irc-pub01/jc171-expglobresp_en.pdf

34. El-Bassel N, Wechsberg WM, Shaw SA (2012). Dual HIVrisk and vulnerabilities among womenwho use or injectdrugs: no single prevention strategy is the answer.*CurrOpinHIV AIDS.7*(4):326-31. doi: 10.1097/COH.0b013e3283536ab2.

35.WHO, UNODC and UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, 2012 revision,

http://www.unodc.org/documents/hiv-aids/publications/People_who_use_drugs/Target_setting_guide2012_eng.pdf

36. Wodak A and McLeod L (2008). The role of harm reduction in controlling HIV among injecting drug users. *AIDS*, *22*Suppl 2: S81-92.

37. Kimber J, Palmateer N, Hutchinson S, Hickman M, Goldberg D. & Rhodes T. Harm reduction among injecting drug users – Evidence of effectiveness. In Rhodes, T. and Hedrich, D., Harm reduction: evidence, impacts and challenges (Eds.), EMCDDA Monographs 10, 115-163, 2010.

38. Hunt N, Trace M and Bewley-Taylor D.Report 4. Reducing Drug Related Harms to Health: A Review of the Global Evidence,Beckley Foundation, Oxford, 2005.International HIV/AIDS Alliance. Good Practice Guide - HIV and drug use: Community responses to injecting drug use and HIV. Brighton, International HIV/AIDS Alliance, 2010.

39. Palmateer N et al (2010). Evidence for the effectiveness of sterile injecting equipment provision in preventing hepatitis C and human immunodeficiency virus transmission among injecting drug users: a review of reviews. *Addiction*, *105*(5):844-859.

40. Vorma H, Sokero P, Aaltonen M, Turtiainen S, Hughes LA, Savolainen J (2013). Participation in opioid substitution treatment reduces the rate of criminal convictions: evidence from a community study. *Addict Behav.,Jul;38*(7):2313-6. doi: 10.1016/j.addbeh.2013.03.009. Epub 2013 Mar 22.

41. Coid J, Carvell A, Kittler Z, Healey A& Henderson J. The impact of methadone treatment, drug misuse and crime, Research Findings, No. 120; Home Office Research Development and Statistics Directorate, London, National Criminal Justice reference Service NCJ 187821, 2000. https://www.ncjrs.gov/App/Publications/ abstract.aspx?ID=187821

42. Davis CS, Burris S, Kraut-Becher J& Metzger D (2005). Effects of an intensive street-level police intervention on syringe exchange programme use in Philadelphia, PA', *American Journal of Public Health*, *95*(2): 233-236.

43. Green TC, Zaller N, Palacios WR, Bowman SE, Ray M, Heimer R, Case P (2013).Law enforcement attitudes toward overdose prevention and response. *Drug Alcohol Depend.Dec 1;133*(2):677-84.

44. Spooner, McPherson and Hall. (2004). The role of police in minimising illicit drug use and its harms. Available at: http://www.ndlerf.gov.au/sites/default/files/publication-documents/summaries/mono-02-summary.pdf

45. Beyrer, C. (2012).Editorial. *Harm Reduction Journal*, *9*:30.

46. Tarantola, D(2012).Foreword: Public health, public policy, politics and policing.*Harm Reduction Journal 9*:22 http://www.harmreductionjournal.com/content/9/1/22

Additional readings

AIDS Projects Management Group, Law enforcement guidance: Prepared for Drug Control and Access to Medication (DCAM) Consortium, Sydney, 2010.

Aggleton P, Jenkins P, Malcolm A (2005). HIV/AIDS and injecting drug use: Information, education and communication. *International Journal on Drug Policy, 16*(1):S21-S30.

Aitken C, Moore D, Higgs P et al (2002). The Impact of a Police Crackdown on a Street Drug Scene: Evidence from the Street, *International Journal of Drug Policy 13*:193.

Altice FL et al (2010). Treatment of medical, psychiatric, and substance-use comorbidities in people infected with HIV who use drugs*. The Lancet, 376*(9738):367-387.

Andresen C and Boyd N (2010). A cost-benefit analysis of Vancouver's supervised injection facility, *International Journal of Drug Policy, 21*, (1) 70 – 76.

Baker A et al (2005). Brief cognitive behavioural interventions for regular amphetamine users: A step in the right direction. *Addiction, 100*(3):367-378.

Ball AL (2007). HIV, injecting drug use and harm reduction: a public health response*, Addiction, 102*(5): 684-90.

Ball A(1998). Policies and interventions to stem HIV-1 epidemics associated with injecting drug use. In: Stimson GV et al., eds. Drug injecting and HIV infection: global dimensions and local responses. London, UCL Press.

Ball A, Crofts N. HIV risk reduction in injecting drug users. In: Lamptey PR, Gayle H, eds. HIV/AIDS prevention and care in resource-constrained settings. Arlington, VA, Family Health International, 2002.

Ball A et al (2005). Supplement WHO Evidence for Action for HIV Prevention, Treatment and Care among Injecting Drug Users. *International Journal on Drug Policy, 16*(1):S1-S6.

Beletsky L et al (2012). Policy Reform to Shift the Health and Human Rights Environment for Vulnerable Groups: The Case of Kyrgyzstan's Instruction 417. *Health and Hum. Rights J. 14*(2) e1-e15.

Beletsky L, Agrawal A, Moreau B, Kumar P, Weiss-Laxer N, Heimer R. (2011). Police Training to Align Law Enforcement and HIV Prevention: Preliminary Evidence from the Field. *Am J Public Health*, 300254.

Beletsky L, Bhatti U, Graff J, Silverman B, Davis C. S. Harmonizing Harm Reduction and Law Enforcement: Strategies for Prevention, Monitoring, and Response. 2008. SSRN eLibrary.

Beletsky L, Macalino G, Burris S (2005). Attitudes of Police Officers towards Syringe Access, Occupational Needle-Sticks, and Drug Use: A Qualitative Study of One City Police Department in the United States, *International Journal of Drug Policy*, *16*, 267-274.

Bewley-Taylor, D (2003). Challenging the UN drug control conventions: problems and possibilities, *International Journal of Drug Policy, 14* (2), 171-179.

Bluthenthal RN et al (2007). Examination of the association between syringe exchange programme (SEP) dispensation policy and SEP client-level syringe coverage among injection drug users. *Addiction, 102*(4):638-646.

Burris S, Strathdee SA (2006). To serve and protect? Toward a better relationship between drug control policy and public health, *AIDS, 20*:117-118

Burris S, Blankenship K, Donoghoe M et al., Addressing the 'Risk Environment' for Injection Drug Users: The Mysterious Case of the Missing Cop, The Milbank Quarterly 82, no. 1 (2004):125.Geneva, WHO, 2004

Chakrapani V, Newman P, Shunmugam M et al (2007). Structural violence against Kothi-Identified men who have sex with men in Chennai, India: A qualitative investigation. *AIDS EducPrev*, *19*(4): 346-364

Chaterjee P (2006). AIDS in India: police powers and public health.*The Lancet, 367*(9513), 805-806

Chheng K, Leang S, Thomson N, Moore T, Crofts N (2012). Harm reduction in Cambodia: a disconnect between policy and practice, *Harm Reduction Journal, 9*:30

Commission on Narcotic Drugs. Resolution 53/9: Achieving universal access to prevention, treatment, care and support for drug users and people living with or affected by HIV. Vienna, Commission on Narcotic Drugs, 2010.

Committee on the Prevention of HIV Infection among Injecting Drug Users in High-Risk Countries IoM. Preventing HIV Infection among Injecting Drug Users in High Risk Countries: An Assessment of the Evidence. Washington DC, 2006.

Cook J. Global State of harm reduction 2010, Key issues for broadening the response, International Harm Reduction Association, London, 2010.

Cooper H, Moore L, Gruskin S et al (2004). "Characterizing Perceived Police Violence: Implications for Public Health," *American Journal of Public Health ,94* no. 7:1109.

Costigan G, Crofts N, Reid G. Manual for reducing drug related harm in Asia. 2nd ed. Melbourne, Centre for Harm Reduction, Macfarlane Burnet Institute for Medical Research & Public Health, Asian Harm Reduction Network. 2003.

Csete, J. Do Not Cross: Policing and HIV Risk Faced by People Who Use Drugs (Toronto: Canadian HIV/AIDS Legal Network, 2007).

Curtis M, Guterman L. Overdose prevention and response: a guide for people who use drugs and harm reduction staff in Eastern Europe and Central Asia. New York, Open Society Institute, 2009.

Degenhardt L et al (2010). HIV prevention for people who inject drugs: why individual, structural, and combination approaches are required. *The Lancet, 376*(9737):285-301.

Des Jarlais DC, Semaan S (2005). Interventions to reduce the sexual risk behaviour of injecting drug users. *International Journal on Drug Policy*, *16*(1):S58-S66.

Donoghoe MC (1992). Sex, HIV and the injecting drug user. *Addiction*, *87*:405-416.

Fairbairn N, Kaplan K, Hayashi K, Suwannawong P, Lai C, Wood E & Kerr T (2009). Reports of evidence planting by police among a community-based sample of injection drug users in Bangkok, Thailand, *BMC International Health and Human rights, 9*: 24,

Farrell M et al (2005). Effectiveness of drug dependence treatment in HIV prevention. *International Journal on Drug Policy, 16*(1):S67-S75.

First Regional Consultation on Enhancing the Role of Law Enforcement in Planning and Implementation of National Response to HIV/AIDS Epidemics in Central Asia and Eastern Europe Kiev October 2012.

Friedman SR, Cooper HLF, Tempalskia B, Keema M, Friedman R, Floma PL, Jarlais DCD (2006). Relationships of deterrence and law enforcement to drug-related harms among drug injectors in US metropolitan areas.*AIDS, 20*:93-99.

Gowing L et al. Substitution treatment of injecting opioid users for prevention of HIV infection (Review). The Cochrane Collaboration, 2009.

Hellawell, K (1995). The role of law enforcement in minimizing the harm resulting from illicit drugs, *Drug and Alcohol Review, 14*(3): 317-22,

HIV/AIDS Asia Regional Programme, Training Programme for Police: Effective strategies for reducing the spread of HIV/AIDS, HAARP, Melbourne, 2008.

Hughes C and Stevens A (2010). What Can We Learn From The Portuguese Decriminalization of Illicit Drugs? *Br J Criminol*, *50*(6):999-1022

Human Rights Watch, Lessons Not Learned: Human Rights Abuses in the Russian Federation, New York: Human Rights Watch, 2004, vol. 16:5D.

Human Rights Watch, Rhetoric and Risk: Human Rights Abuses Impeding Ukraine's Fight Against HIV/AIDS, New York: Human Rights Watch, 2006, vol. 18:2D.

Human Rights Watch, Not Enough Graves: The War on Drugs, HIV/AIDS, and Violations of Human Rights New York: Human Rights Watch, 2004, vol. 16:8C.

Hunt N, A review of the evidence-base for harm reduction approaches to drug use, London, Release, 2003

Islam M, Conigrave K (2007). Assessing the role of syringe dispensing machines and mobile van outlets in reaching hard-to-reach and high-risk groups of injecting drug users (IDUs): a review. *Harm Reduction Journal, 4*(14).

Jurgens R. Harm Reduction in Prisons and other Places of Detention, in R. Pates and D. Riley (eds) Harm Reduction in Substance Use and High-Risk Behaviour, Oxford, Wiley-Blackwell, 2012, 77-100.

International Gay and Lesbian Human Rights Commission (2003) Nepal: Renewed Police Brutality Against Transvestites, HIV/AIDS Outreach Workers 24 July 2003 http://www.iglhrc.org/cgi-bin/iowa/article/takeaction/resourcecenter/584.html

IHRD Police, Harm Reduction and HIV, OSF, New York, 2008.

International HIV/AIDS Alliance, HIV and Drug Use: Community Responses to injecting drug use and HIV. Good Practice Guide, London, 2010.

Joint United Nations Programme on HIV/AIDS. Towards universal access: assessment by the Joint United Nations Programme on HIV/AIDS on scaling up HIV prevention, treatment, care and support UN. New York City, United Nations, 2006 March 2006. General Assembly document A/60/37.

Joint United Nations Programme on HIV/AIDS. Operational guidelines on considerations for countries to set their own national targets for AIDS prevention, treatment, and care. Geneva, UNAIDS, 2006.

Joint United Nations Programme on HIV/AIDS. Operational Guidance on Setting National Targets for Moving Towards Universal Access; Section 4: Setting ambitious targets. Geneva, UNAIDS, 2006.

Joint United Nations Programme on HIV/AIDS. High coverage sites: HIV prevention among injecting drug users in transitional and developing countries - Case studies. Geneva, Joint United Nations Programme on HIV/AIDS (UNAIDS), 2006.

Joint United Nations Programme on HIV/AIDS. Practical guidelines for intensifying HIV prevention. Geneva, 2007.

Joint United Nations Programme for HIV and AIDS (2009), Regional consultation on role of police and law enforcement in AIDS response in Asia and the Pacific, Meeting Proceeding and Recommendations, 3-5 February 2009, Bangkok, Thailand.

Joint United Nations Programme on HIV/AIDS. Monitoring the Declaration of Commitment on HIV/AIDS: guidelines for construction of core indicators, 2010 reporting. United Nations General Assembly Special Session on HIV/AIDS. Geneva, Joint United Nations Programme on HIV/AIDS (UNAIDS), 2009.

Kerr T, Small W, Wood E (2005). The Public Health and Social Impacts of Drug Market Enforcement: A Review of the Evidence, *International Journal of Drug Policy, 16*:210.

Kerr T, Marshall A, Walsh J, Palepu A, Tyndall M, Montaner J, Hogg R, Wood E (2005). Determinants of HAART discontinuation among injection drug users, *AIDS Care*, *17*: 539–49.

Kolodets Charitable Foundation, Narkopolitika v Rossii(Moscow: International Harm Reduction Development Programme of the Open Society Institute, 2006).

Krusi A, Wood E, Montaner J, Kerr T (2010). Social and structural determinants of HAART access and adherence among injection drug users, *Int J Drug Policy*, *21*, 4–9.

Long et al (2006). Effectiveness and cost-effectiveness of strategies to expand antiretroviral therapy in St. Petersburg, Russia. *AIDS, 20:*2207-2214.

Maher L (2004). Drugs, public health and policing in Indigenous communities. *Drug and Alcohol Review, 23*:249-5.

HIV Prevention Among Vulnerable Populations (2008). The Pathfinder Approach. Available at: http://www.pathfinder.org/publications-tools/pdfs/HIV-Prevention-Among-Vulnerable-Populations-The-Pathfinder-International-Approach.pdf

Mathers BM et al (2008). Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. *The Lancet, 372*:1733-1745.

McMillan K, Worth H (2010). 'Sex work and HIV risk in Fiji', *HIV Matters, Vol 2* (1), pp.4-6.

Midford R, Acres J, Lenton S et al (2002). Cops, Drugs and the Community: Establishing Consultative Harm Reduction Structures in Two Western Australian Locations, *International Journal of Drug Policy, 13*:181.

Mimiaga MJ, Safren SA, Dvoryak S, Reisner SL, Needle R, Woody G (2010). '"We fear the police, and the police fear us": structural and individual barriers and facilitators to HIV medication adherence among injection drug users in Kiev, Ukraine', *AIDS Care*, *Vol 22* (11), pp. 1305 – 1313.

Montaner J et al (2006). The case for expanding access to highly active antiretroviral therapy to curb the growth of the HIV epidemic. *Lancet, 368*(9534):531-536.

Morrison E, Madden A (2010). Involvement of people who use drugs in harm reduction in Asia, *HIV Matters, Vol 2* (1), pp.12-13.

Nelson PK et al (2011). Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews. *The Lancet, 378*(9791):571-583.

Open Society Foundations. Stopping overdose: peer-based distribution of naloxone. New York, Open Society Foundations, 2011.

Pearson, G. Drugs and criminal justice A harm reduction perspective in The Reduction of Drug-Related Harm Eds. O'Hare, P.A., Newcombe, R., Matthews, A., Buning, E.C., and Druker, E., Routledge, London and New York, 15-29, 1992

Peters A, Jansen W, van Driel F (2010). The female condom: the international denial of a strong potential. *Reproductive Health Matters, 18*(35):119-128.

Petersen Z, Myers B, van Hout MC, Plüddemann A, Parry C (2013). Availability of HIV prevention and treatment services for people who inject drugs: findings from 21 countries. *Harm Reduction Journal, 10*(13). Available at: http://www.harmreductionjournal.com/content/10/1/13

Quinn T et al (2000). Viral load and heterosexual transmission of human immunodeficiency virus type 1. *The New England journal of medicine, 342*(13):921.

Rawson R A et al (2006). A comparison of contingency management and cognitive-behavioural approaches for stimulant-dependent individuals. *Addiction, 101*(2):267-274.

Rhodes T, Lowndes C, Judd A, Mikhailova L, Sarang A, Rylkov A, Tichonov M, Lewis K, Ulyanova N, Alpatova T, et al (2002). Explosive spread and high prevalence of HIV infection among injecting drug users in Togliatti City, Russia. *AIDS, 16*:F25-F31

Rhodes T, Mikhailova L, Sarang A, Lowndes CM, Rylkov A, Khutorskoy M & Renton A (2003). Situational factors influencing drug injecting, risk reduction and syringe exchange in Togliatti City, Russian Federation: a qualitative study of micro risk environment', *Social Science & Medicine*, *57*: 39-54.

Rhodes T, Platt L, Sarang A, Vlasov A, Mikhailova L, Monaghan G (2006). Street Policing, Injecting Drug Use and Harm Reduction in a Russian City: A Qualitative Study of Police Perspectives. *Journal of Urban Health, 83*:911-925

Rhodes T, Simic M. Transition and the HIV risk environment. BMJ 2005, 331:220-223 27 Drew Thompson, The 'people's war' Against Drugs and HIV, China Brief 5 no. 14 Washington, D.C.: The Jamestown Foundation, 2005

Rhodes T, Simic M, Baros S, Platt L, Zikic B (2008). Police violence and sexual risk among female and transvestite sex workers in Serbia: Qualitative study, *British Medical Journal*, pp.337-343.

Riley D, Pates R. Harm Reduction for Stimulants, In R.Pates and D.Riley (eds),. Harm Reduction in Substance Use and High-Risk Behaviour, Oxford, Wiley-Blackwell, 2012, 171-183

Riley D, Pates R, Monaghan G. O'Hare P. A Brief History of Harm Reduction, in R.Pates and D.Riley (eds), Harm Reduction in Substance Use and High-Risk Behaviour, Oxford, Wiley-Blackwell, 2012, 5-16.

Roberts M, Klein A& Trace M. (2004), Briefing Paper Number 3 – Drug consumption rooms, Oxford, The Beckley Foundation Drug Policy Programme &DrugScope.

Safren S, Martin C, Menon S, et al (2006). A survey of MSM HIV prevention outreach workers in Chennai, India. *AIDS EducPrev, 18*: p. 323-332

Sarang A, Rhodes T, Sheon N, Page K (2010). Policing Drug Users in Russia: Risk, Fear, and Structural Violence. *Substance Use & Misuse, 45*:813-864

Sarang A, Stuikyte R, Bykov R (2007). Implementation of harm reduction in Central and Eastern Europe and Central Asia*. International Journal on Drug Policy, 18*(2):129-135.

Sarang A, Rhodes T, Platt L (2007). Access to syringes in three Russian cities: Implications for syringe distribution and coverage. 24. Sarang A, Stuikyte R, Bykov R. Implementation of harm reduction in Central and Eastern Europe and Central Asia. *International Journal on Drug Policy, 18*(2):129-135.

Sarang A, Rhodes T, Platt L (2008). Access to syringes in three Russian cities: Implications for syringe distribution and coverage*. International Journal on Drug Policy, 19*S:S25-S36.

Shannon K, Rusch M, Shoveller J, Alexson D, Gibson K, Tyndal M (2008). Mapping violence and policing as an environmental-structural barrier to health service and syringe availability among substance-using women in street-level sex work. *International Journal of Drug Policy, 19*:140-147.

Shannon K, Strathdee SA, Shoveller J, Rusch M, Kerr T and Tyndall MW (2009). 'Structural and Environmental Barriers to Condom Use Negotiation With Clients Among Female Sex Workers: Implications for HIV-Prevention Strategies and Policy', *American Journal of Public Health, Vol 99* (4), pp. 1-7.

Shields A. 'The effects of drug user registration laws on people's rights and health: key findings from Russia, Georgia, and Ukraine' New York, USA: Open Society Institute, Public Health Programme, International Harm Reduction Development Programme, 2009.

Small W, Kerr T, Charette J, Schechter MT, Spittal PM (2006). Impacts of intensified police activity on injection drug users: Evidence from an ethnographic investigation. *International Journal of Drug Policy*, *17*:85-95.

Sharma M, Chatterjee A (2012). Partnering with law enforcement to deliver good public health: the experience of the HIV/AIDS Asia regional programme.*Harm Reduction Journal*, *9*:24.

Spire B, Lucas GM, Carrieri MP (2007). Adherence to HIV treatment among IDUs and the role of opioid substitution treatment (OST). *International Journal on Drug Policy*, *18*(4):262-270.

Stevens A, Stover H, Brentari C (2010). Criminal justice approaches to harm reduction in Europe pp. 379-402.

Stewart D, Gossop M & Marsden J (2003). Methadone treatment: outcomes and variation of treatment response within NTORS'. In Tober, G. and Strang, J. (2003), Methadone matters – Evolving community methadone treatment of opiate addiction (Eds.) London: MD Martin Dunitz, Taylor and Francis Group), 249-258.

Stone C and Travis J. (2011). Toward a New Professionalism in Policing.http://www.hks.harvard.edu/news-events/publications/impact-newsletter/archives/summer-2011/a-new-paradigm-for-policing-in-the-21st-century

Strathdee SA, Lozada R, Pollini RA, Brouwer KC, Mantsios A, Abramovitz DA, Rhodes T, Latkin CA, Loza O, Alvelais J, et al (2008a). Individual, Social, and Environmental Influences Associated With HIV Infection Among Injection Drug Users in Tijuana, Mexico. *Journal of Acquired Immune Deficiency Syndrome*, *47*:369-376.

Strathdee SA et al (2010). HIV and risk environment for injecting drug users: the past, present, and future. *The Lancet, 376*(9737):268-284.

Thomson N, Leang S, Chheng K, Weissman A, Shaw G, Crofts N (2012). The village/commune safety policy and HIV prevention efforts among key affected populations in Cambodia: finding a balance, *Harm Reduction Journal*, *9*:31

Trace M, Riley D and Stimson G.UNAIDS and the Prevention of HIV Infection through Injecting Drug Use, International Drug Policy Consortium, Beckley, 2005.

Ukraine HIV/AIDS Country report, 2011, UNAIDS.org, accessed December 16, 2012

Ukrainian Harm Reduction Network, website accessed Dec 7, 10, 14 2012, March 8,9 2013.

UNAIDS/UNODC. Drug abuse and HIV/AIDS: lessons learned. Case studies booklet: central and eastern Europe and the central Asian states. Geneva, UNAIDS, 2001

UNAIDS, Peer Education Kit for Uniformed Services Implementing HIV/AIDS/STI, 2003.

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

United Nations. Preventing the transmission of HIV among drug abusers: a position paper of the United Nations System. Annex to the Report of the 8th Session of the Administrative Committee on Coordination Subcommittee on Drug Control, 28–29 September 2000. Geneva, United Nations, 2000

United Nations Office on Drugs and Crime, World Health Organization, Joint United Nations Programme on HIV/AIDS. HIV/AIDS prevention, care, treatment, and support in prison settings: A framework for an effective national response. New York, United Nations, 2006.

United Nations Economic and Social Council. United Nations Economic and Social Council Resolution E/2009/L.23: Joint United Nations Programme on Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome(UNAIDS); Adopted 24 July 2009. New York, United Nations, 2009.

United Nations Office on Drugs and Crime. Expert Group Meeting on Measuring and increasing coverage of HIV/AIDS prevention and care services for IDUs Vienna October 2005.

United Nations Commission on Narcotic Drugs. Resolution on HIV/AIDS and Drug Abuse. 45th Session, 11–15 March 2002, Vienna, Austria.

United Nations Learning Strategy on HIV/AIDS , UNAIDS, Geneva, 2004

UNAIDS, Reducing Harm, Rebuilding Lives: Law Enforcement Agencies as agents of change, Geneva, 2010.

United Nations Office on Drugs and Crime, World Health Organization, Joint United Nations Programme on HIV/AIDS. HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response. New York, United Nations, 2006.

United Nations Office on Drugs and Crime et al. HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions. Vienna, UNODC, 2012.

Walsh N et al. 3.1 The silent epidemic: responding to viral hepatitis among people who inject drugs In: Cook C, editor. Global State of Harm Reduction 2010. London, International Harm Reduction Association, 2011.

Webb D, Wood E, Small W, Strathdee S, Li K, Montaner J, Kerr T: Effects of police confiscation of illicit drugs and syringes among injection drug users in Vancouver. International Journal of Drug Policy 2008, 19:332-338

Wodak A, Cooney A (2006). Do needle syringe programmes reduce HIV infection among injecting drug users: a comprehensive review of the international evidence. *Substance Use & Misuse, 41*(6-7):777-813.

Wolfe D, Carrieri MP, Shepard D (2010). Treatment and care for injecting drug users with HIV infection: a review of barriers and ways forward. *The Lancet, 376*(9738):355-366.

Wolfe D and Cohen J (2010). Human Rights and HIV Prevention, Treatment, and Care for People Who Inject Drugs: Key Principles and Research Needs, *J Acquir Immune DeficSyndr*, *55,* Supplement 1, December, 56-62.

Wolfe and KasiaMalinowska-Sempruch. Seeing Double: Mapping Contradictions in HIV Prevention and Illicit Drug Policy Worldwide, in Chris Beyer, ed.,Public Health and Human Rights: Evidence Based Approaches (Baltimore: The Johns Hopkins University Press, 2007.

Wood E, Li K, Small W, Montaner JS, Schechter MT, Kerr T. Recent Incarceration Independently Associated with Syringe Sharing by Injection Drug Users. Public Health Reports 2005, 120:150-156.

Wood E, Kerr T, Tyndall MW and Montaner JS (2008). A review of barriers and facilitators of HIV treatment among injection drug users, *AIDS*, *22*, 1247–1256.

Wood E, Spittal PM, Small W, Kerr T, Li K, Hogg RS, Tyndall MW, Montaner JS, Schechter MT (2004). Displacement of Canada's largest public illicit drug market in response to a police crackdown. *CMAJ*, *170*:1551-1556.

Worth H, Watson S, McMillan K and Rokoduru A (2010). The Fiji Crimes Decree: what impact will it have on sex work in Fiji', *HIV Matters*, *2* (1), 7-9.

World Health Organization Europe. Status paper on prisons, drugs and harm reduction. Copenhagen, World Health Organisation Regional Office for Europe, 2005.

World Health Organization, United Nations Office on Drugs and Crime, Joint United Nations Programme on HIV/AIDS. Evidence for Action: comprehensive review of effectiveness of interventions addressing HIV in prisons. Geneva, World Health Organisation, 2007.

World Health Organization. WHO Model List of Essential Medicines, Geneva, World Health Organization, 2010

World Health Organization. Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users. Geneva, World Health Organisation, 2004.

World Health Organization, United Nations Office on Drugs and Crime, Joint United Nations Programme on HIV/AIDS. Evidence for Action on HIV/AIDS and Injecting Drug Use Policy Brief Reduction of HIV transmission in prisons. Geneva, World Health Organisation, 2004.

World Health Organization. Ottawa Charter on Health Promotion. Geneva, WHO, 1986

World Health Organisation. Evidence for action series (E4A): Policy briefs and technical papers on HIV/AIDS and Injecting Drug Users. Geneva, World Health Organization, 2008 http://www.who.int/hiv/pub/idu/idupolicybriefs/en/index.html

World Health Organization. Evidence for Action: Effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users. Geneva, World Health Organisation, 2004.

World Health Organization. ATLAS on substance use (2010): resources for the prevention and treatment of substance use disorders. Geneva, World Health Organization, Department of Mental Health and Substance Abuse 2010.

World Health Organization. Evidence for Action: Effectiveness of drug dependence treatment. Geneva, World Health Organisation, 2004.

World Health Organization. Guidelines for psychosocially-assisted pharmacotherapy for the management of opioid dependence. Geneva, World Health Organisation, 2009.

World Health Organization, United Nations Office on Drugs and Crime. Principles of drug dependence treatment - discussion paper. Geneva, World Health Organization, 2008.

World Health Organization. Basic principles for treatment and psychosocial support of drug dependent people living with HIV/AIDS. Geneva, World Health Organization, 2006.

World Health Organization. Technical briefs on amphetamine type substances. Manila, World Health Organization Regional Office for the Western Pacific, 2011.

World Health Organization, Joint United Nations Programme on HIV/AIDS. Guidance on provider-initiated HIV testing and counselling in health facilities. Geneva, World Health Organisation, 2007.

World Health Organization South East Asia Region, World Health Organization Western Pacific Region, United Nations Office on Drugs and Crime Regional Centre for East Asia and the Pacific. Guidance on testing and counselling for HIV in settings attended by people who inject drugs: improving access to treatment, care and prevention. Manila, World Health Organization Regional Office for the Western Pacific, 2009. http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf.

World Health Organization. Guidance on prevention of viral hepatitis B and C among people who inject drugs. Geneva, World Health Organization, 2012.

World Health Organization, United Nations Office on Drugs and Crime, Joint United Nations Programme on HIV/AIDS. Policy guidelines for collaborative TB and HIV services for injecting and other drug users - an integrated approach. Geneva, World Health Organisation, 2008.

WHO, UNODC, and UNAIDS, Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention, Geneva: World Health Organization, 2004

Yi H, Mantell JE, Wu R, Lu Z, Zeng J and Wan, YA (2010).Profile of HIV risk factors in the context of sex work environments among migrant female sex workers in Beijing, China, *Psychology, Health & Medicine*, *Vol 15* (2), 172 – 187.

Zaal L. Police policy in Amsterdam. In O'Hare, P., Newcombe, R., Mathews, A., Buning, E. C. &Druker, E., (Eds) The reduction of drug related harm, London: Routledge, 93, 1992.

Zelichenko, A. The role of police in harm reduction: the experience of Kyrgyzstan, presentation at LEAHN meeting, Rome, 2012.

Useful Resources and Websites

UNAIDS 2013 Global Report available at
http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/unaids_global_report_2013_en.pdf

UNAIDS 2013 Global Fact Sheet available at
http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/20130923_FactSheet_Global_en.pdf

Country specific information from the UNAIDS Asia Pacific Data Hub available at
http://www.aidsdatahub.org/Country-Reviewscountry level UNAIDS Data Hubs

Quiz on HIV/AIDS available at http://www.avert.org/aids.htm

United Nations Office on Drugs and Crime. World Drug Report 2014.

http://www.unodc.org/documents/wdr2014/World_Drug_Report_2014_web.pd

http://www.aic.gov.au/publications/current%20series/rpp/100-120/rpp111.html

http://www.cdc.gov/hiv/resources/factsheets/oralsex.htm

http://www.leahn.org

http://www.ohchr.org/Documents/Publications/training5Add1en.pdf

http://www.who.int/hiv/data/en/