

# AIDS, Security and Conflict Initiative

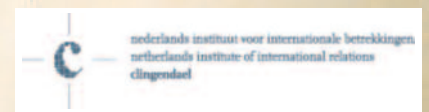


ASCI Research Report No. 2, December 2007

## Current Trends and Issues in Research on HIV/AIDS and Police Forces in Africa

Alastair Roderick

*Justice Africa, UK*



## **About the Author**

Alastair Roderick is the programme coordinator of the HIV/AIDS and governance programme at Justice Africa, a London and Nairobi based think-tank and advocacy organisation that has pioneered a model of producing small-scale, targeted and policy-relevant research on the social effects of HIV/AIDS in Africa. He writes and researches on HIV/AIDS and security, governance, democracy and environmental issues, and edits an electronic newsletter on HIV/AIDS and governance in Africa. He is a trustee of The Atiamah Trust, which provides home-based care for persons living with HIV/AIDS and their families in Northern Ghana, and is a doctoral candidate at the London School of Economics.

## **About ASCI**

The AIDS, Security and Conflict Initiative (ASCI) officially launched in September 2006. ASCI is a global research initiative to inform policy and programming by strengthening the evidence base and addressing critical gaps in knowledge across several thematic areas:

1. HIV/AIDS in uniformed services, including military, peacekeeping and policing
2. HIV/AIDS, humanitarian crises and post-conflict transitions
3. HIV/AIDS, fragile and crisis states
4. Cross-cutting issues of gender, data collection & measurement, and media representation

ASCI has been convened by the Netherlands Institute of International Relations "Clingendael" and the Social Science Research Council with support from the Netherlands Ministry of Foreign Affairs, the Australian Agency for International Development, the Canadian Department of Foreign Affairs and International Trade, the Swedish Ministry of Foreign Affairs, UNAIDS, UN Population Fund (UNFPA) and the Rockefeller Brothers Fund. For more information please visit our website: [www.asci.ssrc.org](http://www.asci.ssrc.org).

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## **Executive Summary**

This paper is an attempt to frame the issues and lead debate at the expert meeting; it is not a comprehensive review of the research in the field, nor does it claim to be 'laundry-list' of the issues that will be of importance to participants. It is, instead, a starting-point for discussions.

It is written from two perspectives. Firstly, it takes an approach from HIV/AIDS research and advocacy and applies this to the issue of policing. Secondly, it is written from the point of view of the Justice Africa research programme on HIV/AIDS, democracy, security and gender. The paper, therefore, has a major, but not exclusively, African point-of-view.

There are three fundamental questions underlying many of the issues discussed here that there is not space to get to here, but are nevertheless important to our discussions, and it may be that participants feel that one or another are important enough to make a much larger focus in our analyses. One, to what extent are police- as arbiters of conflict, guarantors of public order, and protectors of property and the basic personal liberties necessary for economic growth and development- contributors to societies that have high social resilience to HIV/AIDS and other emerging health threats?

The second question is if crime deprives a society of the resources needed for development and economic growth, what effects will this have on a society's resilience to the full effects of HIV/AIDS; and what can the police do about it?

Thirdly, and logically following on from this, do we know that HIV/AIDS is a problem for public order? We understand, loosely, that HIV/AIDS contributes to several social problems. We also know that social problems, particularly socio-economic problems, contribute to high rates of crime. But this is not the same as saying that HIV/AIDS creates public disorder.

### **Who are we including among the police?**

- 1) Before definitions of police are agreed, we should recognise that the interests of reaching all groups vulnerable to HIV/AIDS needs to be balanced in policy making with fixed consensus definitions of the groups that are being analysed in research, so that changes within the same populations can be observed, and that 'like-for-like' comparisons can be made.
- 2) All groups given the name police, that have clearly definable police functions related specifically to domestic law and order, have civilian powers of arrest, and that do not engage in ordinary territorial defence or armed peacekeeping (but with the exception of uniformed police peace-observers, if functionally armed), are recognisably police personnel rather than military forces.
- 3) Prison staff, given their specific functions and the particular threats and circumstances surrounding HIV/AIDS in prisons, should for this analysis be discounted. This, by logical extension, should include parole officers.

- 4) Paramilitary and gendarmerie are difficult 'grey' categories. The response has to be that analyses, when made, need to explicitly show how and why these groups are defined as police officers rather than as military personnel; otherwise they are assumed not to be useful in police analyses.

#### **What are the risks to police officers?**

- 1) Social protection of police forces, and training forces on physical protection methods, is not only a useful activity in it's own right, but contributes to the sense of needing to protect oneself and ones' colleagues from the social causes of HIV/AIDS.
- 2) A lack of knowledge of HIV/AIDS, and the social stigma and discrimination that accompany it, is as much of a threat to police in dealing with HIV/AIDS as exposure to HIV/AIDS is itself.
- 3) More research is needed on whether crime plays a role in helping to spread HIV/AIDS, by either providing more opportunities for the virus to spread, or weakening the capacity of a society to respond to HIV/AIDS, or both.
- 4) Statistics. Better data are needed on the effects of HIV/AIDS on police officers; both in terms of infection, mortality and morbidity, and in terms of social effects. This is a case not only of better data collection, but also the public disclosure of such information by police services and governments.

#### **What is the level of infection in your force? Why is it important to know this?**

- 1) Collecting national, regular, data on HIV prevalence should be made a priority, and this data should be made public for reasons of promoting public trust and accountability; as well as to benefit from the knowledge and experience of expert bodies and members of the public.
- 2) That status, if testing is made mandatory, is not disclosed to individuals without consent, and that aggregate data be used for planning purposes. Consent opt-out implies a necessary programme of information services to explain and encourage knowing ones' status.
- 3) An audit be made generally for police services, but also internally within police services, of skills that the service requires, what it would mean if the service was to lose a significant number of individuals in possession of these skills, and how the service plans to replace skills lost.
- 4) Because police services do engage in sensitive activities, information being distributed on some of these not being in the public interest, to make an alternative audit of services, functions and policies not to be shared with the public in order to protect force integrity.

**What measures are appropriate for dealing with officers who are HIV+? What can be learned from other uniformed services and institutions?**

- 1) Researchers establish what they can learn from military vectoring studies. Visible and representational analyses of how HIV enters and passes through a cohort of individuals can provide an impetus for action, and a visual case for action. Many of these have been completed within security analyses, and can be used for the police.
- 2) Police services engage in risk framework analyses for their communities highlighting i) specific risk vectors in the community; ii) changes anticipated in their risk profiles; iii) proposed policing responses to these risk vectors; iv) the help that the police need from the wider community in reducing these vectors.
- 3) Both working with HIV+ colleagues, and planning to minimise HIV risk be incorporated into basic and senior officer training programmes. The advantage of both ensures that the policy-makers will take the issue seriously; the former is that a culture of HIV awareness, responsibility and planning be instituted at an early stage.

**Does the police force provide special training on HIV/AIDS?**

- 1) Training on HIV/AIDS be incorporated into basic training for police recruits, management training for senior officers, and be adopted by international police training standards and bodies as being considered an essential part of community awareness and harm-reduction training curricula.
- 2) HIV/AIDS is important enough to be incorporated in its own right into essential training curricula, rather than just as part of general health protection and harm reduction knowledge. This will have the effect in all forces of reinforcing the importance of HIV/AIDS, and the role police forces can play in its minimisation.
- 3) HIV/AIDS awareness training provides a good advocacy tool in minimising risk exposure in its own right, and should be promoted by policing and non-policing communities as a socially desirable activity; even if a police force has low levels of HIV/AIDS, anticipates low risk, and promotes a generally positive approach to HIV management.
- 4) Knowledge of police training can provide useful information on how well stigma and discrimination are being approached, tackled and minimised; and provide a useful insight of how police as a social cohort, and as a key mediator in society, are tackling HIV/AIDS.

**How can the police protect vulnerable persons?**

- 1) In the absence of resources to eradicate HIV/AIDS from police services, and the communities they serve, the management of HIV/AIDS, and its risk behaviours, needs to be taken as seriously within analyses as adopting plans to eradicate HIV/AIDS or eliminate its most pernicious threats.

- 2) Applying strategies that simultaneously address different risk behaviours, such as drug abuse, and HIV/AIDS, will have more effect than concentrating limited resources into single programmes.
- 3) Gender-focused programmes are needed in recognition of the fact that stigma and discrimination, overtly or covertly, disproportionately affect women compared to men. This means female-centred programming from police services that may often be male-dominated and headed institutions.
- 4) Support for those living with or affected by HIV/AIDS is contingent on the codification of international human rights standards, including those in 1308.

**What measures are in place for women police officers and support staff concerning gender discrimination and harassment?**

- 1) Female officers be recruited in greater numbers not just for reasons of equality, but for reasons of combating HIV/AIDS; by leading within the police a strategy which empowers women, places them at the heart of a community, and emphasises their particular vulnerabilities to HIV/AIDS
- 2) Gender-based violence be put at the heart of any policing strategy on HIV/AIDS. This will require training on identifying and managing the risks to women, protection of vulnerable groups- especially stigmatised groups such as CSW's- and tougher legal reform and police response to violence targeted against women and girls.
- 3) Research is needed on women as primary caregivers, how this affects discrimination within police services, recruitment of female officers, and influences the police's role in tackling gender-based discrimination. Of particular concern is on personal and family healthcare offered to female officers in police forces.
- 4) Senior officers commission resource-studies to examine what obligations and opportunities exist to their forces from legislation, legal codes, and international instruments to reduce gender-based discrimination and violence.

**What is the country's law on IDU and harm reduction and how is it enforced?**

- 1) The particular threats related to ID use from HIV/AIDS should be clearly mapped and analysed by a police force. Clearly, there will be degrees of magnitude between societies that find high levels of HIV/AIDS within ID users, or high levels within ID users relative to the overall HIV/AIDS burden; and those societies with low levels of HIV/AIDS within ID users, or low levels within ID users relative to the overall HIV/AIDS burden.
- 2) That HIV/AIDS reduction be promoted as a more important objective than the prosecution of ID users. This can be done both by increasing services to ID users, and by legal and police reforms of the emphasis placed on the criminal justice targeting of drug suppliers relative to drug users.

**What are the issues related to HIV/AIDS affecting civilian police and staff in peacekeeping operations and SSR?**

- 1) Civilian police personnel on peacekeeping missions should be specifically counted as police personnel for the purposes of analysis, rather than as military personnel, due to the very different characteristics that these personnel, and their missions, will take on.
- 2) For the purposes of research, and to develop the evidence base, it is necessary to encourage analyses of police personnel on peacekeeping operations, due to the broader literature base in this area that can be built upon. This does not discount such analyses, however, from being treated with the appropriate care and scepticism when the literature makes non-empirical and non-evidence-based assertions.
- 3) The advantage that can be taken from police personnel in peacekeeping operations is that they will be experience personnel, will be lower-risk individuals, and will have greater credibility in promoting risk-reduction strategies than their military colleagues. HIV/AIDS planners should use this advantage.

## Introduction

This paper is an attempt to frame the issues and lead debate at the expert meeting; it is not a comprehensive review of the research in the field, nor does it claim to be a 'laundry-list' of the issues that will be of importance to participants. It is, instead, a starting-point for discussions.

It is written from two perspectives. Firstly, it takes an approach from HIV/AIDS research and advocacy and applies this to the issue of policing. It may sound like semantics, but it is important to note immediately that HIV/AIDS research that considers policing will have very different priorities, objectives and conclusions to police research that considers HIV/AIDS. Secondly, it is written from the point of view of the Justice Africa research programme on HIV/AIDS, democracy, security and gender, which has supported small new research projects on policing and HIV/AIDS in Africa; specifically in Sudan, Benin, Sierra Leone and South Africa<sup>1</sup>. The paper, therefore, has a major, but not exclusively, African point-of-view.

Why focus on the police? There are several reasons for this. First of all, police are first responders. As this paper recounts later, this role puts police officers at potentially greater risk of HIV-exposure due to the greater opportunities to come into contact with populations at risk of HIV, and the potential dangers of contaminated fluid contact, particularly needle-stick injuries. However, as will be shown, these risks are most probably offset by training in risk management, and very simple protective regimes such as including surgical gloves in basic first-aid equipment. Even still, the risks of contact with high-risk communities, greater exposure to personal violence, and the specific risks of needle-stick injuries, create a case for attention.

Secondly, police are a crucial demographic cohort. New recruits are likely to be of greatest age-risk of HIV exposure (15-39), and long periods of service enabled by a clear career and ranking structure that encourages the best officers to stay in service and become senior officers, mean that the senior officer cohort- whose use is predicated on their length of service and experience- are at just the age (30s and 40s) when HIV is likely to produce most HIV and AIDS-related morbidity and mortality.

Thirdly, police are the public face of the state; the symbolic manifestation of public protection. Within wider debates on HIV/AIDS, good governance and democracy, the police play a crucial role in providing the most visible link between citizen and the state. If long- term effects of HIV/AIDS on political development are to be identified and understood, then the police offer both a good case study of what these may be, as well as a key role in mediating these long-term effects.

Fourthly, police are very often talked of as an after-thought of security, and this has been no different in the debates on security and HIV/AIDS. ASCI deliberately made police and other non-uniformed services a principle focus of their investigations- going so far as to devote one of the four working-groups to the issue. As the original ASCI research plan stated: "The police, along with other uniformed services, such as paramilitary forces, customs and immigration,

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<sup>1</sup> This paper draws heavily on the ideas and findings of Themba Masuku, Alison Thompson, Darcel Gabriel-Nelson, and Fatima Elsheikh

coastguard and prison warders, should not be treated simply as poor relations of the military.”<sup>2</sup> This compels us not just to examine the specific effects on police forces, but the effects on the populations they serve too.

A distinction needs to be drawn immediately between ‘uniformed services’ (as analysed in much of the HIV/AIDS and security literature) and ‘militaries’. If we are to accept ‘uniformed services’ as a broad description, this will include both militaries and police together as a cohort for analysis. There are valid reasons to do this. If, on the other hand, we see a need to separate military from police personnel, so that these are discreet categories of analysis, we need to ensure that military personnel (principally, but not exclusively, soldiers) and police personnel (principally, but not exclusively, police officers), are separated and analysed. There are valid arguments this way too. This paper does not argue for one or the other, but instead argues that the choices need to be debated, and clarified within the research. For the purposes of debate, the key problems with applying security frameworks to policing for the purposes of HIV/AIDS research are included in the appendix. Methodological debate as to the use of military-focused security frameworks to the police could fill several papers, and risk overshadowing the debate. It is, however, important to note that key differences exist between the police and military-centred security analyses, and that a key overarching issue to resolve is whether we take the security analysis, knowing its weaknesses, but also using the advantage it gives us of an existing research-base and methodological experience, or whether we decide that new, non-military centred analyses are needed, and that these should be built as a first step on research on AIDS and the police.

There are three fundamental questions underlying many of the issues discussed that there is not space to get to here, but are nevertheless important to our discussions. It may be that participants feel that one or another are important enough to make a much larger focus in our analyses. One, to what extent are police- as arbiters of conflict, guarantors of public order, and protectors of property and the basic personal liberties necessary for economic growth and development- contributors to societies that have high social resilience to HIV/AIDS and other emerging health threats? Police personnel can act as risk ‘condensers’, that is groups that act as effective transmitters of the virus, or reservoirs of infectivity that follow similar routines and patterns. This is obviously something we seek to discourage. Police can also act as risk ‘mediators’, that is groups that are not only at lower-risk of HIV contraction and transmission, but lead and contribute to the social strengthening of a community’s defence against HIV and AIDS, not just contributing to lower numbers of infections, but also to the resilience of a community to HIV/AIDS’ secondary, social, effects.<sup>3</sup>

The second question is if crime deprives a society of the resources needed for development and economic growth, what effects will this have on a society’s resilience to the full effects of HIV/AIDS; and what can the police do about it? Charles Goredema, of the Institute of Security Studies in South Africa, reports that in Angola, scores of trans-national crime syndicates benefited from UNITA-backed trafficking of diamonds and other natural resources to fund their war against the government. Despite the war’s end in 2002, the crime syndicates have maintained, and in some cases strengthened their operations. “The loss of money through these crimes is a

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<sup>2</sup> AIDS, Security and Conflict Initiative (ASCI) Research Agenda, 2006; pp.7

<sup>3</sup> A short appraisal of the use and abuse of the concept of ‘risk’ in HIV/AIDS literature is given by Barnett and Whiteside, 2006 (Revised); pp.85

serious issue for the region because the money is lost by countries which can least afford to be without those kinds of resources”<sup>4</sup>. Angola has an adult HIV prevalence rate of 3.7%<sup>5</sup>, much lower than some of its neighbours, and this has been attributed by some to its history of conflict actually frustrating the normal sexual networks by which AIDS would spread. Angola is one nation whose development goals are frustrated by crime, a factor often overlooked in prescribing for development, but crime could potentially frustrate AIDS prevention efforts by resource loss, as well as resources that could otherwise be spent on healthcare, education and a myriad of other socially-protective programmes, being re-directed to combating crime. We are only just beginning to ask the questions necessary on HIV/AIDS and crime.

Thirdly, and logically following on from this, do we know that HIV/AIDS is a problem for public order? We understand, loosely, that HIV/AIDS contributes to several social problems. We also know that social problems, particularly socio-economic problems, contribute to high rates of crime. But this is not the same as saying that HIV/AIDS creates public disorder. At best, we know that a complexly inter-related set of social issues are influenced by rates of HIV infection, morbidity, and AIDS deaths; and that a similarly complexly inter-related set of social issues are influenced by, and influence, crime. A well-publicised example of a public order clash over HIV/AIDS occurred in South Africa on July 12 2005. The Treatment Action Campaign, a well-known advocacy group, occupied the hospital in Queestown, Eastern Cape, in protest at the regional government’s actions on a number of issues relating to access to public health information and provision of ARV drugs.<sup>6</sup> The occupation was broken up by the local police, in riot gear, in the process of which fifty-four individuals were injured, and several arrested. Unprecedented international condemnation followed this event, taking the regional government and Government of South Africa by surprise with its uniformity and intensity.

Alex de Waal wrote of this event, “From a continent away this looked like a life-and-death confrontation between desperate AIDS patients and an uncaring government with a conspicuously bad AIDS policy, possibly the harbinger of riots and revolution. It wasn’t.”<sup>7</sup> The events were actually created by the enormous blunder by the government in deciding to take an ill-thought-out and unwittingly-baited stand against a pressure group that was exceptionally well-placed to make a global fuss. It wasn’t a renting of the social fabric, a clash between victim and state, it was a police failure- visibly in the resort to unnecessary tactics, but more importantly in terms of management and planning.

This paper’s purpose is not to present a comprehensive overview of what we definitely know about HIV/AIDS and policing, or to provide a ‘state-of-the-art’ literature review; rather, it will attempt to promote and frame the issues for discussion at this seminar, within the over-arching framework and goals of the AIDS, Security and Conflict Initiative. In order to present these issues, this paper will pose several questions that we intend to investigate concerning HIV/AIDS and the police. It will not attempt to comprehensively answer these questions- that is the larger purpose of ASCI- but it will provide a starting methodology behind why we are asking these questions, what priorities we have set to arrive at these questions, and where we might look in order to answer them. It short, rather than sketching out what we do know, it will sketch out

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<sup>4</sup> Mutumi, G: ‘Organised crime targets weak African states’ in *Africa Renewal*, v.21 n.2, July 2007; pp.3

<sup>5</sup> UNAIDS: Report on the Global AIDS Epidemic 2006

<sup>6</sup> Justice Africa Governance and HIV/AIDS Briefing, September 2005

<sup>7</sup> De Waal, 2006; pp.34

what we want to know. These questions are directed at chief police officers, and civil servants and politicians who make policy that affect the police. But they could equally be directed at, and considered by, junior officers and middle-managers.

How did we arrive at these questions? There are three real sources. Firstly, this paper is written by Justice Africa, which has been investigating HIV/AIDS among police services in Africa under the ASCI framework by commissioning researchers to undertake small-scale, empirical, studies in Benin, Sierra Leone, South Africa and Sudan. The geographical spread allows us to examine a pan-African spread of evidence, and working in a diverse range of nations- including a middle-income nation, a post-conflict nation in transition, a ‘police-state’ with high levels of political violence, and a low-income nation- provides appropriate lessons beyond Africa. Secondly, ASCI has been a real source for the issues presented here. The role of police and other non-military uniformed services in security and HIV/AIDS has been a real concern of ASCI since it’s inception, which is why Theme One of ASCI’s research- HIV/AIDS in uniformed services, including military, peacekeeping and policing- is explicit that security services not be used synonymously with militaries. Thirdly, the literature on HIV/AIDS and security has proliferated massively, and while this literature is getting better, and some of it is focusing necessarily on police services, or at least explicitly making the distinction between militaries and the wider security architecture, it is necessary to take a deliberate stand to say that evidence is necessary that specifically focuses on the police, and that general research on AIDS and security, largely using militaries as a proxy for security, needs to make this distinction. By laying out the issues for HIV/AIDS and policing, we can hopefully contribute to better research that decides if it is focusing on militaries, is deliberately focusing on police services, or is including the entire security architecture as one entity.

## **1. Who are We Including Among the Police?**

This is perhaps the most important structural question for the research to consider, and it needs to be considered from an early stage. Just in the course of reviewing the literature for this paper, the author has come across police officers, uniformed immigration officers, undercover immigration officers, customs and illicit-goods trafficking agents, gendarmerie, presidential and parliamentary guard units, UN and UN-mandated police advisers and officers, paramilitary troops, anti-terror and anti-drug agencies, and military police forces.

Definitions can change, and perceptions can sometimes be critical to analysis. In late August 2007, the British Home Office announced with some fanfare plans to provide more ‘police-style’ uniforms to border-control officers at ports and airports across the UK, in order to create a more visible and official presence of immigration controls at UK borders in order to reassure the general public that illegal immigrants, and inevitably, potential terrorists, would be meeting stern controls. The changes were accompanied by a focus on new technical measures to deter smuggling, immigration fraud and crime, but no obvious change to the organisational structure or purpose of border control personnel. There wasn’t even any disguising of the primary purpose of the change, said the Minister in charge: “We are determined to improve public confidence in

how immigration is managed... Key to this is the creation of highly visible staff at our borders, to deter people who have no right to be here.”<sup>8</sup>

The newly-uniformed British immigration officers fulfil one wide definition of police in that they are clearly identified (and identifiable) representatives of an authoritative body charged with a specific function in the maintenance of public order. However, a narrow definition of police, as uniformed, or at least credentialed, officers who exist for the purposes only of providing order and security to a geographically-defined community, and by providing a visible presence by regular patrolling and community engagement, and specifically provide a service of deterring and catching criminals through powers of arrest, would fit less well.

There is certainly a good case to be made from the point of view of conducting rigorous social research that a consensual definition of police be made, or an explicit rationale behind which of several competing definitions is to be chosen. However, this paper is arguing that from an HIV/AIDS research point of view these definitions are important not just for precision, but also for their ability to inform good policy-making. This is actually one area where the general AIDS/security literature can provide some guidance. Barnett and Prins<sup>9</sup>, in their review of evidence on HIV/AIDS and security made for UNAIDS, show us that one assumption often incorrectly made about HIV/AIDS and militaries is that once you split the security ‘nexus’ into its component parts and you look at, say, something as definable as soldiers, even at this level of analysis assumptions that you make regarding the uniformity of the cohort being studied can compromise your analysis. They give the example of the South African National Defence Force, who publicly declared that it did not matter if HIV prevalence rates in their soldiers were higher than national averages in the short term, as the public health logic would be that equilibria would be found- especially in a protracted epidemic- in the long run. This unfortunately, Barnett and Prins point out, did not take into consideration- or perhaps conveniently overlooked- the fact that soldiers aren’t a stable population, and so can’t reasonably be expected to ‘stabilise’ quickly.

This is important; Barnett and Prins point out that this was the fundamental public health logic underpinning whether the South African state would treat its military personnel as a key vector in the spread of HIV/AIDS or not. Just as important as whether the SANDF got the decision right (there is actually evidence to suggest they did), is whether the assumptions underpinning policy-choices are the right assumptions to be making. Deciding on a consensus definition of police, therefore, is not only important in an analytical sense for future research, it is important in a policy-making sense as it will affect policy-making for HIV/AIDS and police services for some time to come.

For the purposes of provoking discussion, this paper is proposing that:

- 1) Before definitions of police are agreed, an even more fundamental point needs to be recognised that the interests of reaching all groups vulnerable to HIV/AIDS needs to be balanced in policy making with fixed consensus definitions of the groups that are being analysed in research, so that changes within the same populations can be observed, and that ‘like-for-like’ comparisons can be made. This does not mean that different studies can not focus on different sub-groups, they may have to, but it does mean that such

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<sup>8</sup> UK Home Office, 2007

<sup>9</sup> Barnett and Prins, 2005; pp.19

differences need to be made explicit and where possible differences between groups explained in the context of potential and apparent influences on data.

- 2) All groups given the name police, that have clearly definable police functions related specifically to domestic law and order, civilian powers of arrest, and that do not engage in ordinary territorial defence or armed peacekeeping (but with the exception of uniformed police peace-observers, even if functionally armed), are recognisably police personnel rather than military forces. This list does not have to be exact- and there may be wider defining features- but police officers are likely to conform to the large majority of this.
- 3) Prison staff, given their specific functions and the particular threats and circumstances surrounding HIV/AIDS in prisons, should for this analysis be discounted. This, by logical extension, should include parole officers. This is not to say there are not important issues related to these groups, it is to rather say that they lie too far outside of policing to provide a reasonable analytical fit.
- 4) Paramilitary and gendarmerie are difficult 'grey' categories. The response has to be that analyses, when made, need to explicitly show how and why these groups are defined as police officers rather than as military personnel; otherwise they are assumed not to be useful in police analyses. It may be that research provides good evidence that paramilitary forces in context are analytically closer to police than militaries, but for now we should make the conservative assumption that they exist in the wider security nexus beyond a precise definition of police.

## **2. What are the Risks to Police Officers?**

Themba Masuku at the Centre for the Study of Violence and Reconciliation (South Africa) has neatly stated and assessed the risks to police officers of contracting HIV/AIDS, or spreading it, just by virtue of being police officers. His observations are based on data he has collected in South Africa, as well as a literature review of evidence from that country as well as from Europe and North America.<sup>10</sup>

Firstly, a key potential risk factor to police officers is increased exposure to high-risk individuals, particularly intravenous drug users (IDU's), and commercial sex workers, who through exposure to bodily fluids, may provide a route of transmission to HIV/AIDS. The logic here is that as emergency first responders, police officers are more likely than the general public to come into contact with trauma victims- such as after a motor-vehicle accident- or violent individuals who may deliberately or indirectly put officers at risk through their violent contact and the potential for fluid transfer.

However, Mauku finds from the literature that what risks are posed by greater potential violent or traumatic exposure to HIV/AIDS are more than off-set by the training and precautions taken in such situations by police officers. A very simple example would be that a police officer, even if

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<sup>10</sup> Mauku; 2007a: 30-33

not equipped with extensive surgical supplies, is likely to carry surgical latex gloves, and is trained to use them in any situation where touching an individual is required or bodily fluids are involved. As simple as this sounds, members of the public wouldn't generally carry latex gloves. Furthermore, the virology of HIV means that percutaneous (through unbroken skin) or mucocutaneous (through mucous membrane) transfer is very unlikely; and even blood-to-blood contact (SEE ESSEX et. al.) is low risk. As a virologically fragile pathogen (it is, however, epidemiologically much more resilient), HIV does not survive outside of living material for very long- it needs to replicate itself very rapidly to avoid being destroyed by the body's immune system. As such, basic medical supplies, or even just basic hazardous bodily fluids training, mean that any heightened risk of exposure to HIV through routine police work is statistically negligible to the overall affect of HIV/AIDS on the police. The key exception here is needle-stick injuries, and the exposure of police officers to IDU communities. Needle-stick injuries are much more hazardous as the risks of subcutaneous transfer of HIV are many degrees of magnitude higher than percutaneous or mucocutaneous. Again, the risks of these injuries may be off-set by greater awareness among the police of the dangers of needle-stick injuries.

Secondly, no studies have been conducted in the South African Police Service (SAPS) to determine the links between exposure and infection. If we can conclude that there is little physical reason to suppose heightened risk from HIV from being a police officer, the same is not true for social reasons to suppose risk. For example, if we suppose that police officers are typically exposed to different high-risk behaviours associated with HIV/AIDS- such as use of commercial sex workers, or access to and exposure to a culture of drug abuse- do we know the social reasons behind officers choosing whether or not to participate in such behaviour that increases their risk of exposure. Such reasons could include the professional culture of the police force, family status, being posted to a service away from one's home community, or the economic working conditions of the service. These social determinants condition the police officer's relative risk of exposure, and these determinants are poorly understood in relation to risk of infection.

Thirdly, whether or not police officers are at greater risk of exposure to risky behaviours, we do know that police officers are at greater risk of exposure to at-risk populations. Chiefly, but not exclusively, these include intravenous-drug using populations (IDU's) and commercial sex-workers. Globally, the spread of HIV by drug-use is high among populations in the former Soviet Union, South-East Asia, and moderate in Latin America and the Caribbean. It is relatively low as a method of transfer in Africa, where drug-abuse is less endemic, and where the global burden of HIV/AIDS is highest.<sup>11</sup> Commercial sex workers are high-risk populations across the world; and commercial sex work contributes greatly to the illegal trafficking of individuals. It goes without saying that this should not prejudice police officers' dealings with these groups, nor should it be taken as an argument for police officers to take a uniformly intolerant line with these groups; management of risk means not only protection from risk but mediating the circumstances by which risk arises.

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<sup>11</sup> UNAIDS, AIDS Epidemic Update; Dec. 2006

For the purposes of provoking discussion, this paper is proposing that:

- 1) For reasons of social protection of police forces- in order to promote the idea that HIV infection should be minimised within the police by all means, physical and social-physically protecting police services, and training them on physical protection methods, is not only a useful activity in its own right, but contributes to the sense of needing to protect oneself and ones' colleagues from the social reasons that cause exposure to HIV.
- 2) The risks of a lack of knowledge of HIV/AIDS, and the social stigma and discrimination that accompany it, is as much of a threat to police in dealing with HIV/AIDS, as exposure to HIV/AIDS is itself. Training therefore should proceed on the assumption that until and only if research can conclusively prove that a police officer is at lower risk of HIV because they are a police officer, then there is little harm in assuming that police need to take real precautions in avoiding and managing HIV/AIDS.
- 3) Little touched on in the research, more information is needed on whether crime plays a role in helping to spread HIV/AIDS, by either providing more opportunities for the virus to spread, or weakening the capacity of a society to respond to HIV/AIDS, or both. A view in the South African literature is that crime and HIV/AIDS are largely epiphenomenal, but there are logical arguments both ways to make the case that high levels of HIV in that nation either provide a demographic incentive for crime to increase (by creating a 'youth bulge' in the population structure), or to decrease by creating greater morbidity (and as the epidemic progresses, mortality) within young men. This is not to say that high levels of crime and HIV/AIDS have no related root-causes.
- 4) Statistics. Better data are needed on the effects of HIV/AIDS on police officers; both in terms of infection, mortality and morbidity, and in terms of social effects such as household income, orphaning, partner-infection. This is a case not only of better data collection, but as Justice Africa researchers have discovered in places such as Benin and South Africa, the public disclosure of such information by police services and governments.

### **3. What is the Level of Infection in Your Force? Why is It Important to Know This?**

The most basic reason to know the level of infection in your force is that police officers are members of the societies that they serve, the level of infection will tell you how much risk your officers face, and whether they pose any more risk to wider society of passing HIV on than ordinary members of the public do. We can draw out five principle reasons why it is important to know the level of infection in your force.

Firstly, HIV infection poses a potential operational threat to your force through increased levels of morbidity (sickness) and mortality (death). Police forces need healthy individuals to perform basic policing duties, and this means that police officers are usually required to be of above-

average fitness and health on recruitment. HIV (the infection) progresses slowly into AIDS (the illness). However, there are precise medical definitions that police officers need to be aware of. HIV positive means that HIV has been detected in an individual by an antibody test. An antibody test is only effective 6-8 weeks after infection, which is why two positive tests some weeks apart are usually required to eliminate false positives<sup>12</sup>. During the early stages of HIV infection, the individual will sometimes experience initial symptoms of 'flu, but apart from this the health of the individual is not initially affected. A period of latency will then occur in most individuals for an average of seven years, untreated in adults, during the latter stages of which further illness will be experienced as general immunity is suppressed. Only after this stage will severe immuno-compromise occur and increased sickness will result, with a general underlying weakness. During this period, a police officer will discover, one way or another, that they can no longer perform their duties. When the immune-system is suppressed to a certain level (usually 10% of healthy adult levels), rapid immune-collapse occurs, opportunistic infections and cancers occur, and the individual will be diagnosed with AIDS. Life expectancy at this point can be from a few months to a few years.

Many individuals who experience slow progressing HIV will detect their status early on, will access medications if available, and will stop working long before they become terminally ill. Some individuals, especially those who are unaware of their status, may experience a very rapid and unexpected decline in health from latent HIV-positivity to terminal illness. Both pose an obvious threat to operational effectiveness. Uncertain levels of sick leave in the police will pose a problem, especially for middle-ranking officers, those charged with planning operational capacity over a given area. It also poses a problem to senior planners who try to devise strategic plans for both geographic and sectoral areas when faced with unknown future force depletion.

Secondly, this is an issue of trust. The whole issue of HIV/AIDS, its effective management by the police, and the need for this for good governance and democracy is another field of research and enquiry that will only come after the basic metrics are learnt. However, one point that we need to consider immediately is of trust, and the need for this in order for the police to effectively operate. One of the key distinctions between militaries and police services is that militaries are rarely called upon to defend public trust in their nations and governments, but when they are it is usually as a last resort and deeply traumatic. For the police, however, maintaining public trust in the state- or at least preventing distrust from threatening public order- is a basic functional requirement. HIV/AIDS provides a potential threat to the level of trust necessary for a police force to fulfil its essential tasks if the police service is seen to increase the spread of HIV, if people living with HIV are seen to be discriminated against or not protected, and if those at risk of contracting HIV are made more vulnerable by the actions or passivity of the police. Knowing the level of infection, and crucially making this public, contributes to public trust by demonstrating that the police service does not stigmatise the disease or its sufferers, is honest with the public on matters of operational ability, and will make the effort to collect the basic data necessary for well-thought-out long term planning.

Thirdly, the police exist within a wider architecture of state organisations that collectively assume accountability- whether willingly or not- for leading the public response to HIV/AIDS. Being embedded within this architecture will result in inevitable problems between organisations that

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<sup>12</sup> Guèye-Ndiaye, A: 'Serodiansis of HIV Infection', in Essex et al, 2002; pp.121-138

need to be planned and negotiated through. For example, if a police service detects high rates of HIV in its officers, who will bear financial responsibility? It is reasonable to assume that planners within the police service, interior ministry and health ministry will all have different opinions as to who should fund treatment programmes, recruitment drives, or medical retirement costs. There are two responses that police planners can make at this stage. One is to logically assume that as knowing there is an HIV/AIDS problem obligates one to do something about it, the best thing to do is to either not test officers for HIV, or if they are already being tested and cancelling such programmes would provoke negative reactions, then to claim that making such data publicly available would undermine public confidence in the police and pose a risk to public safety. The second response is to assume that public confidence in the police to maintain social order amounts to the same thing as maintaining social order, and collect data well, publish it as soon as possible, and explain to the public how you plan to reduce HIV in your officers (if high), or prevent your officers from becoming infected (if low). This is the point at which good relations with other state agencies, and the plans you have jointly worked upon, come into effect.

Fourthly, knowing the levels of infection in your force allows you to make long-term planning decisions. Any resource-constrained police service, and this is not just the case in poor nations, will have limited financial and human resources and will need to plan accordingly. For example, if a police service decides that HIV positive officers will remain on duty, but only in administrative roles, the planners in such a service need to know that enough personnel remain on duty able to be deployed in active policing roles. It may be that institutional re-organisation is sufficient to ensure that the maximum amount of output (policing) is achieved from a given amount of input (human resources). However, it may be the case that long-term plans to increase recruitment are needed, that financial incentives are required to ensure HIV-negative officers are recruited, that suitable candidates are fast-tracked into leadership positions, and that personnel are most appropriately assigned. Depending on the financial circumstances of the nation- but this is changing due to the rise in donor-provision and fall in prices- provision of ARVs for HIV-positive personnel will become an issue; especially balanced against the cost of expanded training. In addition to this, long term policy will need to be made on sick leave, sick pay, medical discharge, compassionate leave, funeral costs and insurance. These decisions, of course, are determined by the financial resources of the nation and the force. None of these issues can be adequately planned for without the basic data, preferably made public, but at least collected specifically for planning.

For the purposes of provoking discussion, this paper is proposing that:

- 1) Collecting national, regular, data on HIV prevalence should be made a priority, and this data should be made public for reasons of promoting public trust and accountability; as well as to benefit from the knowledge and experience of expert bodies and members of the public.
- 2) That status, if testing is made mandatory, not be disclosed to individuals without consent, but that aggregate data be used for planning purposes. Consent opt-out implies a necessary programme of information services to explain and encourage knowing ones' status.

- 3) An audit be made generally for police services, but also internally within police services, of skills that the service requires, what it would mean if the service was to lose a significant number of individuals in possession of these skills, and how the service plans to replace skills lost. Again in the interests of accountability, these should be made public.
- 4) Because police services do engage in sensitive activities, information being distributed on some of these not being in the public interest, to make an alternative audit of services, functions and policies not to be shared with the public in order to protect force integrity.

#### **4. What Measures are Appropriate for Dealing With Officers Who are HIV+? What Can be Learned from Other Uniformed Services and Institutions?**

The AIDS, Security and Conflict Initiative has already presented evidence from Ethiopia and Thailand that militaries in these nations achieved some measure of success in mitigating the effects of HIV/AIDS by recognising and acting early on the epidemic, and by having the leaderships of these militaries personally making the issue a priority.<sup>13</sup> Acting early upon the epidemic allowed these nations to take control of the issue while rates remained low, and to ingrain a culture of openness on HIV/AIDS that provided action, and prevented the issue from disappearing from general view.

One very early, and appropriate, question to ask will be does being HIV+ disqualify one from being a police officer? Openly debating the issues surrounding HIV/AIDS in the police, and promoting defence against HIV/AIDS, does not automatically mean we have answered this question as a negative, and for the reason that we feel that we want to reduce HIV transmission at the same time as promoting the rights and opportunities of people who are HIV+.

There are very good reasons to argue that police officers should be exempt from the norms of positive policy-making on HIV/AIDS; not least because police officers are not fully civilians and for reasons of operational effectiveness police services reserve the right to issue orders to personnel, backed up with the threat of discipline or prosecution should those orders not be carried out. A police service, by logical extension, may exempt itself from employment legislation regarding the chronically sick, just as a military would. Furthermore, a police service can justly claim that their duty to protect the public outweighs any rights of the chronically sick to be treated equally. The counter arguments are that unlike the military, the police force's regular duties do not involve ordering officers, on an ordinary basis, to risk their lives in the pursuit of their duties; and if they ever do need to be ordered in such a way, there is a real qualitative difference between the necessity, likelihood or regularity by which they would do so. This means, therefore, that for pragmatic reasons, police personnel deserve to be treated as civilians would, rather than military personnel, except in exceptional circumstances.

Determining how to build a policy on officers who are HIV positive needs and deserves to be based on solid data. Here, risk assessment criteria used by militaries can provide a model. Mock

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<sup>13</sup> ASCI Issue Paper One: AIDS and the Military, 2005; pp.2-4

et. al.<sup>14</sup> have provided such criteria, and it is useful for these purposes. The framework emphasises two core points; the first that ecological (and they use this term to describe both environmental/medical and social factors) risk factors are important just as individual risk factors are (ie, does an individual choose to expose themselves to risk). The second point is that influences both during and post-conflict need to be compared. This paper argues that conflict (in the sense that Mock et al use it) is not an accurate enough proxy for disorder, and that conflict is moreover a generally short-term phenomena with immediate impacts, where as disorder is a long-term phenomena with slower but deeper impacts.

The framework works like this. Factors that do not really translate well from conflict (affecting militaries) to disorder (affecting police) are shown in bold, with the suggestion that we discount them. Suggested additions to the framework are put in italics.

Non-controlled variables		
	Vulnerability	Ability of a population to withstand shocks
	Hazard Exposure	The ways in which populations mediate their contact, and shared risks, with other populations
	Hazard Opportunity	The ways in which hazards are manifested, and factors that cause this; for disease this is known as a 'vector'
	Risk	The statistical likelihood of a negative event occurring given a fixed set of circumstances
Factors that decrease risk		
	Isolation of communities	This limits the opportunities for HIV to be introduced into a community, or strengthened by new viral strain. It also prevents sexual-culture change
	Increased mortality and morbidity among high-risk groups	This limits the pool of likely already infected, reduces vulnerability, and decreases potential vectors for spread
	<b>Decreased casual sex associated with trauma and depression</b>	<b>Conflict specific</b>
	<b>Disruption of sexual networks</b>	<b>Conflict specific</b>

<sup>14</sup> Mock et al, 2004; ALL

	<i>Socially mediated prevention messages creating sexual-habit change</i>	<i>This is only likely to occur without the presence of conflict, but is not necessarily dependent on the police</i>
	<i>Increased protection of vulnerable persons, especially IDUs and sex workers by legal form and social service provision</i>	<i>This is only likely to occur without the presence of conflict, and will necessarily involve on the police</i>
Factors that increase risk		
	<b>Increased interaction between military and civilians</b>	<b>Conflict specific</b>
	Increased levels of commercial or casual sex	This increases the opportunities for HIV to be transmitted
	Decreased availability of reproductive health and other services	This limits the opportunities for physical and education interventions to prevent transmission of HIV
	<b>Increased malnutrition</b>	<b>Conflict specific (although not only dependent on conflict, it has less direct bearing on police)</b>
	<b>Decreased use of prophylaxis</b>	<b>Little evidence either way as to whether police have an impact</b>
	Increased population mixing	This does not need to be entirely due to conflict; a number of social factors could cause mixing, and would have likely effects on the police.
	Emergence of norms of sexual predation and violence	Although linked with violence and conflict, sexual predation and violence is certainly a police matter!
	<i>Sexual networks (especially exploitative networks) interconnected with police corruption and informal law and order maintenance</i>	Police involvement in managing crime- especially commercial sex work or ID use- by soliciting favours in return for tolerating low(er) levels of such activity
	<i>Greater contact with IDUs as with commercial sex workers above</i>	Greater contact can lead to greater voluntary or involuntary use of risk behaviour

For the purposes of provoking discussion, this paper is proposing that:

- 1) Researchers establish what they can learn from military vectoring studies. Visible and representational analyses of how HIV enters and passes through a cohort of individuals can provide an impetus for action, and a visual case for action. Many of these have been completed within security analyses, and can be adapted for use with the police.
- 2) Police services engage in risk framework analyses for their communities highlighting i) specific risk vectors in the community; ii) changes anticipated in their risk profiles; iii) proposed policing responses to these risk vectors; iv) the help that the police need from the wider community in reducing these vectors.
- 3) Both working with HIV+ colleagues, and planning to minimise HIV risk, be incorporated into basic and senior officer training programmes. The advantage of both ensures that the policy-makers will take the issue seriously; the former is that a culture of HIV awareness, responsibility and planning be instituted at an early stage.

## **5. Does the Police Force Provide Special Training on HIV/AIDS?**

There are three reasons why a police force should provide special training on HIV/AIDS. Firstly it reinforces ownership of HIV/AIDS, and the collective need to address it, within the police force. Secondly, it encourages and promotes leadership on HIV/AIDS at all ranks, and evidence shows repeatedly that leadership in AIDS policymaking is a more important factor than getting the technical details of policymaking right first time<sup>15</sup>. Thirdly, it ensures accountability, by demonstrating to the community that the police serves that HIV prevention is an important activity, that the police are taking responsibility in preventing it, and that the police are doing what they can to decrease it in their ranks.

These are the reasons why training is important, but why do we need to know if the police are providing training? Firstly, the police have a duty of care to their colleagues and members of the public to ensure that in the provision of policing and the maintenance of law and order that they minimise the risks that they expose others to HIV; whether transmitted by them or by a third party. A police officer, therefore, would be expected to be able to identify risks and communicate these to others. Secondly, police have a duty of care to themselves, to maintain their health so that they can carry out their duties: this certainly extends to the responsibility to avoid contracting HIV where possible, to understand the risks of HIV/AIDS, and to avoid stigmatising those living with the disease.

Having established if training occurs, the next step is to establish if it is being used in practice. A variety of techniques can be used here. First of all, surveys can be made of officers to see how much training is recalled, what is adhered to, and which is ignored. In addition to this, impact studies can be made in communities that the police will deal with, in situations where police face exposure to HIV/AIDS, to see whether practice accords with knowledge. Finally, impact

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<sup>15</sup> This was an explicit goal of ASCI

assessments can be made of the communities police officers work in to see if one or both of the police and the general public has had their risk exposure reduced.

The next stage is to ascertain if it is having an effect. A lot of the evidence needed here will be gathered in stage two, but it will require more extensive data collection and the referral to original HIV-prevention strategic goals and formal policies to ascertain if consensual and public goals are being met. After this stage, we logically move onto the analysis of whether training can be improved. Are their specific deficiencies in the training, or is it failing systemically? We also need to review when the training is given, by whom, and in what format. One issue to consider during review is whether a police instructor is the best teacher, given the police hierarchy, or whether an expert instructor will have more credibility.

Finally, and importantly, we need to review whether the training is reaching enough third parties, either by instruction or example by police officers. This will be a difficult stage, but will be necessary if the police take advocacy on HIV/AIDS seriously, and to see its role as more than minimising the police's net contributions to HIV/AIDS. This will need to be done by accessing at-risk populations, as well as the more general public. This would seem to be a good place to encourage some more research. Not only would research findings be important in their own right, they would act as good advocacy for the need for police forces to play an engaged part in HIV-mitigation.

For the purposes of provoking discussion, this paper is proposing that:

- 1) Training on HIV/AIDS be incorporated into basic training for police recruits, management training for senior officers, and be adopted by international police training standards and bodies as being considered an essential part of community awareness and harm-reduction training curricula.
- 2) HIV/AIDS is important enough to be incorporated in its own right into essential training curricula, rather than just as part of general health protection and harm reduction knowledge. This will have the effect in all forces of reinforcing the importance of HIV/AIDS, and the role police forces can play in its minimisation.
- 3) HIV/AIDS awareness training provides a good advocacy tool in minimising risk exposure in its own right, and should be promoted by policing and non-policing communities as a socially desirable activity; even if a police force has low levels of HIV/AIDS, anticipates low risk, and promotes a generally positive approach to HIV management.
- 4) Knowledge of police training can provide useful information on how well stigma and discrimination are being approached, tackled and minimised; and provide a useful insight of how police as a social cohort, and as a key mediator in society, are tackling HIV/AIDS.

## 6. How Can the Police Protect Vulnerable Persons?

Simply, what bureaucratic, legal, and criminal justice reforms can be instituted to enable the police to protect people from HIV/AIDS? Recognition needs to be given to the fact that a number of groups are particularly vulnerable to HIV infection, and among the most are intravenous drug users (IDUs), because of the high chances of HIV transmission by blood transfer, and commercial sex workers because of their large numbers of sexual partners, vulnerability to sexual abuse and violence, and inconsistent adherence to prophylaxis. However, among vulnerable persons, we also need to include those in custody (toward whom the police have a duty of care); children, especially orphans and other especially vulnerable children; the disabled and elderly, who may be targets of abuse; racial minorities, especially refugee and displaced populations not under the care of the UNHCR; and itinerant workers, especially transport and mine workers.

Groups at increased risk of HIV/AIDS will also include those groups particularly stigmatised, including racial minorities, but also homosexuals. Chatterjee<sup>16</sup>, in the *Lancet*, gives an example from India, where for practical reasons laws against homosexuality are only sporadically applied, but that when they are applied this is often for political reasons, to undermine gay organisations from becoming too organised, or to put on a public display of clamping down on immorality. Here, because of a stigmatised sexual culture, and competing desires to both liberalise and tighten laws on sexual morality, Chatterjee argues that the Indian state has only succeeded in confusing the public, rather than decreasing stigma, by passing the Immoral Traffic (Prevention) Amendment Bill, which was initially seen as progressive as it tried to shift the criminal burden away from the sex-worker to the sex-client. However, by shifting the burden to the client (rather than reducing supply) it has had the effect driving sex work underground where already only semi-legal AIDS programmes will find it harder to reach their target populations.

Another example of social stigma contributing to regress on HIV prevention, involving the police can be seen in the aftermath of the Beslan terror incident in the Russian Federation. Joanne Csete<sup>17</sup>, again in the *Lancet*, reports that pursuit of “an unfettered security agenda” led the Russian security services to announce, several weeks after the siege had been so catastrophically resolved, that all of the terrorists involved were drug addicts; despite all terrorists being dead, the autopsy reports not being made public, and no reports made at the time from hostages that the terrorists were using drugs. Csete reports that was a symptomatic tactic of a state that had grown used to demonising drug users, associating them with death and disease, rather than tackling drug dealers or treating (mostly IDU-using) AIDS patients. Csete’s Beslan example illustrates a wider point that anti-terror and security legislation since 9/11 has allowed a proliferation of discrimination and repression against vulnerable and ‘anti-social’ groups, such as IDUs, prostitution and homosexuality, under public order laws that unfairly target persons living with HIV, or engaging in risk behaviours associated with it. This illustrates a wider point that international agencies have largely avoided the controversy of talking about groups criminalised by HIV status. It also shows that police forces aren’t always the best instruments to be used in the social work of HIV prevention.

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<sup>16</sup> Chatterjee, P, 2006; pp.806

<sup>17</sup> Csete, J, 2007; pp.720-721

Policy Project<sup>18</sup> have devised five fundamental policy guidelines within which to analyse HIV-related stigma, and this is instructive for the police in protecting vulnerable persons:

- 1) It is important to collect a strong base of evidence-based knowledge of HIV-related stigma and discrimination, to not only plan responses, but also to keep the issue on the public agenda.
- 2) Applying simultaneous, multi-targeted strategies (such as on HIV and homosexuality) in any given situation. This requires flexibility from public agencies.
- 3) Strategies need to be gender-focused in order to identify the gender-based discrimination apparent or underlying in a given society
- 4) General human rights maintenance needs to be developed and strengthened, and codified where necessary
- 5) Empowering individuals and communities to sustain stigma reductions strategies; so it needs to be grass-roots led

It bears repeating that each of these activities are not only relevant to the police, but by implication compel police by their underlying mandates to tackle both stigma and HIV/AIDS as closely related, and as discreet but interlinked entities in terms of social protection. Indeed, it would be very worthwhile for the purposes of future analyses to review successes that police forces have made in tackling stigma and discrimination as a contributing and complexly-interrelated factor with HIV/AIDS. A good start to review situations where such programmes have learnt from previous successes and failures is in Cathy Cambell's 'Letting Them Die: Why HIV/AIDS Prevention Programmes Fail.'<sup>19</sup> Campbell's studies of mine-workers in Summertown (a pseudonymous South African mining community) make the point that although sex work is illegal in South Africa (and was even more restrictive during Apartheid), communities like Summertown are sustained by the migrant labour and all-male hostels that support, and are supported by, a vibrant sex industry that the police manage and turn a blind-eye to, rather than oppose. Unemployed local men often provide protection to these women, again with the tacit consent of the police. A social contract of sorts is described by Campbell in great depth where public order is maintained by tolerating a certain amount of law breaking in one area, largely because the local police is under-equipped to end the industry, to take on the vested interests of the groups involved, or deal with the unknown negative social and- in this community- economic consequences of ending the trade. The unfortunate result is a self-sustaining, and police-assisted foci of HIV transmission and spread. The fundamental question is raised: what priority will AIDS prevention take if seen to be in opposition to public order or community relations?

For the purposes of provoking discussion, this paper is proposing that:

- 1) In the absence of resources to eradicate HIV/AIDS from police services, and the communities they serve, the management of HIV/AIDS, and its risk behaviours, needs to be taken as seriously within analyses as adopting plans to eradicate HIV/AIDS or eliminate its most pernicious threats. Frameworks that address these management issues are of greater use than reduction strategies.

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<sup>18</sup> Policy Project 2006; ALL

<sup>19</sup> Cambell, 2003; pp.64

- 2) Applying strategies that simultaneously address different risk behaviours, such as drug abuse, and HIV/AIDS, will have more effect than concentrating limited resources into single programmes.
- 3) Gender-focused programmes are needed in recognition of the fact that stigma and discrimination, overtly or covertly, disproportionately affect women compared to men. This means female-centred programming from police services that may often be male-dominated and headed institutions.
- 4) Support for those living with or affected by HIV/AIDS is contingent on the codification of international human rights standards including those in SC Res.1308.

## **7. What Measures are in Place for Women Police Officers and Support Staff Concerning Gender Discrimination and Harassment?**

There has been a concerted focus on women, girls and gender issues in relation to HIV/AIDS as the global epidemic has changed from affecting greater numbers of men to affecting greater numbers of women. Higher relative levels of HIV in IDU populations and in male-dominated economic groups such as transport workers and itinerant workers meant that in the early years of the epidemic, men were the locus of infection, and their behaviours largely determined the vectors of HIV.

This has stopped being the case for some years. As HIV has generalised in populations (that is affecting all groups, not just particularly vulnerable groups, and usually said to be above 5% adult infection), spread of the virus has become overwhelmingly heterosexual in nature. The global burden of HIV/AIDS has been becoming more female over the past decade, disproportionately in Africa, and this has meant that women living with HIV now outnumber men living with HIV. It has been understood since the early stages of the epidemic that HIV was biologically a greater threat to women than to men, because of the greater opportunities for transfer from men to women than from women to men. HIV is also socially a greater threat to women than to men because of gender discrimination, the threat of sexual abuse, and a disproportionate number of women amongst vulnerable groups- including commercial sex workers, refugee and displaced communities, and both the urban and rural poor. "AIDS... exposes women's vulnerability. Both men and women are affected by AIDS, but women particularly so, given how gender relations configure with sexual behaviour and economic security. Gender relations not only underlie women's particular vulnerability; they also inhibit women's attempts to protect themselves and their families"<sup>20</sup>

Violence against women and its' impact on HIV/AIDS is often cited, but poorly understood in the precise mechanics of HIV spread, beyond the fact that the two are complexly linked. As Tlou (2002) points out; "Violence against women is deeply rooted in stereotypical gender beliefs and roles. Physical violence, the threat of violence, and fear of abandonment act as significant barriers

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<sup>20</sup> Baylies in Baylies and Bujra; pp.1

for women who want to negotiate the use of a condom, discuss fidelity with their partners, or leave relationships they perceive to be risky”<sup>21</sup>

As argued previously, the police mediate social influences on HIV/AIDS, and none as clearly as gender influences- whether on sexual violence, discrimination, family and community coping strategies, or access to social, economic or political resources. However, understanding the gender and power issue, we need to turn our attention to the central question of what measures are in place for women police officers concerning gender discrimination? The first thing we need to address is that in many nations, police services will be masculine environments with only a minority of female staff, sometimes not employed in the full range of professions as men. This affects not only the numbers of women represented in a force, but also the numbers of women in senior positions.

How then to address gender discrimination and its impact on AIDS? The first observation to make is that the police service is an example to the wider community, and the best argument to make to senior police officers is that police forces that are representative of the communities they serve may have an easier time engaging with their publics. Think of the hard-won, but generally accepted, consensus in North America and Europe that racial integration into the police is not just an objective in its own right, but is necessary to successfully police racially diverse societies. There is a wider case, therefore, for recruiting more female officers, but there is also specific case for recruiting female officers as an effort to positively police societies with members who are HIV+, and to contribute to the wider effort by governmental authorities to reduce the burden of HIV/AIDS. A primary research objective, therefore, is to determine the extent to which female staffing levels, and gender-sensitive policing strategies, contribute to police services that achieve successes in dealing with HIV/AIDS, and engaging with HIV+ and at-risk populations. The basic parameters of what these studies need to measure needs to be established, and could include some or all of i) levels of HIV incidence in vulnerable women; ii) impact assessments of staffing levels on service provision for vulnerable communities; iii) the effect on levels of HIV incidence in the police service of increased female recruitment; iv) prophylaxis use in police services related to increased female recruitment. Where possible incidence studies are preferable to prevalence studies, but this will be determined by financial restraints and access.

Why is it necessary to know what measures are in place, rather than to assume a force needs to do better? Firstly, it may be that there is redundant capacity to protect female officers. Often there may be significant legislative commitment to gender equality and female empowerment, but it is social conditioning that causes these laws to be ignored or un-enforced. Many nations are signed up to international legal instruments such as the UN Convention on Human Rights, the International Covenants on Civil and Political, and Economic and Social Rights, or the African Union Charter, which promote sexual equality and the compel action on discrimination. The police have an enormous advantage here in advocating for improved gender relations and control of HIV/AIDS in their societies by committing themselves to act on gender discrimination within their own ranks.

Secondly, establishing what measures are in place will demonstrate how these measures are succeeding or failing; it will make the case to advocate for improved measures much easier by

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<sup>21</sup> Tlou in Mboup et al; pp.658

being able to demonstrate how female officers are supposed to be protected but aren't being so. For example, if there is a clear sexual-violence policy within the force, several claims are made, but little disciplinary or investigation action taken, it helps to make this process-failure public, so that officers can advocate for a better replacement.

Thirdly, it will become clear who is responsible for tackling gender-based stigma and discrimination. Ultimately, the responsibility is for every officer; but practically, some will have more power to act- or ability to frustrate- than others. This creates better understanding of the issue, and a stronger case to act. Sometimes, it will remain a complicated issue. One factor rarely discussed, but important, is the indirect, or low-level discrimination against female officers by being primary care-givers, or by needing and taking maternity or child-care leave.<sup>22</sup>

For the purposes of provoking discussion, this paper is proposing that:

- 1) Female officers be recruited in greater numbers not just for reasons of equality, but for reasons of combating HIV/AIDS; by leading within the police a strategy which empowers women, places them at the heart of a community, and emphasises their particular vulnerabilities to HIV/AIDS
- 2) Gender-based violence be put at the heart of any policing strategy on HIV/AIDS. This will require training on identifying and managing the risks to women, protection of vulnerable groups- especially stigmatised groups such as csw's- and tougher legal reform and police response to violence targeted against women and girls.
- 3) Research is needed on women as primary caregivers, how this affects discrimination within police services, recruitment of female officers, and influences the police's role in tackling gender-based discrimination. Of particular concern is on personal and family healthcare offered to female officers in police forces.
- 4) Senior officers commission resource-studies to examine what obligations and opportunities exist to their forces from legislation, legal codes, and international instruments to reduce gender-based discrimination and violence. These should then be used as an advocacy basis for reducing discrimination and violence; with HIV exposure reduction as a core part of this message.

## **8. What is the Country's Law on IDU and Harm Reduction and How is it Enforced?**

Drug use has been intimately associated with HIV/AIDS since it was first identified in 2001; indeed it has been the longest known about, and stigmatised, group in relation to HIV/AIDS apart from homosexual men. As with homosexual men, HIV spread among this population rapidly in the early stages of the European and North American epidemic, reinforcing the notion that HIV was associated with illegal and immoral acts, and that 'social deviancy' was a driver in the spread of the disease.

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<sup>22</sup> Tlou in Mboup et al; pp.659-660

HIV/AIDS has become less intimately associated with drug use in recent years as the epidemic has found convenient social and environmental vectors in the heterosexual networks and behaviours of people, principally in Africa, but also significantly in southern and South-East Asia, as well as the Caribbean and Latin America. This has been accompanied by early understanding in western nations that ID-use was so overwhelmingly more convenient as a vector for HIV<sup>23</sup> than heterosexual contact, and the ID-using community was a clearly definable group, that resources would best be spent by containing the virus within this group by offering testing, counselling, and two most important things: needle-exchanges, and policing strategies that sought to emphasise reducing ID-use and availability, rather than criminalising ID-users (so that addicts would be encouraged to access free services). This has often been cited, although too often generalised, as the most important public health intervention responsible for containing the spread of HIV/AIDS in these nations (although there is significant debate as to which of these interventions actually worked and which just got lucky<sup>24</sup>.)

This brings us back to an earlier point about policing strategies being not about achieving social order objectives, but about being public health strategies in their own right. The success of needle-exchange schemes and targeted interventions was not due just to money. Nor was it due to better medicines- the early-exposure prophylaxis for HIV did not become available even in rich nations until the early-1990s. Nor still was it a matter of political priorities being set early, and courageous, electorally risky political decisions being made (Baldwin describes in length about how political decisions regarding HIV in the early years was tackled more according to public health culture and luck than to political will. It was the ones that were successful that were retrospectively determined to be due to wise decision-making<sup>25</sup>)

Stigma and discrimination against ID-users may be real problems within a police force, but even if progressive mechanisms and policies are in place in police forces to reduce this stigma, and even if they work, the opposition of ID-users who at best may occupy a legal 'grey space' (and at worst may be both criminalised and treated as such), and the police, who are charged with public order which will most often include the reduction of drug use, is apparent. Successful initial ID-user interventions worked not so much because police took on the role of benign actors, but because police forces either made a deliberate decision, or were obliged by circumstances, to act as passive guardians; guaranteeing certain legal protection to ID-users in return for adherence to treatment regimes and needle-exchange.

One example of where 'progressive' policing related to ID-users is in New York City, as recounted in *The Lancet*.<sup>26</sup> Here, the NYPD in one precinct were analysed by the authors using a public health methodology. They found that 'drug crackdowns', visible policing operations against ID-users and suppliers, while successful using police definitions, were certainly not successful in reducing stigma associated with drug use within the community, and actively undermines community relations with the police by being perceived to target all who come to the attention of the police, and not just ID-users. It also had the clear disadvantage by visibly criminalising and selecting for special punishment, those most at risk from HIV/AIDS. Clearly,

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<sup>23</sup> Ordinary Male-Female risk exposure to HIV is 1:200-1:2,000 in heterosexual intercourse with an HIV+ male; needle-stick transfer risk exposure is 1:200, and needle-share exposure 1:150; Barnett and Whiteside, 2006; pp.41

<sup>24</sup> See eg, Baldwin; 2005

<sup>25</sup> Ibid

<sup>26</sup> Cooper et al, 2004; 1109

ID-policing strategies, and HIV/AIDS reduction strategies are complex issues that need clear analysis.

For the purposes of provoking discussion, this paper is proposing that:

- 1) The particular threats related to ID use from HIV/AIDS be clearly mapped and analysed by a police force. Clearly, there will be degrees of magnitude between societies that find high levels of HIV/AIDS within ID users, or high levels within ID users relative to the overall HIV/AIDS burden; and those societies with low levels of HIV/AIDS within ID users, or low levels within ID users relative to the overall HIV/AIDS burden.
- 2) That HIV/AIDS reduction be taken as a more important objective than the prosecution of ID users. This can be done both by increasing services to ID users, and by legal and police reforms of the emphasis placed on the criminal justice targeting of drug suppliers relative to drug users.

## **9. What are the Issues Related to HIV/AIDS Affecting Civilian Police and Staff in Peacekeeping Operations and SSR?**

Civilian police in peacekeeping operations are an important category of personnel we need to look at. Clearly, this is an element of the AIDS-security nexus that we need to accept as a caveat to our rule, if we accept it, that we draw distinct lines between military and police personnel when discussing security and HIV/AIDS. We need to consider that police officers on peacekeeping operations will be removed from their home community, and will be mostly operating within a military professional culture (even one involving police officers in addition to military personnel), two defining features of military personnel that separate them from police officers. However, against this we consider that police personnel are unlikely to serve on UN missions in active war zones- they usually join to maintain law and order, observe peace conditions, to train local police, or to replace police who for reasons of racial, cultural or historical politics are not fully accepted by the communities they work in. In addition to this, police on UN missions are unlikely to be raw recruits as military troops are; often they will be selected for their particular skills or experience, often over a career in policing, or may join the UN policing corps after reaching mandatory or voluntary retirement age in their home forces.

The United Nations estimates that it has 9,602 police personnel out of a total peacekeeping force of 83,783 spread over 19 missions, or roughly 11.5% of the total, as of July 2007.<sup>27</sup> However, it needs to be recognised that large numbers of soldiers are posted on specific missions such as UNIFIL Lebanon (13,539), MONUC DRC (18,368) and UNMIS (Sudan) (10,058) which are clearly military rather than police operations (that is engaging combatants or providing a visible 'buffer' between armed groups, rather than assisting local agencies to maintain law and order). A certain number of missions, UNMIK in Kosovo, UNMIT in East Timor, and UNIOSIL Sierra Leone, for example, have very low numbers of personnel and very high percentages of police,

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<sup>27</sup> UNDPKO, July 2007

and are clearly in post-conflict transitions. What is possibly more important for our analysis is that police personnel serve on 13 out of 18 current UN peacekeeping missions.

There are several issues related to civilian police and related staff on peacekeeping missions.

First, it bears repeating from above that such officers do not police the communities in which they live; which is a generally accepted practice in police forces, unless there are deliberate political reasons to mix police officers across communities as part of a community-integration programme, such as with the Police Service of Northern Ireland (and this was after a long period of ghettoised policing, and the dominance of certain political and religious groups in the police force.) Therefore, we can assume that the epidemiological profile of such an officer cohort will be different to the community that they police. We can also assume that the ordinary sexual culture and norms that integrate police officers into the epidemiological profile of their home communities will be different. These may increase or decrease risk exposure.

Second, peacekeepers have a fairly-well established literature base on their vulnerabilities to HIV/AIDS, relative to the overall AIDS-security literature, because peacekeepers' role in spreading or contracting HIV has been an important international political issue.<sup>28</sup> Simply put, peacekeepers have at various times been accused of spreading HIV in host populations, and being at risk of contracting HIV from host populations. For obvious reasons the politics surrounding these issues is intense. Fear of exposing your military to HIV infection can and has been used as a reason to prevent deployment on UN and UN-mandated peacekeeping mission, to deploy your troops on separately-commanded and billeted missions, and to accuse other nations of deliberately inviting harm to your military personnel. The issue has been important to the UN, the African Union and to NATO in determining how to encourage their members to contribute personnel to peacekeeping operations; and it is not an exaggeration to say that it can make the difference to whether nations commit troops or not. Police will not be immune from these high (and low) political issues.

Third, police on peacekeeping missions are an important constituency to understand as they are likely to actually be somewhat different to ordinary police officers, and the comparisons may prove useful. Principally, police officers on peace-keeping missions are likely to be somewhat older than either their domestic colleagues, or peacekeeping troops. If older men (and there is no reason they need to be men), they are likely to be of reduced risk of contracting HIV due to their likely lifestyle; and if older too they are less likely to come to the mission whilst HIV positive (regardless of whether tested or not), as they would be likely to have developed HIV at a younger age. Furthermore, older officers are likely to be senior officers, especially if they serve in an advisory capacity to train or plan for indigenous services. Socio-economic status would determine these officers to be lower statistical risk.

Fourth, the methodological problem of whether to include police on peacekeeping missions as within the police or not, is actually balanced out by the methodological advantage of such groups in that they fall neater into risk-prevention and protection strategies that have largely been developed for military groups. Therefore, in research terms, there are certainly cases to be made that the best place to analyse police on peacekeeping missions is within police frameworks.

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<sup>28</sup> Roderick, 2006; pp.56

One obvious difference between police and those on peacekeeping missions is that whatever the effect of conflict on the spread of HIV, the effect of conflict on the breakdown in normal health systems is apparent and obvious. Therefore, no matter what the state of the health systems affecting the job of police officers in their home nations, we can generally say that if it wasn't for the presence of the conflict in the host nation, healthcare systems in the nation would likely be far better in the absence of conflict. One important issue here is the status of epidemiological surveillance systems. These are important as they act as the basis for which public health can be planned, resources allocated, and priorities made for which groups get what. Despite the relatively high levels of healthcare that may be offered to personnel on peacekeeping missions, these advantages could be offset by an officer being in an environment where disease protection and risk-management are much harder to assess than their home community.

**Lessons learned from HIV/AIDS prevention in the UNMEE intervention in Eritrea**

- 1) Use a peer to peer approach. Military personnel responded best to military personnel- it adds credibility and there is respect for hierarchy and rank. Especially useful in multi-national forces.
- 2) Link up with the national army and other local stakeholders
- 3) Institutionalise, by establishing a planning and consultative mechanism early on
- 4) Participation of all essential
- 5) Use DPKO/UNAIDS leadership
- 6) Involve commanders
- 7) Plan for rotation
- 8) Involve trainers
- 9) Encourage VCT
- 10) Consider religions and cultures
- 11) Enforce action plans
- 12) Include gender issues
- 13) Develop a training manual
- 14) Use trained peer educators to train peacekeepers

**From 'HIV/AIDS prevention and care among armed forces and UN peacekeepers: The Case of Eritrea'; UNAIDS, 2003<sup>29</sup>**

For the purposes of provoking discussion, this paper is proposing that:

- 1) Civilian police personnel on peacekeeping missions be specifically counted as police personnel for the purposes of analysis, rather than as military personnel, due to the very different characteristics that these personnel, and their missions, will take on.
- 2) For the purposes of research, and to develop the evidence base, it is a useful activity to encourage analyses of police personnel on peacekeeping operations, due to the broader literature base in this area which can be built upon. This does not discount such analyses, however, from being treated with the appropriate care and scepticism when the literature makes non-empirical and non-evidence-based assertions.

<sup>29</sup> HIV/AIDS prevention and care among armed forces and UN peacekeepers: 'The Case of Eritrea', UNAIDS, 2003; pp.30-32

- 3) The advantage that can be taken from police personnel in peacekeeping operations is that they will be experience personnel, will be lower-risk individuals, and will have greater credibility in promoting risk-reduction strategies than their military colleagues. HIV/AIDS planners should use this advantage.

## **10. Research Methodologies: Challenges, Problems and Solutions**

This paper does not claim to be an extensive guide to research methodologies for HIV/AIDS and the police, nor does it claim to yet know which methodologies are most profitable. What it can do is to lay out the issues, and these result in a number of challenges, problems and (hopefully) solutions for future research.

### Challenges

1) Defining a methodology that acknowledges the debt to security, but does not become captive to it. The security literature can provide good direct and indirect examples of research objectives methods, and applied well these can be of use to police researchers using a smaller evidence base. However, problems exist in both the reliability of some of the security literature, and in assuming that the literature can be applied wholesale to the police. As shown, there are major differences between militaries and police forces, not least in location relative to home community, length of service and age of personnel, approach to risk-management, and functional purpose of service.

2) Coming up with a definitive list of threats, protections and strategies for police. This paper is not a full list, nor has it come across a full list that is unimpeachable. The challenge is that problems may exist contingent on local, universal or contextual factors. Only more and better research can develop such a list, and it needs to be emphasised that a framework for constructing solutions to threats needs to be produced in the same process as that for a framework to observe threats. The next logical step for research, after such frameworks are developed and refined, is developing an early-warning system to identify, and strategise for future risks.

3) Engaging with police. Although largely absent from the literature, the experience of Justice Africa researchers has been that researching among police forces can be problematic. Hierarchy structures mean that consent to speak to rank-and-file officers, and what to talk to them about, is dependent upon senior officers; and when consent is given, information may not be felt to be easily given. Talking only to senior officers may increase confidence that what is said goes for the service's policy, but these officers are unlikely to have a ground-level of the situation. The challenge is how to obtain the maximum amount of information whilst retaining the police's consent and trust.

4) Balancing the protection of the police and the protection of the population. This is perhaps the hardest challenge for research, and coming up with credible answers to this dilemma may prove to be the difference between whether research is taken seriously or not. Social research, by definition, is seen to be of use when applied to social problems. The problem to be solved by this research is can both the police and a population be protected from HIV/AIDS at the same time?

Many would claim that both can, and have to be protected. Research that loses sight of the need to address both, risks losing applicability and legitimacy

### Problems

1) Is this the police's problem? One problem faced is intellectual and bureaucratic resistance to such work, and the inevitable posing of this question. The question, however, has more credibility that it appears. A logical, and legitimate, response to all the questions raised here is that HIV/AIDS is a health problem, not because the police have no moral responsibility for HIV/AIDS, but because they are neither structurally nor practically equipped to deal with such issues, and dedication of resources to the problem is both a waste and an undermining of the necessary efforts by the healthcare sector. A better case than just a moral one needs to be made to persuade police officers to act.

2) Police culture seeks to close down, not encourage research. Justice Africa researchers have discovered that police cultures are not the best environments to encourage research. Both a rigid structural organisation, and a widely held fear that such research will undermine public trust in the police, contribute to research being frustrated and discouraged. Any strategies for research within police services needs to look carefully at engagement with the police service involved, including being willing to hear conditions and requirements that police services might have. The problem remains of convincing police services to welcome research as useful in pursuing their own professional objectives, as well as being useful activities in their own right.

3) Stigma will always create more problems than the police can solve. This probably sounds obvious, but it bears repeating that stigma towards certain groups or individuals exist in all societies. The challenge is not to remove all stigma and discrimination forever- that would be utopian- but to manage it at levels at which it does not become socially destructive, and nor do the police have to achieve equality by force. It is, at heart, a policing issue; the management of social phenomena at levels at which they are not socially destructive.

4) Data collection. Planning for HIV/AIDS within police services can only be achieved based on the production of accurate data on which threats can be assessed and opportunities can be identified. This data simply does not exist in sufficient quantities, and neither is it extensive enough to be able to draw conclusions based on differences in epidemiological profile, population structure, socio-economic indicators, or police capacity. Sustained deficiency in data collection and presentation will have effect not only in poor planning and policy-making, but will also hinder the capacity to advocate on the needs to protect people against HIV/AIDS.

### Solutions

1) Whilst taking note of necessary precautions in using this literature, there is an in-built advantage that police planners can take from the security literature. This is that the structure of a highly hierarchical organisation such as a police service offers certain advantages in defending itself against HIV/AIDS. First of all, the police, as militaries do, have an interest in maintaining personnel fitness. HIV morbidity is a threat to force fitness. The Ethiopian army also found that the advantages of an order-giving and taking organisation, and the reprisals for non-adherence to this system, have an in-built effective system of command-flows. As stated earlier, police officers

are not going to be ordered to risk their lives to achieve an objective no matter the cost. But the point is that police officers may be ordered to assess the risk of an objective, and then proceed on the assumption that they will take that risk if they feel they can manage it. This command system, with in-built redundancy, can be used to tackle HIV/AIDS, both by the formalised command flows that can be utilised, and by the authority with which orders will be taken.

2) As with any organisation assessing the financial costs of new programmes, advocates for HIV-control in the police can make the valid case that planning for HIV/AIDS, and managing its effects, will likely be far cheaper and easier than not planning and then finding a problem exists. In the police, the costs of recruitment, training, and pensions and medical care invoked by HIV/AIDS are likely to be more than offset by the savings made by training personnel in risk management and treating vulnerable groups; not to mention the costs mitigated by contributing to HIV/AIDS prevention in wider society, the costs of failing coming directly back to the police. Making the case, therefore, that savings can be made by openness on HIV/AIDS should be a good way to engage with policy-makers.

3) Emphasise policing strategies as wider AIDS control strategies. Fundamentally, the police can not be divorced from the communities in which they work. High rates of infection, and wider social problems related to HIV/AIDS, will affect the police and how they do their job, regardless of infection rates in the police themselves. As part of a state-led response to HIV/AIDS, police services can play an important part by mediating between groups, and protecting the most vulnerable, by demonstrating a positive face that attempts to minimise stigma, and is open about its own experiences of HIV/AIDS.

4) Use police forces' training advantage. One clear advantage that police services have over other groups, particularly other public bodies, is a clear and refined training regime both for initial deployment, and throughout a police career. This means that training on minimising risk exposure and protecting vulnerable persons can be, and is, inbuilt into a police officers professional culture- particularly if emphasised as a responsibility of the job, rather than just as an afterthought. Research is very much needed on how HIV/AIDS is incorporated into training curricula, and the effects this has on risk management and stigma reduction.

## **11. Agenda-Setting for Research on HIV/AIDS and Policing**

How, then, to set a research agenda for HIV/AIDS and policing? This is very much where this background paper needs to pass over to the conference participants. This would seem a good point to note that there is a difference between priorities and prioritising. Because HIV/AIDS and policing programmes- as with all HIV/AIDS programmes- will never have too many resources, nor a self-confidence that they have all the evidence they are ever going to need, knowing that priorities not only exist, but need to be set is a point worth making.

Several sources can be consulted here as a basis for setting such an agenda. The ones drawn upon here are Barnett and Prins (2005)<sup>30</sup>; Masuku (2007)<sup>31</sup>, and the UN Inter-Agency Standing Committee Guidelines for Interventions in Emergency Settings.<sup>32</sup>

- 1) Establish an integrated surveillance system for recording rates of HIV/AIDS in police services globally
- 2) Establish a database of the demographic structure of police services, experiences with anti-retroviral medications, terms of access for personnel and families, and policies related to recruitment, testing, treatment and care.
- 3) Produce research on the integration of prevention, diagnostic, treatment and care services for households and families of police personnel, paying particular attention to gender issues.
- 4) Comparative studies of police services between nations, as well as derived-studies within police service.
- 5) Ethnographic studies of police officers within peacekeeping operations
- 6) Testing the hypothesis that isolation of groups may reduce rates of transmission, and the implications for police services
- 7) Examining the link between training and sexual risk exposure in police services
- 8) Analysis of the role of HIV in staffing levels for strategic policing objectives, and overall crime prevention activities
- 9) Implications for HIV/AIDS in contributions of policing personnel to international peacekeeping operations.
- 10) Attempting to understand which police practises increase risk. These are by no means entire elucidated or apparent
- 11) Analysis of existing policing HIV/AIDS strategies, and as time progresses, assessing goals that have not been met
- 12) Advocating for HIV/AIDS indicators to be included in strategic set for and by senior police officers
- 13) How best to encourage voluntary counselling and testing
- 14) Investigating certain human resource issues, and keeping consistent data on especially the rates and effects of absenteeism, the numbers of early retirees on health grounds, and death rates
- 15) Capacity of research needs to grow; this means police, social service, and academic research departments need to be invested in

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<sup>30</sup> Barnett and Prins, 2003; pp.38

<sup>31</sup> Masuku 2007a

<sup>32</sup> UN Inter-Agency Standing Committee Guidelines for Interventions in Emergency Settings (pub.?): pp.8-9

## Annex 1: Terms Used in the Document

These are by no means standardised linguistic conventions. They are just the way they are used here.

**AIDS (Acquired or Auto-Immune Deficiency Syndrome):** An inter-related set of chronic illnesses related to immune-deficiency that develops in an individual living with HIV. Diagnosis of AIDS is complex, but is often characterised by the presence of opportunistic infections and sarcomas, and a level in a specific blood-cell that coordinates immune-response at 80-90% below regular adult levels. The ‘Acquired’ means that it is actively, rather than passively, contracted to an individual by engaging in certain behaviours.

**Anti-Retroviral Therapy (ARV):** The combination of medications given to persons living with HIV, given to slow viral-replication, and support the immune-system. The medications and associated supplements can often be quite complicated in their combinations; the most well-known drug is Zinovudine (AZT), which is one of the components of Triple Combination Therapy

**Gender-Based Discrimination or Violence:** This is discrimination- the denial of access to goods or services, or to participation- or violence- the application of physical or psychological force, or the withholding of the relief of such- that is based upon the gender of the individual. It may be applied by a person, a group of persons, or be said to be socially-conditioned.

**HIV (Human Immuno-deficiency Virus):** The pathogenic agent that cause AIDS. HIV survives in the human body by targeting the cells that co-ordinate immune-response as a food source. It avoids the immune-system’s attempts to kill it rapidly mutating to avoid detection. HIV is transmitted by the intermixing of bodily fluids only, with certain behaviours- such as blood transfers- providing far greater opportunity for transfer than others- such as sexual intercourse.

**HIV Positive:** This is the status of being infected with HIV, detected by an antibody test. An HIV test is usually only reliable 6-8 weeks after first infection, and for confirmation should be followed by a further test after several more weeks. HIV detection tests have become more sensitive and easier to administer, however their complexity and awkwardness has been accused of creating false positives. Hence the need for a second test.

**Military:** For the purposes of this paper, a definition of military personnel is taken to include any individual performing a role as a troop in a unit charged with national security and the deterrence of threats against the state by means of organised violence; usually uniformed and identified as such. It includes soldiers on peacekeeping missions, even those on post-conflict ‘policing missions’ who have not passed on their duties to police personnel, and who are quartered as military personnel.

**Police:** For the purposes of this paper, a definition of police is taken to include any individual uniformed or credentialed as an agent charged with the prevention of crime and the promotion of public order. For the purposes of precision, it does not include gendarmerie, presidential or ‘special units’, or other groups that display behaviours or professional roles more akin to soldiers.

It does, however, include police on international peacekeeping missions unless such personnel are only observers on clearly military operations.

**Stigma:** The holding of negative views- that may or may not lead to discrimination- of an individual or group based on status. Status may include ethnicity, age, sex, wealth, refugee-status, disability or HIV-status, and such.

**Vector:** A vector is a route by which a pathogenic agent is transmitted. For some diseases this will be by sharing normal contact- by breathing, sharing water or food. These are known as contagious diseases. HIV is not a contagious disease, it is passed on by contaminated bodily fluids, and thus is only transmitted by vectors such as by dirty syringes, blood transfusions and sexual intercourse. The vectors for HIV, importantly, are all socially conditioned.

## Annex 2: Problems With Applying a Security Framework to HIV/AIDS and Policing

Problem	Description
Definition	Conflict is not a synonym for disorder; and neither are the very complex social effects of conflict entirely equivalent to the very complex social effects of disorder. There is a danger that analyses will not compare 'like-for-like'.
Time	Conflict has exceptionally traumatic, but often time-limited, effects. Disorder provides effects that, while perhaps less immediately traumatic, can be longer-term, deeper and more attritional.
Location	Military recruits are likely to be taken from their home communities at a young age and inducted into a fixed and idiosyncratic professional culture. Police recruits are more likely to be slightly older, to be part of a professional culture but display domestic routines more akin to civilians, particularly by being more likely to live in their own homes, and with the rise of community policing strategies in many nations, are less likely to be removed from their home communities and social cultures for extended periods of time
Role	While militaries and police exist within a broad security 'nexus', professional roles at the individual level are very different. A typical soldier will be trained in warfare, be a young recruit, be isolated from their family and community, and be integrated into a rigid hierarchy enforced by a rigid code of discipline. A typical police officer will be trained in public order, may therefore be better educated than a typical military recruit, and is more likely to be female and posted in their home community. Basic length of service, too, will be longer in police services.
Function	Militaries exist to deter violence directed against the state, principally from external threats, but also if necessary from internal ones. Police forces exist to maintain public order almost exclusively from internal threats, so as to minimise the risk of violence occurring, either from within society and directed at the state or within society itself.

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