

HIV among Drug Users in Poland:

The Paradoxes of an Epidemic

Kasia Malinowska-Sempruch

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ABSTRACT

HIV Among Drug Users in Poland: Paradoxes of an Epidemic

Kasia Malinowska-Sempruch

Since 1988 when the first HIV positive drug user was identified in Poland, for close to two decades, the predominant route of HIV transmission has been through injecting drug use. In mid 2000s, Polish officials reported that injecting drug use no longer contributed to increasing HIV incidence. The consequences of such a statement are that many of the structural and personal risks associated with HIV infection go unaddressed, that drug users are neglected by HIV prevention efforts, that HIV treatment is not made available to drug users and that the policy environment does not adequately support effective public health initiatives.

This case study is based on documentation, archival records, interviews, participant observation, and physical artifacts shows that these assertions were made, and continue to be repeated, in a highly political context. Poland is a post-socialist state with strong neoliberal leanings, and it is highly invested in successful integration with the European Union. Powerful Catholic Church serves as an important backdrop. While people considered “at risk” now have more freedom to conduct their lives, they also have a set of neoliberal expectations and religious pressures placed on them. Country’s geographic location adds to this complexity – situated between “Old Europe” where HIV problem has been successfully contained and the former Soviet Union, where the HIV incidence among drug users is the highest in the world, Poland attempts to align itself with the success of the West. Furthermore, examination of the available data suggests that the assertions made by Polish officials omit numerous variables.

My research shows that even though Polish leadership in the area of HIV and drug policy wishes to resemble Western Europe, Poland does not meet international standards for the prevention of HIV transmission. The interviews I conducted, as well as the review of the literature on drug and HIV policies and programs suggest that these services are scattered, often unavailable, and that their number is stagnating, at best, and in some cases, even decreasing. This maybe a direct result of lack of engagement of drug users in their design. Excluded from the discussion of risk, drug users are thus not the focus of prevention efforts.

Based on gathered data, there are seven crucial issues that require immediate action if Poland is to manage HIV prevention and care for people who use drugs in a manner consistent with the international standards. The areas requiring action are: a change in the drug policy from the current very punitive approach, expansion of needle and syringe programs and other harm reduction services, improved data collection and an increase in the availability of HIV testing, scaled-up substitution treatment, improved quality of other forms of drug treatment, greater investment in civil society organizations, improved access to HIV treatment, and educational and training efforts that encourage greater attention to HIV related matters across disciplines.

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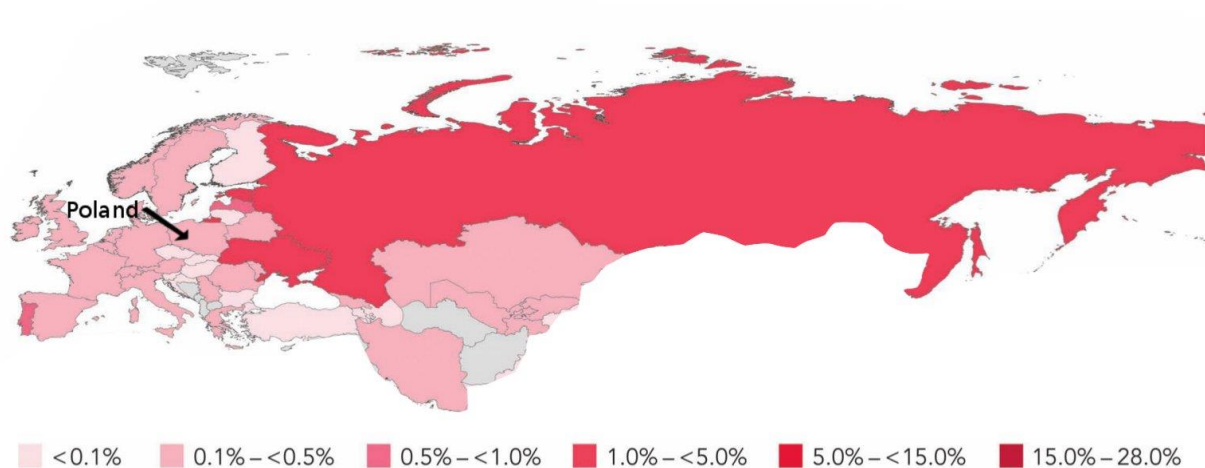
Chapter One: Introduction -- The End of HIV Infections For Drug Users in Poland?

In 2006, at a meeting at the Polish Parliament, the director of the National AIDS Center reported that injecting drug use no longer contributed to the HIV and AIDS crisis in Poland. Two years later, the Director of Poland's National Bureau for Drug Prevention reiterated this assertion. This assumption is highly significant to the epidemic as a whole because, since 1988 when the first HIV positive drug user was identified, the predominant route of HIV infection in Poland has been through injecting drug use. The consequences of such a statement by Poland's drug and HIV policy leadership are that many of the structural and personal risks associated with HIV infection go unaddressed, that the focus is removed from injecting drug use as a factor leading to HIV infection, that drug users are subsequently neglected by HIV prevention efforts, that HIV treatment is not made available to drug users and that the policy environment does not adequately support effective public health initiatives.

My research shows that these assertions were made, and continue to be repeated, in a highly political context. Poland is a post-socialist state with strong neoliberal leanings, and it is highly invested in successful integration with the European Union. Powerful Catholic Church serves as an important backdrop. Furthermore, similarly to other parts of the world and regardless of political period, drug use and HIV have been viewed and responded to with a political agenda. Country's geographic location adds to this complexity – situated between “Old Europe” where

HIV problem has been successfully contained and the former Soviet Union, where the HIV incidence among drug users is the highest in the world, Poland attempts to align itself with the success of the West.

Figure 1. HIV Prevalence in Europe and former Soviet Union (UNAIDS, 2013)



Furthermore, my research shows that even though Polish leadership in the area of HIV and drug policy wishes to resemble Western Europe, Poland does not meet international standards for the prevention of HIV transmission. Availability of services and their quality are closely aligned with the political context – humiliation of patients as a tool of “treatment” in abstinence centers, as well as very high threshold opioid substitution serve as powerful examples. The interviews I conducted, as well as the review of the literature on drug and HIV policies and programs suggest that these services are scattered, often unavailable, and that their number is stagnating, at best, and in some cases, even decreasing. This maybe a direct result of lack of engagement of drug

users in their design even though elsewhere, the literature shows that involving persons who use illicit drugs in discussions about relevant interventions has been instrumental in controlling the HIV epidemic (Friedman, 2007). As Outlined by Parker (2000b) and Degenhardt (2010) the national and local politics and policies contribute to the structural risk, especially in area of drug policy. Farmer suggests that the war on drugs is one of the newer ruses for managing inequality and criminalizing poverty (2005).

Neither Poland's drug nor HIV policies acknowledge that the resources that determine the extent to which people are able to avoid risk are, in fact, fundamental social cause of disease (Link, 1995). Instead, the limited discourse that exists is focused on controlling risk factors at the level of the individual, and emphasizing personal responsibility. With politics increasingly focusing on "law and order" paradigm, the few services that are still available are increasingly hostile towards public health goals. As explained by one of my interviewees, "In the narrative of the Polish HIV epidemic, drug users are the voiceless actors. They make every effort to disappear from public view. One has to make a conscious effort to want to see them. There are no active users in Poland complaining about the lack of services." Excluded from the discussion of risk, drug users are thus not the focus of prevention efforts.

Several international guidelines¹ on drug use related matters discuss the public health interventions and policy context required for effective HIV prevention. These guidelines suggest that the following components are necessary for successful national HIV prevention efforts among people who use drugs: needle and syringe distribution and/or exchange; outreach services such as condom and other paraphernalia distribution; provision of STI and other disease screening and treatment; referrals to or direct provision of housing, food and clothing; substitution treatment; other evidence-based drug treatment; HIV testing and treatment, and overdose prevention. All of these interventions must be multilayered and properly funded. They must also be delivered in a non-punitive policy environment that emphasizes public health rather than criminal justice since it is widely recognized that the fundamental social causes of a disease determine the extent to which people are able to avoid risk (Link, 1995).

Data from numerous international studies demonstrates that the rate of HIV transmission has decreased as the result of concerted efforts (Parker, 2000b; EMCDDA, 2011), many of which aim to empower people at risk. Global HIV prevention efforts frequently adopted strategies focused both on upstream factors, for example access to HIV medicines and targeted media

WHO/UNODC/UNAIDS position paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention; Joint UNAIDS statement on HIV Prevention and Care Strategies for Drug Users; UNODC/WHO discussion paper – Principles of Drug Dependence Treatment; WHO, UNODC, UNAIDS, Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users; EMCDDA¹

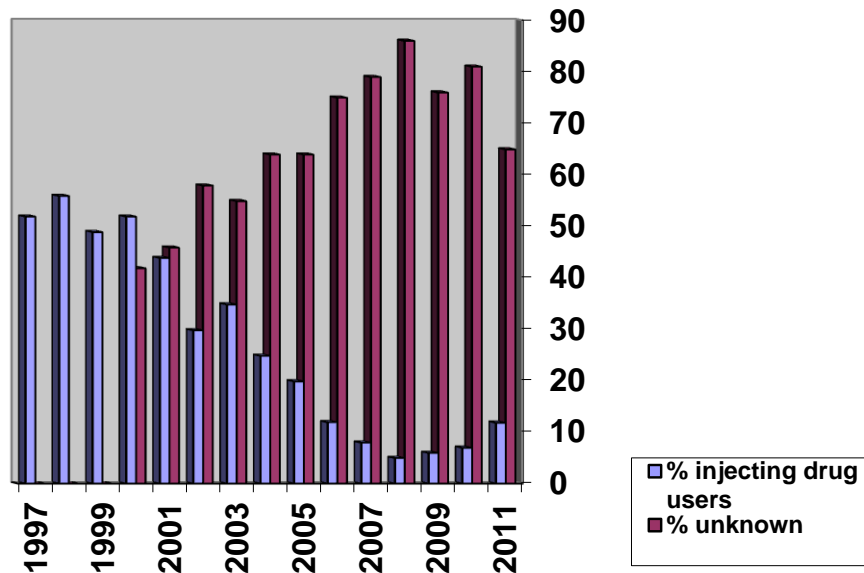
campaigns, and downstream factors such as needle exchange. Addressing all of these influences maximizes a person's chances of reaching his or her highest attainable standard of health (Koh, 2010). Similarly, the international guidelines emphasize that countries that have piloted prevention services, but have not taken them to scale, have not been successful in containing HIV infection rates (Hunt, 2003; Rehm, 2003; Reference Group, 2010). Since pilot programs have no effect on structural risks, the guidelines stipulate that services should be widely available to all drug users who may need them.

Preliminary examination of the available data on HIV in Poland suggests that the assertions made by Polish officials in 2006 concerning the end of the drug-related HIV epidemic omit numerous variables. Furthermore, multiple and mutually reinforcing explanations were offered by a number of persons I interviewed, often citing politically conservative, law enforcement focused and catholic backdrop of the country as reasons for misinterpretation of data by the government. It is interesting to notice that Poland's struggle with HIV very much mimics the current international discourse and pressure for success as evidenced by the global UNADS 2011-2015 strategy of "Getting to Zero" (2010) as well as "Treatment 2015" (2012). In both of these documents, drug users are for most part, unattended in global prevention and care efforts. As shared in correspondence with one of its members, UNAIDS Reference Group on HIV and Human Rights offered the following analysis of "Treatment 2015" strategy: "UNAIDS, and particularly the Secretariat, has to be much more balanced between achievements/"end of AIDS" messages and the very hard issues that need to be, and are not being, addressed as we move forward". The group goes on to talk about the need to better address unjust application of criminal law and its consequences as a major barrier to testing and treatment access in many

parts of the world. In similar spirit, a recent analysis as to what has been achieved in HIV prevention, treatment and care for people who inject drugs between 2010-2012 concludes: “As long as law enforcement responses counter public health responses, health-seeking behaviour and health service delivery will be limited’ (Degenhardt, 2013).

In this context of multiple political interests, it is increasingly difficult analyze and understand HIV and drugs data. From 1999 to 2004, out of 3,561 newly detected HIV infections reported through the routine surveillance system in Poland, injecting drug use was the most common transmission route, accounting for 78.6% of registered infections (Rosinska, 2006). After 2004, and each year subsequently, the proportion of newly reported infections attributed to drug users decreased. At the same time, as reported by the Polish Public Health Institute, there is a notable trend in the increasing proportion of new infections identified as having an “Unknown” route of transmission (Figure 2). This trend in the use of “Unknown” has likely disguised the number of new infections transmitted through drug use thus influencing the understanding of government officials.

Figure 2. Routes of Transmission For New HIV Infections, as a Proportion of the Total



Though the Directors of Poland's National AIDS Center and National Bureau for Drug Prevention have stated publicly that injecting drug use no longer contributes to the HIV and AIDS crisis in Poland, there is little evidence that this is accurate. In my dissertation I will endeavor to show why this assessment is flawed. I will also identify the consequences of structuring policy around unconfirmed assumptions and a lack of accurate data as to the true extent of the epidemic in Poland. Since its inception, the predominant route of HIV infection in Poland has been through injecting drug use. HIV is still transmitted through injecting drug use. The consequence of assuming otherwise is that many of the structural and personal risks associated with HIV infection are not addressed. To successfully prevent HIV transmission in Poland it is necessary to support effective and appropriately scaled public health initiatives. Unless Poland responds to the fact that HIV continues to be transmitted through injecting drug

use with such initiatives as needle and syringe distribution and/or exchange and substitution treatment on a wide scale, it will fail to successfully prevent HIV transmission and will follow the trend recently observed in Europe, of countries such as Greece and Romania, with a significant increase of HIV incidence among drug users,

In support of my hypothesis, my dissertation will review the history of drug and AIDS policies in Poland, drug and HIV prevention efforts, and the delivery of services to people who are living with HIV and who use drugs. I will also analyze the social, historical, religious and political context that contributes to the structural risk. Finally, I will offer recommendations for improvements to current policy and service delivery that are consistent with international evidence and standards for effective drug and HIV policy and respond to structural vulnerabilities through approaches that modify social norms, institutions, and laws to reduce vulnerability and create environments in which individuals can protect themselves against HIV infection (Auerbach, 2009).

The Historical, Political, and Social Context of the HIV Epidemic in Central and Eastern Europe

The epidemic in Poland is best understood with a grasp of the regional context. Eastern Europe experienced the HIV epidemic later than most of the world. Its arrival in the region was concurrent with the dramatic political and economic changes that took place during the late 1980s and early 1990s: the fall of the Berlin Wall, the shift from socialism to democracy and free market economies, and the dismantling of the Soviet Union.

All of these factors resulted in major changes to the political culture and the institutions responsible for addressing health and social services as well as to the way citizens related to these institutions and to each other. Throughout the region, strong states that held great control over their citizens in all spheres of life, including public health, were swiftly transforming. Poland's former minister of economics identified the following symptoms of a newly emerged "soft" Polish state: legislative problems, deficits in the rule of law, increasing corruption, use of political power to serve special interests, inefficient public spending, poor performance of public servants, and delayed implementation of reforms that support social justice (Hausner, 2007).

By the time sub-Saharan Africa, parts of Asia, North America and Western Europe had already detected sizable HIV epidemics in the late 1980s, Eastern Europe had reported only a few HIV cases. Seven Eastern and Central European countries - Albania, Bulgaria, Czechoslovakia, Hungary, Poland, Romania, and Yugoslavia - reported a total of 1,704 AIDS cases, out of a total of 48,144 reported for all 31 nations of Europe (WHO, 1991).

Consistent with fundamental social causes theory, the risk of HIV transmission, similar to other infections facilitated by human behavior, is greatly shaped by the environment in which it occurs (Reid, 1992; Farmer, 1996; Rhodes, 2005). Although the World Health Organization (WHO) attempted to bring attention to the prevalence of risk associated with HIV transmission that was present in Eastern Europe, little notice was paid. During its fifth meeting in November 1989, the Management Committee of WHO's Global Programme on AIDS expressed concern over the

factors that could lead to the spread of HIV in Eastern Europe; the opening of borders and liberalization of travel could expose previously secluded populations to contact with communities where HIV had been present for some time; an increase in unemployment and migration resulting from the political and economic alterations could lead to changes in attitudes and practices, resulting in further exposure to HIV; and an increase in sex work with the introduction of free market economies (WHO, 1990). The overall lack of social and economic stability and increased access to illicit substances increased rates of drug use across the region. Interestingly, drug use related risks were not identified by the WHO, nor anyone else, as a mode of transmission that could increase the risk of HIV transmission in Eastern Europe.

With the political and economic reorientation from socialism to democracy and the arrival of a neoliberal philosophy with a newly established free market economy, the social services systems in the region came under severe financial pressure. The public health programs that were still in place, typically called “The Sanitation and Epidemiology Departments,” were based on the Soviet model of public control. As the countries in the region gradually moved away from socialism to democracy, the Soviet model was perceived with increasing mistrust. Consistent with Nathanson’s findings (2007), and even more so in this time of dramatic political change and scarce economic resources, public health held a low position within the ministerial hierarchy. It was in this political context, and within these structures, that the National AIDS Center and the National Bureau for Drug Prevention were created in Poland.

While governments and economies were restructuring, the Catholic Church was gaining authority throughout the region, especially in Poland, which considered Pope John Paul II, a fellow Pole, to be its most influential leader. Mr. Kazimierz Kapera, Poland's Vice-Minister of Health, declared that, "A morally sane life is a one hundred percent guarantee that one will not contract the fatal disease" (Hendriks, 1991). According to a ministerial staff member holding a public health post at the time, the spirit of prevention efforts was consistent with the aforementioned philosophy. She gave an example of outreach to college students at campuses in the North, in Szczecin. Prevention efforts there consisted of persuading students to handwrite a pledge that they would not engage in sexual activity. The collected statements were then provided to the Ministry. Minister Kapera's declaration was quickly followed by a statement from the Primate of Poland, Cardinal Glemp, who asserted that sin was the main means of HIV transmission. Many Eastern Europeans, indoctrinated to believe that the disease was a horror of capitalism and would pass them by, had a hard time accepting the realities of the problem. "The roots of [HIV] transmission are the American and Western way of life, unrestrained and flourishing homosexuality, drugs and an obsession with sex," explained one Soviet official (Eistein, 1990). "The key to early and effective public health action by the state is that action be embraced by the holders of political power," states Nathanson in her study of the harm reduction policies in four industrialized countries (2007). In Central and Eastern Europe this did not occur in relation to HIV prevention, particularly among injecting drug users. This still holds true for most of the post-Soviet region, with a few exceptions of Slovenia and the Czech Republic (Csete, 2012). In Czech Republic, a government made a remarkable decision to invest in a large-scale, rigorous research project to evaluate the impact of the drug law and based on its

outcomes -- that tough, expensive enforcement did not decrease use prevalence, produced the current progressive policies.

Figure 3. Map of Europe



In 1990, three countries in the region showed worrisome signs of increasing HIV incidence: Poland reported 1,178 HIV infections, Yugoslavia reported 2,023 HIV infections, and Romania reported 1,436 cases of AIDS (WHO, 1991). Note that the first HIV cases in these countries were detected in 1985 and 1986. Poland and Yugoslavia shared a common profile of new infections: drug users living in urban centers were at the epicenter of the epidemics. The profile

of the epidemic in Romania was quite different where hundreds of children living in orphanages, a side effect of Romania's anti-family planning and anti-abortion policies, were infected through medically questionable procedures. Ill children in various institutions and hospitals were injected with blood to improve their health. Also, needles and syringes were reused multiple times to immunize infants.

Like the Americans who framed HIV as the disease of the dangerous "other" and legitimized exclusion (Nathanson, 2007), Eastern Europeans set off a process of severe social isolation of persons living with AIDS. Those living with AIDS were feared and discriminated against by the medical establishment, law enforcement agencies, employers, housing providers, and family members. In Romania, gravediggers refused to bury the bodies of children who died of AIDS. In Bucharest's mortuaries parents feared HIV and refused to claim the bodies of their children (Hendriks, 1991). Poland and Hungary tested all prisoners and kept HIV-positive individuals isolated for the duration of their sentences (Hendriks, 1991) practice that was eliminated by the end of the 1990s. In Poland, people with newly identified HIV were becoming homeless and to set up temporary shelters and halfway houses became a pressing issue. According to one of my interviewees active in the area of HIV in the late 80s, many people were so terrified of their status being disclosed that they left their simple homes and moved across the country. Simultaneously, little, if any, medical care was available for those infected. As a result, most people avoided being tested. This, in turn, created a self-perpetuating problem: the threat of social ostracism and lack of care deterred people from getting tested, the low number of tested individuals resulted in low incidence data, which, in turn, allowed governments to ignore the problem and minimize the need to fund prevention and treatment.

Many countries continued the practice of the Soviet system, which was to designate sex work and homosexual activity as crimes punishable by imprisonment. Even though the new political establishments based on democratically elected governments claimed to protect the human rights of all individuals, some groups were clearly not included in the promise. Persons who identified themselves as gay and agreed to be tested for HIV became the target of bigotry and violence. Women in the sex industry were publicly ridiculed and mistreated. At the same time, the sex trade was expanding with the rise in tourism and the arrival of Western businesses. Sex work became a highly profitable industry and was, therefore, aggressively protected by those who profited from it. These factors, in conjunction with high levels of stigma, made it difficult for prevention workers to access the people who were most at risk (Kreniske, 1991).

During the Soviet domination of Eastern Europe, sexuality was not discussed openly and human rights were ignored. As the political systems evolved, attempts to begin a public discourse about sexuality came under assault by the increasingly powerful Catholic Church (Nowicka, 2008).

The absence of psychological support or any counseling infrastructure, combined with the constant presence of powerful social controls, also made effective interventions difficult. As stated by Marcu, the designer and facilitator of a workshop on HIV and Human Rights held in The Hague in 1991:

It is very difficult for people whose ideas have been deformed for such a long time to recover rapidly their capacity to discriminate, and to acquire a capacity to understand and evaluate the importance of the psyche, and of its care. In a way the minds and souls of these people will have to be reshaped in order to fit again in the mold of the norms accepted by most European countries.

During the waning years of Soviet-style medicine, when HIV was first spreading, there were no legislative means for ensuring confidentiality. Voluntary and confidential testing was not available. Instead, most governments invested in compulsory testing. In Poland, for example, by 1989 sex workers were required to test every six months, foreign residents tested twice a year (March and October), and prisoners were tested upon entry into the prison system (Stapinski, 1989). At the same time, in the former Czechoslovakia, all foreign students had to present an HIV-negative test result to be admitted into the country. Czechoslovak nationals returning home after extended travel had to submit to an HIV test. A number of HIV-positive foreigners were deported (Hendriks, 1991). As recalled in an interview by a former staff of the Polish Ministry of Health, “When I began my job I opened a huge cabinet of WHO documents which no one paid attention to. The more I read the more it became clear to me that what the WHO was recommending and what our Minister wanted to do was very different. We often argued about it and, in the end, this was the reason I lost my job. Then he went to a meeting of Ministers in Paris and came back astonished. I do not think he had any idea as to what needed to be done, but at least he understood that coercive and punitive actions would hurt Poland’s image at the international level.”

The Alma Ata Declaration of 1978, to protect and promote the health of all the world’s people, was born in the former Soviet Union. It defined community participation as, “....a process by which individuals and families assume responsibility for their own health and welfare and that of the community, and develop a capacity to contribute to their own and the community’s development.” While the social determinants approach in other regions involved defining health needs and disparities in a way that engaged people to become advocates for change (Koh, 2010)

and despite the origins of the Alma Ata Declaration, individual action and community organizing were not supported and was often prohibited throughout the region. According to Cockerham who studied health outcomes in the communist and then post-communist Russia, health lifestyles are collective patterns of health-related behavior based on choices from options available to people. Choices are a form of agency -- the process by which individuals critically evaluate and choose their course of action. In communist societies, the choices of individuals were confined to a one social and political realm – socialism -- and expected to conform to the ideology it represented (Cockerham, 2002).

This paradigm had a powerful impact on the scope and effectiveness of the groups that emerged to address the HIV and drug use crisis. It has been documented throughout Europe, North America that engaging persons who use illicit drugs in the development of interventions acknowledges their human rights and shows respect for their right to self-determination. When civil society finally began to organize around AIDS, drug users did not participate in the efforts. Consistent with trends in other regions, they have been the most stigmatized and least visible members of the HIV affected population. If the existence of a “competent community” (Minker, 1997) is a predictor of successful HIV prevention, drug users in Central Europe have a long struggle ahead of them. The region lacks groups resembling the articulate, visible, and well-funded social action organization ACT UP, in which gay men in New York fought for access to prevention and care and advocated on behalf of other, less politically experienced and underfunded groups (Nathanson, 2007). It is possible that the risk associated with advocacy for men who have sex with men (MSM) has been so great that absorbing the potentially even greater risk of demanding attention for drug user’s issues was not possible. While much literature exists

about how governments can actively facilitate and support the role of civil society to address social determinants to improve health outcomes, today, well over two decades into the HIV epidemic among injecting drug users in Central Europe, there are still very few AIDS organizations and no strong national organizations representing the interests of people who inject drugs. One of my interviewees, a journalist specializing in the issues of vulnerable groups, commented on the state of civil society in Poland, “There is no place here that teaches you how to organize effectively, how to form an NGO, how to collaborate and run an effective network. These are things that people on the other side of the Iron Curtain have been learning for decades. There are academic centers dedicated to this across the world - none of it exists here.” Another, a retired academic, commented that on top of this lack of experience there are now “superstructures” such as the European Commission and others that are placing great bureaucratic expectations onto tiny groups and, in the process, are destroying their already limited capacity for advocacy.

The Post-Socialist State and the Influence of the Catholic Church on HIV in Poland

The first case of HIV was reported in Poland in 1985, following a period of intense political and social turmoil. To crush the political opposition, the government imposed martial law from December 1981 until July 1983. During martial law, close to 2,000 Poles were imprisoned and over 20,000 went underground. Though martial law was lifted in 1983, many prisoners were not released until 1986 during the general amnesty. As a result, the space for public discussion of social issues was virtually nonexistent. The collective memory of these events remains very present in Polish consciousness today. This may offer one explanation as to why a country which was first to fight for democracy under the banner of Solidarity, almost a decade before the

fall of the Berlin Wall, no longer holds solidarity as an important social value. Instead, it opts to draw moral distinctions between “us”—perceived to be those who are free of HIV and drug use - and “them.” These artificial boundaries legitimize exclusion as a response to drug use and HIV.

Ironically, in the early days of Poland’s democracy, it was General Jaruzelski, a communist general and a key person responsible for introducing martial law, who defended people living with HIV. In 1990 a new democratically elected local government in a small town neighboring Warsaw had passed an ordinance banning HIV positive persons from entering the community. At the time Poland had yet to enact a new constitution that protected citizens from discrimination so the President was the only one with the authority to overrule such a law. As this event occurred during the transition of power, the country’s last Communist leader, General Jaruzelski, used his authority to waive the ordinance (Osiatynski, 2009). The number of HIV cases has grown steadily since the political changes of 1989 and the relationship between Polish politics and the disease remains complicated.

HIV and drug use reveal the processes and contours of post-socialist Poland where the “paternalistic” state has been replaced by one founded on neoliberal principles -- a union of classical liberal thought and a new set of ideals which are relevant to an increasingly individuated society based on autonomy, choice, and economic primacy (Barry, 1996). The collapse of socialism has had dramatic implications for the changing relationship between the state and its citizens, as well as for the way people have managed these changes, and for the different ways these changes have affected various segments of society. In order to understand

the Polish response to HIV and drug use it is important to follow the process of post-socialist changes, including Poland's entry into the European Union, and the Polish identity and notions of patriotism. It is also necessary to look at how various actors with frequently competing agendas defined the terms that now predict the rules of engagement between people living with HIV and drug users, the state, civil society, and others. Membership in the European Union makes available a potential external referee when the state and the individual are in conflict and provides a framework for human rights. This has been seen in practice in multiple court rulings that have been handed down to Poland by the European Court of Human Rights (ECtHR) in Strasbourg. For example, the ECtHR ruled against Poland for not providing an abortion to a 14 year old who suffered severe medical complications that resulted in her death though she had met all of the legal requirements for the procedure (European Court, 2012). In 2005 a decision against Poland was handed down in response to a local government's ban of a gay pride march (European Court, 2005). In addition, it became the philosophical basis on which to advocate for the extension of rights to diverse groups traditionally outside state-sanctioned support. European administrative channels fund networks of people living with HIV, advocates for lesbian, gay, bisexual, and transgender (LGBT) concerns, and, to a lesser extent, drug users. New expectations and strategies for accessing rights and resources have emerged.

Since the collapse of the Soviet Union and the socialist influence in Central Europe much analysis about moving from socialism to capitalism and democracy focused on economics and politics with less attention paid to how it affected state-citizens relations. This is a change that is complex and slow to emerge, as made evident by ongoing reports of difficulties with national and local administrations (Housner, 2007), as well with how individuals relate to each other.

Forms and sources of state power differ significantly in socialist and capitalist institutions and have direct implications for how the state and citizens interact. In a capitalist system, goods are produced and sold to accumulate profit, whereas the socialist state worked to accumulate distributable resources and increase its citizens dependence by determining which resources were distributed to whom and when (Verdery, 1996).

Neoliberal governance is based on the idea that the state should have a reduced role in both the economy – the invisible hand of the market -- and the provision of public services. The model that existed before 1989, in principle, guaranteed employment and intervened in the market to prevent economic depression. Neoliberalism ended central planning and granted state funds to nongovernmental or private agencies that administer services; and directed expenditures towards unemployment programs and poverty assistance rather than subsidies for food, rent, education, childcare, and cultural services (Gal, 2000). By enthusiastically embracing the economic reforms and integrating with the western markets, Poland began what has been termed, “shock therapy.” Jane Hardy, in her assessment of the transformation described it as, “more shock and less therapy.” The country was so eager for political and economic reform that little effort was made to assess whether any of the socialist policy would be useful to maintain. Moreover, whatever was perceived as a legacy of the socialist system was almost automatically considered undesirable and was swiftly replaced or privatized. Consistent with neoliberal practices elsewhere, the role of the state was reduced to that of a manager of the process of privatization with an ever shrinking mandate to provide social security (Hardy, 2010). Childcare centers were closed, work opportunities for women were reduced, medical clinics in rural areas were scaled down, as were other forms of social assistance. All the while, the role of the church was

growing. Many Poles felt that they had lived through a failed Soviet experiment and thus rushed to replace it with what they perceived to be a well-tested success – a western democracy. People, who only months ago had participated in freedom strikes and supported the Solidarity movement, at great personal cost, were suddenly confronted with the new reality of unemployment, an ever shrinking social safety net, and disappearing social services. Basic survival became a priority for the majority of citizens who found themselves in an economic free fall, a stark contrast to their recent experience of social solidarity. This experience is different from one of Western Europe. Since 1960's economic circumstances have improved for most western Europeans. In the countries in Eastern Europe, material circumstances changed little between 1970 and the late 1980s and have deteriorated since 1990. According to Babak (1998), perhaps as many as 50 per cent of citizens in the East, experienced a fall in their standard of living.

As explained by a social scientist and think tank leader, “For many years the United States was our adopted homeland, it was our point of reference. As soon as we had a chance, we began copying it by replicating its banking system. We wanted to have the best stock market in the region. However, we were not copying the other side of the coin - the social activism, philanthropy, multiculturalism, and the political engagement of civil society. A country that held such promise and the intellectual strength to stand up to the Soviet Union, when it finally succeeded, began behaving like a child, by simply copying the West. We disappointed ourselves, but we also disappointed the West which was looking at us with amazement and hope that something inspiring and instructive for them would emerge from our process.” For a time there was discussion of what was called the “Third Way,” a paradigm that introduced the values

of democracy and the free market while maintaining relevant socialist policy. However, this idea was drowned out by a Hungarian slogan that spread throughout the region, “The Third way leads to the Third World.”

This idea of an individuated society sharply contrasts with the socialist notions experienced by citizens of Eastern Europe for the preceding half-century. According to Cockerham (1999), health lifestyles in a society with high dependency on the state and discouraging individual initiative in daily life are not likely to feature a strong sense of personal responsibility for health. This sense of responsibility was unlikely to appear in the immediate aftermath of socialism’s fall, when alternative mechanisms of support were unavailable and established norms for health promotion were lacking. Ericson (2000) argues that a belief in the notion of individual responsibility is one of the five basic characteristics of neoliberalism, alongside minimal government, market fundamentalism, risk management, and the inevitability of inequality due to choice. Elizabeth Dunn’s (2004) research on the privatization of a Polish baby food company shows that a very specific notion of personhood is required for the new capitalist institution. She suggests that the introduction of capitalism requires a clear focus on the independent and self-sufficient individual centered on work. The “socialist” reliance on a generous safety net was peeled away and replaced with increasingly constrained conditions for various entitlements. This shift to neoliberalism meant that people were increasingly expected to be self-reliant and to negotiate the rapid shift to capitalism and the marginalization of their concerns (Kideckel 2002).

This collision of neo-liberal thought, individual responsibility, and the individual's right to choose, has resulted in a new understanding of health outcomes (Cheek, 2008). Poland has been moving away from a social determinants approach, where the focus on social and economic factors, social support networks, physical and social environment, access to health services, and social and health policies are a part of an integrated multilayered effort (Koh, 2010). It is not to say that the socialist government's health policies were entirely informed by the notion of contextualizing risk factors or the theory of fundamental causes. The socialist philosophy was, however, less focused on individualism in all spheres of life and was closer to the social determinants theory than the contemporary approach. Susan Santag described this in 1995, "What has followed in the wake of 1989 and the suicide of the Soviet empire is the final victory of capitalism and of the ideology of consumerism.... Individualism and the cultivation of the self and private well-being— featuring, above all, the ideal of 'health.'"

As described by Blaxter (1997), with emergence of neoliberal approaches, there is a noticeable rise in the rhetoric that blames the individual for health outcomes and attributes fault, "not simply through a carelessly unhealthy lifestyle, but also because of character failings or weakness of will." People are blamed for both their acts and their omissions—what they do wrong and what they fail to do right (Yoder, 2002). The belief that we can freely select our ways of living is fundamental to the claim that illness results from behaviors associated with faulty lifestyle 'choices.' It is in this way that chronic illness becomes defined as an instance of personal moral failure in contemporary times, for if we can choose to be healthy by acting in accordance with the lessons given us by epidemiology and behavioral research, then surely we are culpable if we become ill (Galvin, 2002). According to Link (1995), health policies built on

such premises, “can be lead astray if their purview is narrowly limited to a focus on individually based-risk factors.” Without understanding the social conditions that expose people to individually based risk factors, interventions have an increased chance of failure. Some social conditions are fundamental causes of disease and, as such, cannot be effectively addressed by individual interventions but rather, the intervention must address inequality in the resources that fundamental causes entail (Link, 1995).

When economic and political transitions are taking place, institutions of the state tend to be consistently weak. There seems to be a general consensus that the process of democracy building was successful in some areas, while others require greater attention, most especially in the area of public administration. Polish citizens perceive the sphere of public administration as the battlefield of party groupings and their relationship to the church. The turbulent history of public administration after 1989 shows that the ambitions of politicians trying to appropriate public institutions for their own party interests continues to trouble the country. This is not the case in some other post-communist countries – for instance in the Czech Republic or Estonia the civil service has been functioning without any major disturbances (Burnetko, 2010). In Poland, the two primary institutions responsible for HIV and drug use related matters are the National Bureau for Drug Prevention and the National AIDS Center. While they are under the purview of the Ministry of Health, it was a Catholic priest, in a capacity of a ministerial advisor, that was charged with overseeing them. Though both institutions, since their inception, have presented themselves as innovations in Polish public policy, they fail when judged against Boise’s definition, which is that an organization can be "credited with an innovation if it accurately predicted the need for an idea which was new to the organization and implemented it in advance

of some irresistible external demand." Rather, they serve as an illustration of Parker's concept of "administering the epidemic" (Parker, 2000a) as, for the most part, they produce data and avoid any discussion of the structural drivers of HIV risk, drug use and drug dependence. These institutions are clearly the children of the political and economic changes that have characterized Poland's emergent democracy over the past 20 years. At the same time, the state of civil society in Poland is not promising. Before 1989, the socialist government did not allow instruments through which citizens could contribute to the common good. Whatever did exist functioned as organizations formed by the government, for example Polish Scouts (Zwiazek Harcerstwa Polskiego), Societies of Rural Women (Kolo Gospodyn Wiejskich), etc. At the same time, an illegal underground social movement, "Solidarity," gathered those who were most active in their opposition to socialist government. When the government fell, it was not only necessary to sustain this civic spirit, but also to allow for an institutional framework for civil society to be created. After 20 years of democratic transformation, it has turned out that the institutionalized civil society is unable to perform the most basic functions, which the "illegal" civil society of the socialist times did so well. Non-governmental organizations have become contractors of the neoliberal state (Markowski, 2010).

The Catholic Church

The idea that health and illness are matters of personal responsibility is embedded in traditional notions of illness and sin and it is strongly reinforced by the Polish interpretation of Catholic teachings and its practice. As stated by Galvn (2002), those who function on the margins of neoliberal society because they are unable to maintain their health and fitness are not likely to feel any less damned than those whose illnesses were believed to be the result of sin. Chronic

illness, such as drug dependence or HIV is viewed as culpability in the face of known risks, an instance of moral failure. The Church aligns with Beck's view on "Risk Society" -- the idea that individuals are responsible for calculating risks and bearing costs and with John Knowles' proposition that the individual has the power -- indeed, the moral responsibility -- to maintain his own health. "The cost of sloth, gluttony, alcoholic intemperance, reckless driving, sexual frenzy, and smoking is now a national, and not an individual, responsibility. This is justified as individual freedom -- but one man's freedom is another man's shackle in taxes and insurance premiums. I believe the idea of a 'right' to health should be replaced by the idea of an individual moral obligation to preserve one's own health -- a public duty if you will. The individual then has the 'right' to expect help with information, accessible services of good quality, and minimal financial barriers" (Knowles, 1997). This view is further reinforced by the Church's historically strong opposition to the socialist government, making the polarized discourse, which exists elsewhere in Europe and the United States between the political left and right, even more stark in Poland. Pope John Paul II spent much of his life arguing against the Soviet influences in Poland and the socialist philosophy. And while Knowles recognizes that illness and unhealthy habits often follow poverty and lack of knowledge, and argues that health depends on economic investment in poor communities, the availability of jobs, access to transportation and housing, and public safety, no such recognition appears in the church's teachings. Rather, one is expected to do the best they can and submit to the larger call of his or her destiny. Risk society and individual risks mix with political Catholicism promoting populism and xenophobic nationalism. The political discourse, in which a "true Pole" is ethnically Polish and a practicing Catholic, aims to exclude ethnic or religious minorities, sexual minorities, drug users, and all "others." The Church's philosophy ignores literature documenting that changing the social conditions can

alter the determinants of disease. Consistent with the idea of contextualizing risk factors, policy makers should require an identification and analysis of the factors put people at risk (Koh, 2010).

The Catholic Church played a somewhat ambiguous role in the Polish transition to democracy. As one of the most trusted institutions it greatly contributed to the orderly and peaceful transition of power from socialism to democracy. During the first free elections in Poland in June 1989, the Church hierarchy sympathized with and often aided the Solidarity activists. In the run up to the accession referendum, Pope John Paul II helped to neutralize the “Eurosceptics,” who depicted Europe as morally decadent and atheistic and opposed Poland’s accession to the EU on both nationalistic and religious grounds. At the same time, at the grass roots level, some within the Church sympathized with the nationalist and Catholic fundamentalists. Tadeusz Rydzyk, a Catholic priest and Redemptorist runs a media empire, which includes a radio station (Radio Maryja), television network, a newspaper and a college. These outlets, operating under the auspices of the Church, reach millions of Poles daily with messages of xenophobia, anti-Semitism as well as distrust of anything ‘non-Polish’ and ‘other,’ providing populists with institutional backing and ideological support (Kucharczyk, 2010). The view of the Polish Catholic Church on drug use is consistent with that of Christians in the United States. The anti-drug fervor that has swept contemporary America has enjoyed acceptance from Christian churches. For most, illicit drug use ranks high on lists of vices meriting disdain (LaHaye, 2000). Catholic and evangelical policy analysts, “support the enactment of strong and effective laws against all illegal drugs and their strict and impartial enforcement” (Ball, 1992). What is missing in this discourse in the United States and in Poland is the recognition of the nineteenth-century discussion of the virtue of “temperance.” The Temperance Era began by urging individuals to

drink with moderation and prudence. It ended by insisting that moderation was impossible and that government enforcement of total abstinence was imperative (Bischke, 2003).

In this context of disciplined citizens who comply with the demands of neoliberalism and a strong Catholic dogma and receive little support from existing, politically driven institutions of government administration or weak civil society groups, discussion of HIV prevention and drug use has left little room for considerations of the fundamental social factors and structural violence which determines social vulnerability of groups and individuals. While people considered “at risk” now have more freedom to conduct their lives, they also have a set of neoliberal expectations and religious pressures placed on them – preferably to abstain entirely or take control over various aspects of their drug use and sexuality, to create conditions that will allow for safe choices and, as described in later chapters, cannot expect much support from the National AIDS Center or the National Bureau for Drugs Prevention.

Chapter Two: Methodology

My hypothesis is that the assertion by Poland's senior drug policy and HIV officials, that injecting drug use is not a significant driver of HIV in Poland, was based on incomplete evidence and is likely to be inaccurate. My intention is to assess the political foundations and implications of these statements with regard to the facts and their social uses. In addition to evaluating these claims, in and of themselves, I will also consider their ideological content. The resulting analysis will provide an account of the relationship between the HIV epidemic, drugs, the systemic disempowerment of drug users, and how all of these factors result in policies and practices that are woefully inadequate for curbing the HIV epidemic and treating those in need of care.

According to Hunting (2012), assessment is the foundation of public health, "Before decisions can be made, before policies can be determined, before programs can be planned, public health professionals must assess the situation at hand . . . Case-based learning may be an effective approach for developing competency in highly applied cross-cutting domains such as communication, informatics, diversity and culture, leadership, professionalism, program planning, public health biology, and systems thinking." My method is to fully explore the real world complexities of the phenomenon of HIV transmission among drug users in Poland as a single, holistic case study that encompasses the contextual conditions, as they are highly pertinent to the subject. As defined by Robert Yin (2009), the case study focuses on the

contemporary and allows investigators to retain the holistic and meaningful characteristics of real life events – such as individual life cycle, small group behavior, organizational and decision making processes on multiple levels, and international relations, and it does not require control of behavioral events. This case study is based on five of the six sources of evidence defined by Yin (2009): documentation, archival records, interviews, participant observation, and physical artifacts. Direct observation was the only recommended method that was not engaged. The use of multiple sources of evidence allowed for converging lines of inquiry – a process of triangulation and corroboration addresses the potential problems of construct validity.

The findings of this dissertation draw on primary and secondary sources. The primary sources include transcripts of Polish Parliamentary debates and sub-committee hearings related to drugs and AIDS, newspaper and media reports covering current debates about the quality of drug treatment, and legislative amendments to the existing drug law. Accounts in Polish newspapers as well as magazines were valuable for documenting specific instances of conflict as well as portraying the broader social context and popular attitudes toward drugs and HIV. In order to assure construct validity, I used multiple sources of evidence. For example, I reviewed, in detail, drug policy and HIV articles of both *Gazeta Wyborcza*, considered a source for Poland's liberals, and *Rzeczpospolita*, a source respected by conservatives. I also researched magazines that cater to audiences with varied demographics such as youth and Catholics and identified a number of drugs and HIV related articles in these sources. Newspapers offered a more detailed analysis including various policy options while magazines were mostly descriptive and offered various forms of advice. Many of these debates have taken place through electronic media, such as discussions generated by electronic campaigns. To track this, I followed engaged listserves and

portals. My primary sources also include in-person, semi-structured interviews with 17 key actors involved in the events. These interviewees include city and national officials currently responsible for drug and HIV policy, current and past legislators engaged in health-related issues, advocates in the area of drug policy and HIV, as well as drug treatment providers. All of the interviews were carried out in the Polish language and were transcribed. The interviews took place in the cities of Warsaw, Krakow, and Bialystok. I also spoke by phone and corresponded with a four sources from two additional cities in the West of Poland: Szczecin and Wroclaw. The process of interviewing allowed me to assimilate information that was shared as the participants formulated their answers to the questions I posed, but also enabled me to capture the mood and affective components. Each recorded interview lasted between one and a half and two hours. One interview was broken up into two hour and a half sessions.

Secondary sources include extensive historical and contemporary documentation related to HIV and drug policies including scholarly literature, “gray” literature, international reports, and official documents of the National AIDS Center, the National Drug Prevention Program, and numerous NGOs. Reliance on secondary sources raises concerns about the reliability and validity of the data. I attempt to resolve this problem by identifying the points that are corroborated by multiple sources.

The internal reports of the government entities responsible for drugs and HIV and their annual reports, and parliamentary records were essential to establishing how policies were developed and implemented. They demonstrate, for example, how various officials responded to public

concerns related to HIV transmission, the safety of health personnel, and perceptions of drug use as well as how they assessed their progress in the provision of services and their HIV and drug prevention efforts. At the same time, I observed that some reports are highly political as can be seen when comparing the published accounts of meetings with the verbal reports of the participants. In some instances the published reports were “cleaned up” of any controversy. The documents of international organizations such as the United Nations Office on Drugs and Crime (UNODC), the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), as well as professional journals serve as important forums for the publication and discussion of standards for policy making in the areas of drugs and HIV and assessment of practice in the area of service provision. *Alkoholizm and Narkomania* is the only Polish journal where the practice of drug treatment is discussed. *HIV & AIDS Review* is the only journal specific to HIV and it focuses on the medical aspects. The extreme scarcity of peer-reviewed literature indigenous to Poland poses a threat to the reliability of this dissertation, as well as any work specific to drugs and HIV in Poland. I relied on international publications for policy-related, peer-reviewed publications.

The literature on methodology points out that adaptability and flexibility are important for a researcher conducting a case study (Yin, 2009; Rowley, 2002). A substantial amount of time was needed to collect the data for my research, during this period many relevant changes took place: the national legislation changed, a number of organizations ceased to exist, new people joined existing groups, and a new political party important to the debate emerged. My attempts to avoid bias by engaging all sides of the debate were challenging. Since I am professionally and publically engaged with advocacy for drug policy reform and harm reduction, a few persons who

were affiliated with the abstinence-only movement declined my requests for interviews. I attempted to compensate for this by paying special attention to the publications and public statements of these individuals and the groups they represent.

Collecting and analyzing publications, websites, listserves, records, and archives of non-governmental organizations (NGOs) that engage in HIV and drugs policy debates allowed me to understand their priorities and also, the institutional relationships they had to each other and to various other actors. This also enabled me to see how the NGOs understood the social and political context surrounding them. The NGOs include the Social AIDS Committee, the Polish Drug Policy Network, MONAR, and JUMP. Modest archives consisting of a few rows of documentation shed light on the historical context in which drug use and also HIV emerged in Poland.

Finally, as a means of direct participation, I took part in parliamentary hearings and several conferences and meetings on AIDS or drugs related matters organized by civil society and governmental actors. It was through these organizations that I established contact with the many of the people I interviewed. As was the case with the interviews, I made every attempt to listen objectively and to understand the affect and non-verbal communication of each gathering's participants. There were a number of instances in which the affect of the gathering was in direct conflict with an articulated message. In those cases I made efforts to understand the roles of the individuals involved in the discussion and to learn whether they spoke in a personal capacity or that of an official.

Analysis of case study evidence was an evolving process as new data became available. In order to analyze all the transcribed interviews, I created an index with the following themes: drug policy, drug use, HIV policy, human rights, civil society, HIV activism, drugs activism, drug treatment, HIV treatment, HIV testing, governance, harm reduction, capacity building, international organizations, significant political events, peer reviewed publications, and political changes or events. This helped me demonstrate how drug and AIDS themes relate to broader social and political events. For all of the other research, the observations, document analysis, listserves, and TV and radio programing, I created an informal database that was based on my electronic notes and applied the same “interview index” themes in order to analyze all of the material in a consistent manner. The database allowed for patent matching and identification of meaningful frequencies of themes as well as explanation building and time series analysis.

As an organizing framework, the dissertation focuses on three discrete time periods which are followed in chapters three through five.

- The first period includes the years of socialist rule after World War II when the Soviet Union dominated Central Europe (1945), and the time of the Round Table Agreement (1998) when Soviet rule ended. This included the period of Martial law (from December 1981 to July, 1983) when the government severely curtailed civil liberties in an attempt to crush political opposition represented by the Solidarity movement.
- The second period, from 1990 through 1999, was the decade when Poland first put into practice neoliberal principles and, at the same time, strengthened Catholic influence in public life. It occurred under the leadership of the first freely elected president, Lech Walesa. At the

time, tensions between the Catholic Church and the liberal authorities that emerged from the resistance Solidarity movement were high. In 1993, access to abortion, became extremely restrictive while at the same time, in a sphere that was of less interest to the Church, a new progressive drug law was passed.

- During the third period, between 2000 and 2011, the presence of a strong, well established Catholic Church was solidified – religion was introduced into public schools, a cross appeared in the chamber of the parliament, political discourse became increasingly conservative, and the law and order theme dominated the discourse that led to a more punitive revision of the country’s drug law.

My data is presented in a chronological account of how the problems emerged, were identified, and responded to. In the introductory chapter I expanded my focus beyond Poland, and described the larger, regional context. Poland was the first country in the region to shed Soviet authority, with others soon following. In this chapter I discuss how the political, social and economic changes have impacted drugs and HIV policies in the countries of Eastern and Central Europe: the Czech and Slovak Republics, Hungary, Romania, Bulgaria, and the states of former Yugoslavia. Chapter one also introduces the hypothesis and discusses relevant theory. Chapter three details the story of drug use and drug policy in Poland. Chapter four offers a history and current account of the state of drug treatment and harm reduction. And chapter five tracks the evolution of HIV policy in Poland. In the final two chapters, I address the issues from a human rights perspective, summarize the lessons learned and recommend changes to policy and practice based on the international literature and guidelines in the area of drug use and HIV.

Chapter Three – Drug Use and Drug Policy in Poland

During the first decade of the HIV epidemic in Poland, starting in late 1980's, the relationship between injecting opiate use and HIV infection was clear. At the time, the majority of people infected with HIV were drug users. However, in subsequent years, it became increasingly difficult to understand this relationship as the HIV reporting system was modified, drug use patterns changed and diversified, and Poland underwent dramatic political and economic changes and became a member of the European Union. Structural violence towards drug users intensified as a result of decades of shifting drug policies and the more recent process of political, social and economic transformation. This structural violence has had a detrimental effect on the HIV epidemic in Poland.

The History of Drug Use in Poland

Mentions of drug use in Poland between World Wars I and II are scarce and only reference three substances: morphine, coca, and codeine. Heroin is not mentioned in the documentation from this period. Historically, drug control has been strict in Poland, even in the 1930s, when only one pharmaceutical company was allowed to use imported opium and coca in its products. When codeine production from locally grown poppy began, a second pharmaceutical producer was given permission to use it. At the time, one gram of morphine cost 20 Polish Zloty, the equivalent of a blue-collar worker's weekly salary. Morphine use was almost exclusively an

experience of the middle class (Frieske, 1987). To say that World War II, from 1939 to 1945, was violent and traumatic for Poland would be an understatement of vast proportions. The subsequent reconstruction of the devastated nation, followed by the establishment of a socialist regime, left almost no record of drug use. It is not until the late 1950s and early '60s that there is increased mention of reliance on medications for relaxation and anxiety alleviation. There is also some suggestion that physicians were quite liberal in prescribing tranquilizers, pain medicines, and benzodiazepines (Frieske, 1987). The late 1960s and early '70s brought noticeable shifts in the use of drugs. Western social movements of the sixties found their way into Poland. The use of illicit substances, for some people, became a ritual that bonded the young and freedom-seeking in an increasingly oppressive society. Additionally, since alcohol use has historically been a serious problem associated with violence, and intellectual and emotional impairment, it has been suggested that the selection of illicit substances became, for the youth, a way to distinguish themselves from earlier generations (Fatyga, 2002).

However, drug use was not exclusive to the hippie movements. As documented throughout the world, drug use is motivated by a variety of environmental, developmental and social factors, as well as genetic vulnerabilities (Tatarsky, 2007; Reuter, 2010; Drucker, 2011a). In Poland there were several different social groups whose experimentation with illicit substances was not at all inspired by ideological motives. The most common explanations for drug use have been difficulties in the family, school, and efforts to avoid mandatory military service (Frieske, 1987). In the absence of cannabis and LSD, at the time unattainable in the socialist block, the quest for psychoactive substances led users to pharmaceutical as well as chemical products. It was

discovered that *TRI*, a stain-removing compound, caused euphoria and hallucinations when inhaled, as did various mixtures of pharmaceuticals. As the 1970s progressed, locally grown poppy attracted the interest of those experimenting with psychoactive substances.

Experimentation with various chemicals and pharmaceuticals was gradually replaced by products derived from the more widely available poppy. Poppy-based products included: *milk* (mleczko) extracted from unripe poppy heads, *soup* (makiwara) produced by cooking poppy straw and, the most potent of all, *kompot*, also known as *Polish heroin*. Competently prepared *kompot* could contain up to 80% morphine. By the end of the 1970s, 90% of patients hospitalized for drug dependence were there because of their use of *kompot*. Law enforcement reports on drug use began to increase. In 1973, the police reported, for the first time, 528 cases of group drug consumption (an illicit activity under Polish law). In 1970, 8 people were reported to have distributed illicit substances, in 1973 this number went up to 539. In 1968, a total of 14 drug related offenses were reported in all of Poland, by 1973 this number rose to 819. In the first half of the 1970s, the media and professional publications expressed concern over growing drug use.

There is almost no documentation from this time describing any prevention efforts, except for sporadic activities undertaken by catholic youth groups. A Catholic University in Lublin, KUL, was the first institution to address drug dependence in its curricula for psychology, sociology, and re-socialization (Ciekiera, 1998). For the most part, the KUL curriculum viewed drug use as an outcome of increasingly unstable families, escalating divorce rates, and eroding morals. As reported by one of my sources, a therapist specializing in drug treatment, Warsaw University offered an alternative perspective to that taught at KUL, “During the late 1970s, I became the student of an avant-garde department, the Institute for Reintegration and Prevention of Social

Problems. It was the first department that was truly interdisciplinary and included a basis for practice, but also for policy making, and activism. We created an informal group of psychologist-activists working in opposition to the prevalent practices of socialist control. We were, for example, against viewing drug use only as a pathology. Dr. Ewa Andrzejewska, one of our faculty and a child psychiatrist, espoused a more humanist view of drug use.” While over time, some students did specialize in drug-related matters and are still active as practitioners; the group was not influential in defining new forms of dependence treatment outside of psychiatric institutions. Szkolny Osrodek Socjoterapii (SOS) in Warsaw, was another organization that took an alternative approach with its work assisting troubled youth. SOS offered support and acceptance of young people who were in trouble for various reasons, often for drug use. Many of their clients were in great need of psychological assistance. In a series of testimonies produced to celebrate the 30th anniversary of SOS, a long-time graduate described the institution as a filter that helped those who would not have made it in a regular school, “We were a mixture of people who came from everywhere and for every reason; fear of mandatory military service, avoiding a life of crime, living with drug addiction, a part of the political opposition, coming from a hippy commune, an anarchist squat, a religious sect, or a psychiatric institution.” One of the former staff of SOS recalled, “We had no ambition similar to Marek Kotanski’s, to replicate our approach or to look for facilities in other cities. We wanted it to be the other side of drug treatment in Warsaw, the alternative to MONAR. So we became a pilot that now, 30 years later, is still in existence. Many popular musicians and writers were our students. Something good happened there, but we were unable to get our message out in order to mainstream our approach. Maybe because our message was not about being tough and punitive it did not fit well with the political climate of the time nor with the public’s perception of how to deal with drugs.”

Toward the end of communist rule, the level at which drug use and users were visible was contingent on explicit political goals. When the political system was showcasing Poland as a successful, socialist state, drug users were hidden in psychiatric institutions and portrayed as anomalies of a “happy, successful society.” Later, when the Western influence over Poland increased, images of drug users were brought out of the shadows as proof of the decadent and decaying Western way of life. Because of the political agenda driving the level of visibility of drug use, the data from this period is inconsistent and questionable.

In the mid 1970s, there was a sharp decrease in media coverage as well as in the public and professional interest in drugs. Therefore it is difficult to understand how the next phase of the history of drug use unfolded in Poland. The only consistent reports are from the *milicja* (the national police force), which continued to reflect an increase in drug use. Half of the 2,300 recorded drug crimes committed in 1977 were identified as “group drug use.” The police increasingly harassed drug users, especially those who were visibly identified as part of the hippie culture. Their views, often aligned with and inspired by the freedom movement from the West, were considered unpatriotic and a threat to the socialist state. Repression of the hippie movement escalated to the point where some were considered enemies of the socialist state. In response to the crackdown, larger drug using communities began to fracture into much smaller, harder to identify, groups. The process of *kompot* production, in individual apartments for small groups, facilitated this trend. By the end of the 1970s, a problem that had been visible and openly discussed was relegated to the shadows.

It was not until the summer of 1980, which saw the biggest political protests in Poland since the war and the emergence of Solidarity, when a wave of media interest in drug use reemerged. The “solidarity festival,” as described by one of the advocates I interviewed, also had an impact on drug using behaviors, “I remember the summer of 1980 – people felt defiant, free. They travelled to summer music festivals in groups and once you arrived, the smell of cooking *kompot* was overwhelming. The police did nothing. Only later it became clear that their lack of action was intentional. The government needed proof that things are going to hell and that a crackdown was justified. We were just one small piece of a huge puzzle.” In 1981 alone, the first year of martial law, 300 articles on drug use were published in the popular press (Frieske, 1987). While the scientific community estimated that approximately 20,000 people used *kompot*, a number of press reports speculated that there could be anywhere between 100,000 and 500,000 users (Ciekiera, 1998). The divergent estimates in the media are now attributed to internal power struggles within the socialist party; the newly elected leadership depicted drug use as proof of the failure of their predecessors (ISP, 2009). Growing moral panic about drugs occurred a few more times and always seemed to have a political motivation. A few years later, for example, an influential Polish weekly, *Wprost*, as evidence against the socialist state, estimated the number of *kompot* users at 1 million, while the scientific community put the number closer to 50,000. As recently as 2010, at a moment of political difficulty, Prime Minister Tusk employed militant, law and order language to rapidly shut down shops selling “smart-drugs” (various unregulated substances that had sprung-up around Poland), by using questionable estimates of users and associated risk (Pacewicz, 2010).

As Poland gained independence and opened up to the West in 1989, so did its illicit drug market. Various imported substances slowly replaced the native *kompot*. In 1990, the cultivation of poppies became illegal without a government permit, and a new, morphine-free species was introduced to enable farmers to continue poppy cultivation (Curtis, 1992). Over a decade later, in 2002, the first national survey was conducted to document the lifetime prevalence of drug use, as well as that in the previous year and in the 30 days prior to the survey. With 6,340 face to face surveys of randomly drawn sample aged 16 and older, the study documented several changes in the market for drugs. Cannabis, a drug that was unavailable during the socialist regime, had become the substance of choice. Six and a half percent of the respondents had tried marijuana or hashish at least once in their lifetimes. Respondents who identified as currently using these drugs made up 2.4%, while 1.1% admitted having used cannabis in the previous 30 days. Amphetamine use was reported at 2% by experimental users, 0.6% for occasional users and 0.2% for frequent users. The third most frequently used drug was LSD: 1.0% of respondents had experimented, 0.4% used it occasionally, and below 0.05% were frequent users. The lifetime prevalence of drug use was greatest within the age group of 16 to 24 year olds, of whom almost one-fifth had experienced cannabis. At the same time, only 1% of the oldest respondents admitted to its use in their lifetime (Sieroslawski, 2003). While this national survey showed very little heroin use, a smaller and regionally concentrated study in 2002 by the Institute of Social Affairs carried out among 1,119 middle school “gimnasium” students (13 to 15 year olds), reported the use of heroin at a lifetime prevalence of 3.1% (Fatyga, 2002). While the study focused on rural communities with twice as many respondents residing in small towns and villages, the rates of self-reported heroin use was greater in urban areas. The urban/rural

difference is especially significant among girls: 0.5% of 385 girls from rural areas and 4% of 198 girls from urban areas reported having used heroin.

The increasing trend of cannabis use where lifetime prevalence increased from 5 per cent in 1992 to over 30 per cent in 2005 does not pose controversy and is consistent with average rates of use throughout the rest of Europe. What is less clear, and requires further analysis, are the number of opiate users. *Kompot* and heroin users were not included in the 2009 National Report due to the marginal prevalence of both substances. However, in the same year, 16% of people in residential treatment were documented to be opiate users. The situation is further complicated by the fact that 63% of people in treatment fall into the “combined and unspecified” category and an unknown portion of them are opiate users as well. The difficulty in understanding opiate use in Poland has been a problem for decades, and is often the result of various political tensions and interests that will be discussed in greater detail in Chapter Four.

Drug Policy Setting Institutions

The two most significant institutions responsible for national drug policy, treatment, and prevention are the National Bureau for Drug Prevention and the Council for Counteracting Drug Addiction. The National Bureau for Drug Prevention was created in 1993 and is an agency of the National Ministry of Health. Its primary goals include maintaining regular contact with the organizations responsible for implementing the various tasks of the National Program for Counteracting Drug Addiction performed by ministries, central administration institutions, as well as the provincial, county and communal authorities. The Bureau’s responsibilities include:

drafting the National Program itself, organizing meetings and conferences that serve the monitoring activities, initiating new legislative solutions, co-financing supply reduction programs, preparing and launching anti-drug campaigns, cooperating with international organizations, coordination with the European Union priorities, and initiating new prevention, rehabilitation, and harm reduction activities (Jablonski, 2006). During the 1990s, the Bureau also funded various drug treatment efforts, but with the creation of the National Health Fund (NFZ), the responsibility of funding drug treatment shifted to this new entity while the Bureau provided guidance on treatment standards. The Bureau is highly technical, coordinates national studies, and represents Poland on various international bodies, but is not visible in ongoing debates. An examination of 160 articles in the press over a four-month period during a debate on drug policy revealed no statements from this institution.

The Council for Counteracting Drug Addiction was established on March 6, 2001. Its first meeting took place on July 10, 2002. It is chaired by the Deputy Minister of Health and is composed of secretaries and undersecretaries of state from various ministries and representatives of local governments. The Director of the National Bureau for Drug Prevention, Piotr Jablonski, carries out the role of Secretary. The Council is to shape national anti-drug policy including substitution treatment, supervision over precursors and pharmaceuticals, poppy and hemp cultivation, the use of opiates in pain treatment and palliative care, and the efficacy of primary prevention (Drug Report, 2003). As with the National Bureau for Drug prevention, there were no Council statements in any of the media coverage of the turbulent public discussions of the current legislative process.

In order to democratize, introduce capitalism and join the well-established and bureaucratically developed European Union (EU), many of the Polish policies, tools, and institutions simply mimic those of Western Europe without having gone through the discussions, tensions, and debates that the West spent decades on to build consensus. A prominent sociologist, Jadwiga Staniszkis, termed this phenomenon an “institutional mix” – a process through which various inspirations for institution-building are absorbed from external sources but without proper reflection and integration (Staniszkis, 2004). Historically, this process of “adaptation” is natural for the Polish administration. For forty-five years, during the socialist system, the Polish bureaucracy received instructions from the Soviet Union and integrated them into its political system, national policy and public life. The current integration process with the European Union, with all its benefits, has left little room for Poland to discover its own way and no provisions were made to inspire these reflections. The process of “adaptation” can also be misleading to the casual observer. Poland’s drug and HIV related institutions, on paper, are strikingly similar to those of our Western neighbors. However, on the ground, one finds evidence of a weak state where ineffective governance results in insufficient delivery of services, superficial discourse, and limited engagement of potential partners. This process of mimicking was strongly encouraged, through substantial financial and moral backing, by the United States and Europe (Hardy, 2010). It was also important to Poland and its neighbors that it fit smoothly into the Western hemisphere and this goal often took precedence over domestic processes occurring at the national level.

An additional problem identified by Jerzy Hausner, an economist and former Finance Minister, is the “non-responsibility of civil servants” who avoid accountability and are mostly invested in

protecting their own positions. Because drug and HIV related policies and interventions are often controversial and can be hard to manage constructively in a public debate, these areas are easily relegated to a passive bureaucratic approach. This is especially the case in a deeply socially conservative country. As the following chapters explore, Poland lacks the individual and institutional leadership in the areas of HIV and drugs that drove progress in many other countries, for example Switzerland and Portugal (Csete 2010).

The general perception of the Polish government is that it is excessively cautious, ineffective, and panders to the expectations of a demanding population. Such a reputation precludes constructive discussion of defining and meeting the needs of the citizens (Sadura, 2011). It should come as no surprise that the two institutions mandated to prevent HIV and to support people living with HIV, drug dependents, and drug users, lack strong leadership and, as will be explored in the following chapters, are slow to respond to the needs of their constituents.

National Drug – related Expenditures

Each year, Poland submits a national report to the European Monitoring Center for Drugs and Drug Addiction and each report states that, in accordance with a 2002 regulation of the National Ministry of Education, each school is obliged to develop and implement a school-based universal prevention program (2004, 2005, 2006, 2007, 2008 National Report). The same report breaks down expenditures for the implementation of the National Program for Counteracting Drug Addiction. In 2003, three institutions-the police, the border guard, and the military police-reported total expenditures related to the implementation of the National Program which came to

122,754,515 PLN. The smallest of the three, the border guard, spent 410,188 PLN, which is four times the amount dedicated to drug prevention by the Ministry of Education (56,880 PLN). The table below highlights the national expenditure's emphasis on law enforcement.

Figure 4. Expenditures of National Program for Counteracting Drug Addiction (Euros)

	Police	Prison Services	Ministry of Education
2004	30,450,500	479, 500	14,220
2005	31,503,155	89,760	22,360
2006	35,139,949	2,791,657	45,148
2007	41,131,105	2,471,582	134,099

The minimal expenditure on prevention at the national level may help to contribute to understanding the results of a 2009 study that compared drug-related attitudes in six European counties. Among the surveyed nations, Poles had the least faith in prevention, only 16% of respondents thought that it is an important anti-drug initiative, this was in contrast with 54% of Hungarians and 53% of Danes (HCLU, 2009).

A number of my interviewees had difficulty making sense of the expenditure figures. Since much of the responsibility for implementing national drug prevention programs lies with local

governments, financing drug prevention, for example, is difficult to account for. There have been many instances in which improvement to the roads and walkways leading to the soccer field was reported as drug prevention. A similar example related to AIDS expenditures was also provided by one of my sources, “I read a report, from 2009, I think, listing institutions paying for drug-related efforts. To my surprise, the largest funder was the National AIDS Center. When I tried to understand what they paid for, it turned out that they include the cost of centrally purchased HIV medication of people who had been infected through drug use. I found it somewhat absurd and dishonest. It shows the focus on the need for success on paper, and has little to do with documenting what happens in reality.”

The financing of various public health initiatives has undergone significant change. Seventy percent of the funding for drug prevention efforts comes from local districts. While this is often portrayed as a success of decentralization, and progress over the centralized Soviet system, many of my sources reported that prevention funding at the local level was part of a much more general pool that included resources allocated for building soccer fields, after-school programs, and soup kitchens. While these are all worthy expenditures it is not clear that they contribute to the goal of HIV or drug prevention. Such methods for managing public spending often allow for the more difficult issues, such as condom promotion or needle exchange, to go completely unaddressed, especially in smaller, predominantly catholic communities.

Polish Drug Legislation

The first drug law in Poland was adopted on June 22, 1923, *On the Subject of Psychoactive Substances and Items*. The first paper on the subject was published in 1935 by Julian Fristenberg, a prosecutor, who described 95 cases of drug dependent persons in the Warsaw judicial districts between 1932 and 1934. In the mid-1930s, physicians created the Polish Committee on Narcotics and Prevention of Narcotics Use and organized a multidisciplinary conference on the subject. The second drug law came into effect in 1951, *Control of Pharmacological, Psychoactive and Other Sanitary Items*. The content of this legislation was similar to that of the previous law, with one exception, it criminalized drug use in the presence of another person with a penalty of up to one year in prison. This article of criminal law remained in effect for several decades.

The first modern legislation fully dedicated to drug related matters was adopted on January 31, 1985, a time when the country was negotiating various political freedoms. The legislation put Poland in the vanguard of progressive thinking about drugs in Europe, as it did not consider personal possession of illicit substances to be a criminal offense.

As Poland changed its political and economic system in 1989, legislative changes followed. It is difficult to understand how external political interests influenced this process. The United States was the most significant and respected supporter of the Polish quest for democracy and the purging of socialism. A 1992 United States-funded report criticized the Polish drug law as antiquated, “Drug use is not a crime in Czechoslovakia, Poland, the Russian Federation.... In

Poland, penalties are not necessarily imposed for possession of large quantities of drugs. Incredibly, only about 30 full-time drug enforcement police patrol the entire country, ...authorities themselves exhibit a relatively relaxed attitude toward illicit drugs. Prosecutors, judges and even police regard this crime in the same category as petty theft.” (Lee, 1992) The author is clearly alarmed by increasing drug use in the region, but also by the laws and relaxed attitudes that are significantly different from the “War on Drugs” style rhetoric prevalent in the United States. The report concludes, “Police and public health officials everywhere from Warsaw to Bishkek desperately crave large infusions of anti-drug assistance from Western nations, especially the United States ... When the United States signs an aid agreement, such assistance should depend on the prospective recipient documenting legal and law enforcement reforms... The United States also could influence conditions on multilateral aid by using its leverage with institutions such as the International Monetary Fund and the World Bank.” (Lee, 1992)

The 1985 Legal Act put Poland on the map of countries with a liberal drug policy. As stated by one of my sources, the Polish socialist government had a somewhat hostile relationship with the United States at the time so it is likely that the Polish drug policy was the exact opposite of what was internationally promoted by the United States. Personal possession of illicit substances was not penalized and addiction was considered to be an illness which required medical treatment. This legislative framework was in place until 1997 and was not questioned during the first years of democracy. If there was any difference in the Polish approach to drug policy, as compared to its liberal European neighbors, it would be the concept of drug users’ rights. This discussion, while ongoing in Western Europe, was not a part of the Polish discourse. Rather, the socialist

state viewed people who use drugs as infirm and requiring the care of the state apparatus. It may be this crucial difference that is responsible for the ease with which the drug policy shifted and drug use was criminalized only a few years later, without regard for any lessons learned from the previous practice. Even though the legal penalties were not focused on users, in practice, many were absorbed by the criminal justice system. Since production and distribution were considered a felony and most of opiate use was a homemade poppy brew called kompot, ongoing harassment by the police and the resulting criminal charges were a reality of drug users' lives. Given this policy context, the level of discrimination against drug users, and those living with HIV specifically, is not surprising.

In 1997, Poland began the process of negotiations for accession to the European Union with a referendum in which 72% of Poles voted in favor of joining (Stulik, 1998). In 1999, Poland joined the North Atlantic Treaty Organization (NATO). Drug law came under scrutiny and in April 1997 new legislation was adopted bringing with it significant changes. The 1985 law focused on production and sales, but did not comment on possession of illicit substances. Parliamentary debate of the new act took a moralistic tone as many were concerned that the law was too permissive. The vote was almost split in half, with a small margin in favor of continued decriminalization. Though the 1997 Drug Abuse Prevention Act made personal possession illegal, a compromise was reached by introducing Paragraph 48, Article 4 suspending criminal penalties for personal possession. Since the amount considered "for personal possession" was left undefined, each case had to be assessed at the discretion of the courts. In practice, the police and the prosecutor's office avoided prosecuting petty consumers, and the courts were reluctant to punish them.

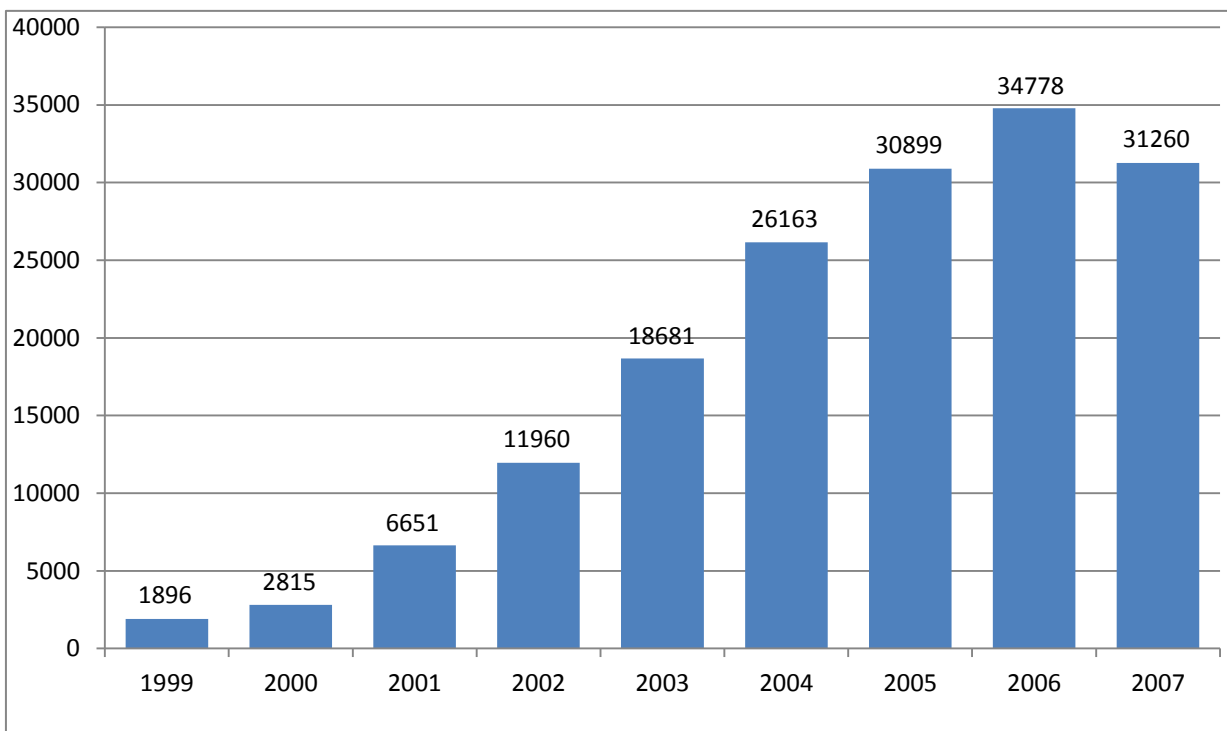
With a noticeable shift toward the political right, only three years later, a new legislative proposal was tabled. In October of 2000 the non-punitive nature of the Polish drug law was rolled back with Article 62 introducing criminal charges for possession of any amount of illicit substance. Three options for punishment were instated; the first and most favored was incarceration for up to three years; the second was incarceration for six months to eight years for cases involving considerable quantities of drugs; and the third was the “privileged” penalty that included a fine, the limitation of liberty, or incarceration for up to one year in cases of “lesser gravity.” (Kuzmicz, 2010)

This change began the process of power reconfiguration and greatly increased the influence of law enforcement. Since then, Poland has had one of the most restrictive anti-drug laws in Europe, punishing possession of any amount of illegal substances with either a prison sentence of up to 3 years, financial penalties, or both. The police were given unfettered power to conduct body searches, which occur for trivial reasons, and to raid homes when there is suspicion of a drug offense. The number of drug users entering the criminal justice system and charged with personal possession has risen significantly with each year since 2000 and are presented in figure 5. The first study summarizing the impact of the amendment of 2000, that criminalized personal possession, was conducted by a professor of law at Jagiellonian University in Krakow, one of the most prestigious in Poland. It has shown a substantive increase of arrests for drug possession. In 2000, less than 2000 people were arrested for drug possession. By 2002 this number doubled. In 2004 it reached 25,000 and in 2006, over 30,000. This trend continued thorough the decade. Besides showing a dramatic increase in the number of arrests for drug possession after the introduction of the 2000 law, the study pointed out that 56% of those possessing cannabis and

60% of those with amphetamines had less than 1 gram of the illicit substance. It went on to say that less than 5% of the cases were in possession of more than 20 grams, an amount typically held by a dealer. In addition, Krajewski's research showed that 60% of drug arrests were the result of routine patrols in gathering places of young people whereas only 20% were the result of specialized police investigations targeting drug dealers.

Figure 5. Drug Possession Offenses, 1999 – 2006

(Krajewski, 2009)



In the limited public discussion that immediately followed, two reasons were given for toughening the law. First, it was thought that criminalizing possession would help reduce drug trafficking because allowing for personal possession made it more difficult for law enforcement

to discern drug dealers with small amounts of a substance from personal use possession. Furthermore, it was assumed that criminalizing personal possession would deter young people from using illicit substances and that the example set by severely punishing a few, would have the great social benefit of protecting many. Nine years later, the Institute of Social Affairs tested both of these assumptions. Almost half (48%) of surveyed police officers and 60% of prosecutors did not find criminalizing personal possession to be an effective tool in apprehending drug traffickers. Similarly, as many as 66% of prosecutors, 58% of probation officers, 46% of judges, and 51% of police officers did not think that criminalizing personal possession deterred potential drugs users (Kuzmicz, 2010). The Institute of Social Affairs also published an analysis of police data from 2008 showing that only 4% of drug offenses were due to possession of a significant amount of an illicit substance (ISP, 2009). Krajewski's data showed that 24% of defendants were assisted by a lawyer and that 76% "negotiated" with the prosecutor unassisted being told that pleading guilty on the spot will greatly improve chances for reduced sentence (2008). This is a great concern to practitioners of criminal justice since such pressure undermines the principle assumption of the European Convention for the Protection of Human Rights and Fundamental Freedoms. Article 6: Right to a Fair Trial states, ". . . everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law." In 2008, Jagiellonian University's analysis inspired the Minister of Justice, Zbigniew Cwiakalski, to establish a committee to suggest changes to the drug law. Krajewski was appointed to chair the committee.

The legal changes of 2000 were initiated by the political opposition, a progressive Democratic Left Alliance, Sojusz Lewicy Demokratycznej (SLD), in response to demands from parents that

the government more actively control illicit drug use. The person who inspired and led the legislative process that toughened the law in 2000 was Barbara Labuda, a Minister in the Presidential Chancellery, ironically, the most progressive minister in that government with a long history of feminist activism. Ms. Labuda's explanation of her role in the policy change is consistent with Desveaux's suggestion that a shock or galvanizing event, or a key interest group is needed to engage and inspire policy change. According to Ms Labuda: "I am not a doctor or a chemist. I am a politician and a social activist. When parents and drug counselors visited my parliamentary office to tell me that they need assistance, that 7 year olds are using drugs, that 15% of students take drugs, you expected me to do nothing? Doing nothing would be comparable to offering kids poison in school shops. Polish law had to take a stand and to speak against it." (Staszewski, 2011) This emotional reflection, offered 10 years after the policy change, gives some insight into the politically charged parent supported anti-drug campaign that Minister Labuda led. The campaign's motto, "Better in Prison Than in a Cemetery" was a reference to the high HIV infection rates among drug users.

Interestingly, a few years earlier, neighboring Lithuania also experienced a surge in activism by parents who were concerned about their children's drug use. Their goal, however, was entirely different. "These moms gathering in Vilnius engaged in advocacy with the tools of democracy. They paid visits to public authorities, organized meetings with politicians, and liaised with the media about the need to offer treatment and other necessary services for drug users. It was due to the help of these moms that, in 1994, the rehabilitation center, Vilnius Centre for Dependency Diseases, opened its doors" (I can Live, 2009).

The legislative change in Poland occurred at a time when the political right was gaining strength and the future President Lech Kaczynski was emerging with his conservative Law and Order discourse. It appears that the left sacrificed on an issue that was less important to them to appease the increasingly powerful right. It is also worth noting that President Kwasniewski enjoyed a strong relationship with the United States, which supported Poland's entry into NATO. Drug use, previously considered a social and medical issue, was transformed into a problem of law and order in which drug users were now viewed as criminals, social outcasts, a threat to public safety, associates of the Russian Mafia, and perpetrators attacking law abiding citizens with HIV infected needles. Popular culture perpetuated these stereotypes through such vehicles as *Ekstradycja* (Extradition), a cops versus Mafia crime drama mini-series that ranked at the top of Poland's favorite television shows.

Ten years later, former President Aleksander Kwasniewski, who had signed the 2000 amendment into law, had a different perspective from that of Minister Labuda's. When confronted with data on how the 2000 law criminalized young people, he became one of the signatories of a letter from 44 Polish intellectuals advocating for changes to the repressive drug law (Krytyka Polityczna, 2010). Since the law under discussion can be clearly traced to Kwasniewski's presidency, many have advocated that the former President speak out on the issues. The international debate, including the existence of the Global Commission on Drug Policy which is comprised of multiple former Presidents, Kofi Annan and other high level politicians received much coverage in Poland assisted this process. In 2012, former President Kwasniewski went so far as to publish an op-ed in the New York Times in which he admitted making a mistake by signing one of the most punitive drug laws in Europe:

In the year 2000, as the president of Poland, I signed one of Europe's most conservative laws on drug possession. . . We assumed that giving the criminal justice system the power to arrest, prosecute and jail people caught with even minuscule amounts of drugs, including marijuana, would improve police effectiveness in bringing to justice persons responsible for supplying illicit drugs. We also expected that the prospect of being put behind bars would deter people from abusing illegal drugs, and thus dampen demand. We were mistaken on both of our assumptions. Jail sentences for the possession of illicit drugs — in any amount and for any purpose — did not lead to the jailing of drug traffickers. Nor did it prove to be a deterrent to drug abuse. . . It is my hope that political and community leaders in other countries, especially in Eastern Europe, will learn from Poland's experience in criminalizing drug possession, a move that clearly fell short of its goals. Such a policy failure should not be repeated anywhere else in the world.

(Kwasniewski, 2012)

He joined the Global Commission on Drug Policy with a commitment not only to engage in efforts in Poland, but also in neighboring Ukraine where HIV is heavily driven by injecting drug use.

It is worth noting that after 15 years with a relatively liberal law intended to be non-punitive for petty users and 11 years after the democratic changes had been in place in Poland, Minister Labuda's amendment raised little opposition. The trajectory she proposed was not consistent with the public's understanding and views, at least in Warsaw. A survey carried out in 2002 in Warsaw, *Psychoactive Substances: Attitudes and Behavior*, reported that 95% of people described a drug addict as someone who suffered from a physical illness and almost all respondents agreed with the medical definition of a drug addiction. Only 10% of respondents defined drug addiction to be criminal. When listing strategies for dealing with the problem of drug use, 12% favored punishment through the criminal justice system while the majority of

respondents favored treatment (Drug Report, 2003). It is likely that, even though Poles had a basic understanding of addiction, they saw little to be gained from spending their political capital standing up for drug users, especially, as perceptions in Poland and other post-socialist countries, had begun shifting. Criminalization of the drug scene had been progressing not only in practical terms but also in the eyes of the public. Fear and exclusion replaced compassion and understanding (Moskalewicz, 2002). It is also likely that the views of relatively cosmopolitan Warsaw residents did not represent the perceptions of all Polish citizens. Minister Labuda, an experienced politician, was well aware of this dynamic -- the neoliberal notion of self-reliance and individual responsibility were taking hold and the idea of contextualizing risk was losing acceptance. Finally, as the AIDS literature points out, democratic institutions and norms have played a mixed role in prevention efforts in their response to the epidemic (Putzel, 2001).

Though the drug policy discussions never used overtly religious language and the church did not visibly participate in the debate, the presence of the church was strongly felt. It greatly influenced perceptions of how illicit substances affect human dignity, and the conceptualization of the ideal post-socialist Polish citizen as an independent, morally strong actor, responsible for his or her own destiny. In the first case, it was argued that human dignity is based on the ability to make a distinction between what is morally right and what is morally wrong. The use of drugs, at best, blurs this ability and, at worst, annihilates it completely. "Blessed sobriety" is a phrase often used by church leaders when they publicly engage in discussions of substance use. In the second instance, drug users were categorized into a larger group labeled "Homo-Sovieticus," a term recognized by contemporary Russian psychology which was popularized in Poland by one of the most significant and progressive figures in the Polish Church, Professor Tishner. "Homo-

Sovieticus” is a person so stuck in the past and in the Soviet mentality that he is unable/unwilling to assume any individual responsibility for his own existence and remains forever dependent on the paternalistic, Soviet apparatus and according to Cockerham (2002) is of collectivist orientation and supports the notion of socialist heritage. Both of these church-promoted notions were present in public debates about drug policy. As the politics in Poland shifted to the right and aligned more closely with the church, the discussion over who does and does not deserve state-funded care became more dominant as did a rhetoric of blaming individual for health outcomes. Having a Polish citizenship was no longer sufficient to be considered worthy of state-funded public health measures or to health care. In the new paradigm, one had to be morally deserving as well.

It is important to note that there is one church representative, Arkadiusz Nowak, who played a critical role in response to HIV and drug use in Poland. He served as an AIDS and Drugs Advisor to three consecutive Ministers of Health beginning in 1994. While he consistently stood up against discrimination of people living with HIV and supported substitution treatment on the grounds of providing medical service to the infirm, his statements were always carefully aligned with the views of the church and with the notions of risk society where individuals are responsible for calculating costs and bearing the costs. During a recent discussion of amendments to the drug law he spoke against decriminalization because “it would send the wrong moral message.” Recently, he spoke to the press about condom promotion in the context of a public health campaign for the Euro Cup 2012 taking place in Poland, “Only living a moral life and remaining faithful will prevent HIV” (Kania, 2012).

Beginning in the early 1980s, the process of political transformation in Poland can be divided into two periods. The early years were characterized as pro-democracy and liberal-leaning with a relatively transparent set of goals, and leaders with long political histories, and wide recognition, who were not always agreed with, but were generally respected. Whereas in the second phase, it has been the populist appeals that largely drive public debate. Paradoxically, integration with the European Union opened a forum for a nationalistic discourse that reflected back on Poland's difficult history under German and Soviet occupation (Fundacja Batorego, 2010). It was in 2005, at the initiative of the progressive Minister of Health, Marek Balicki, that the drug legislation was amended again. Not surprisingly, taking into account the increasingly conservative climate, attempts to liberalize legislation related to personal possession of illicit substances met with significant resistance by both conservative and liberal parties, and ultimately failed. However, in mid-2011, due to a major mobilization of civil society, a much more modest attempt at changing the law to offer additional alternatives to the criminal justice system was successful.

Anand Grover, upon appointment as the United Nation's Special Rapporteur on Health and Human Rights, made his first country visit to Poland in 2010 where he engaged in a discussion and evaluation of the drug policy. The resulting report stated:

“The Special Rapporteur wishes to underline that national criminal laws and regulations have a significant impact on the success of harm reduction measures implemented in countries. National criminal laws need to complement harm reduction strategies and programmes. In this regard, criminal laws should not impede, but facilitate measures taken by States to reduce

the transmission of HIV and to provide HIV-related care and treatment for people using drugs. Research has shown that criminal laws proscribing syringe possession and promoting police practices targeting people using drugs increase the risk of HIV transmission and other health-related consequences, both directly and indirectly. Furthermore, such laws are likely to create a fear amongst people using drugs of seeking treatment and other health-related services, further fostering unsafe practices and risky behaviour.....In the context of harm reduction policies the Special Rapporteur notes with concern that the Law on Counteracting Drug Addiction penalizes even the possession of very small amount of drugs, making it difficult for people to receive necessary substitution treatment (Grover, 2010).

This observation was confirmed by an outreach worker from Warsaw, “Here people congregated in various groups and were always on the run, looking over their shoulders for dealers who wanted their money and the police who pushed them around. At that time, about 20% of the drug users in Warsaw were from Russia, Belarus, and the Ukraine and all of them were afraid of the police. Providing services in that environment became harder and harder.”

After the introduction of the punitive drug law in 2000, harm reduction programs, to be discussed in detail in Chapter Four, began reporting problems with uptake. Drug users became reluctant to access services concerned that participation would implicate them as partaking in an illegal activity. This user behavior in Poland is consistent with the international literature that suggests that criminalizing personal drug use deters users from seeking health services out of fear of arrest (Beyrer, 2010; Jelsma, 2009; Sarang, 2012). A long time outreach worker and drug counselor I interviewed observed that restrictions in the law might have had an entirely different effect. In his view, the gathering places, called *bajzel*, where drug users could easily be found by outreach workers to share information and exchange injecting equipment, were the same spaces where, as he describes it: “Everything else was shared, including drugs and HIV. If you have a

large number of people that are coming and going and there is a constant rotation, this creates the possibility of rapidly spreading HIV. This stopped with the change of the law because people stopped coming together.” At the same time, he admits that over the last ten years, the fear of police intervention has tightened drug using networks making it harder to locate gathering points and more difficult for outreach workers to engage with these groups.

In 2005, a year after Poland joined the European Union, Health Minister, Marek Balicki, attempted to undo the 2000 amendment, in part out of concern for the difficulties faced by the harm reduction programs. Minister Balicki’s effort failed in parliament. Most of the drug treatment providers, including MONAR, did not support Balicki’s plea. It claimed that the changes to the drug law had no influence on access to harm reduction services and were purely reflecting a decreasing number of injecting drug users (MONAR, 2009). The police argued that criminalizing possession improves police effectiveness in combating the illicit drug industry, but did not provide any hard data to support this assertion. Along with the production, trafficking, distribution, and transporting, the possession of illicit substances continued to be criminalized. The production, trafficking, purchase and possession of any equipment used for drug production was also illegal. In addition, liabilities were imposed on the owners and managers of various establishments to report distribution or trafficking of forbidden substances. The police are unrestricted in their right to conduct body searches as well as searches of a person’s place of residence. When formulating the charges for drug possession, the prosecutor often suggests that the accused admit guilt thus speeding the judicial process. Once the defendant pleads guilty there is little opportunity to recant their plea later. For these reasons, the system weighs heavily on the

side of the police and judicial system, and results in thousands of young people entering adulthood with criminal records.

This legislative process, and all others related to illicit drugs since, illustrates what Wiktor Osiatynski, identified as “a superiority of moralistic culture over the rule of law.” A prominent scholar of Polish constitutional law, Professor Osiatynski was referring to the tendency in post-communist societies to judge according to moral criteria rather than against a backdrop of legal norms. In his view, this tendency is particularly strong in Poland where historically, traditional values and cultural norms had been subordinated to collective ones (Stulik, 1998). This theory can be expanded to account for the limited consideration given to social science and public health research whenever data is in conflict with moral norms. At the same time, the body of research addressing policy change is at its fledgling stage since policy making during socialist times was steered by the Soviet Union.

The Two-Year Debate, June 2009 to June 2011

It was clear that any shifts in drug policy would not be easy. As proposed by James Desveaux, complex problems addressed by governments usually involve high political stakes (Desveaux, 1994). The multidisciplinary committee established by the Minister of Justice completed its work and presented its recommendations in mid-2009. Recognizing the conservative political climate in the country at the time, its suggestions for change was cautious. One suggestion was to replace Article 62.1, related to personal possession, with a measure that would prevent automatic sentencing and give prosecutors the option to suspend criminal proceedings when the amount of the illicit substance is small, in the case of first offenses, or if the defendant is drug dependent

and has a history of treatment. This proposed amendment was so minor that after it was accepted by parliament on April 1, 2001, Poland is still one of the most restrictive countries in Europe.

In 2008, four years after Poland joined the European Union, a study of six European countries (Bulgaria, Sweden, Denmark, Holland, Czech Republic) carried out by the Hungarian Civil Liberties Union (HCLU), revealed Polish attitudes to be the most restrictive in the group, on occasion matched by Bulgaria. Regarding punishment for possession or cultivation of cannabis for personal use, 41.5% of Poles favored imprisonment, the most drastic criminal justice measure, as compared to only 11.1% of Czechs. Fifty-nine percent of Poles, the highest of all surveyed populations, supported the “total war on cannabis” approach, while in the Czech Republic, the Netherlands, and Denmark the majority felt that cannabis users should not be punished. In Poland, 18.7% of respondents answered that the best reason not to use drugs is that, “It is forbidden by law,” while in Denmark this rate was 3% (HCLU, 2009). This study reveals a significant departure in Polish public opinion from the beliefs identified a decade earlier, when the majority of Poles saw drug dependence as a medical problem requiring social and medical assistance. Staniszki describes this decade as having been ruled by “capitalist logic” where social services became marginalized, the “common good” was devalued, collaboration became unimportant unless it resulted in monetary savings, the multigenerational solidarity and contract was broken. Poland’s neighbor, the Czech Republic, also endured decades under a totalitarian regime but took a different approach to drug policy, as shown in the HCLU study. It is more aligned with the liberal trends in Denmark and Holland on almost all indicators. Vaclav Havel, first Czech President after the transformation, considered drug policies matters early in his presidency, as evidenced by publication of his personal writing. He suggested that the approach to be taken by his country should be non-punitive and supportive of the young people (Hvisdala,

2007). Following “Velvet Revolution” Czech political and economic transformation, with all its consequences, and the process of integration with the European Union were somewhat slower and less dramatic than the changes in Poland. Poland, with its Solidarity movement that inspired the other Socialist Block countries, went through the transformation at a much faster and dramatic pace. It is also surely relevant that the Czech Republic is significantly more secular and that religious leaders, unlike in Poland, are not present in public debates about policy issues.

Consistent with HCLU findings about Polish views on drugs, the two-year debate in the Polish media, political life, and among civil society about drug policy changes was complicated.

Gazeta Wyborcza, a leading, liberal Polish daily, launched a campaign supporting the committee’s recommendations with the front-page headline, “My Narkopolacy.” The campaign sought to reshape Poland’s perception of drug addiction and to inspire change (Soltysiak, 2009).

All other print media, including significant monthlies, professional journals, and local and national dailies representing a wide political spectrum also responded. From the end of June (the campaign began on June 6th, International anti-drug day) and July, 38 articles were published on the topic: 23 favored liberalization, 6 opposed it, and 10 were neutral. August followed with 34 articles: 8 were in favor, 7 were opposed, and 19 were neutral. In September, 26 articles were published: 5 were positive, 1 was negative, and 19 were neutral. In October, there were 32 print media articles about drug policy: 13 favored liberalization, 2 opposed it, and 17 offered no opinion. In November, 29 articles appeared: 11 favorably related to the proposed changes, 2 were against them, and 16 did not address the issue. In the course of six months, a total of 160 articles on drug policy appeared in the mass media. Sixty of these articles favored drug policy liberalization, 18 were against it, and 81 offered no view on the proposed policy

changes, but did cover drug related issues in Poland and internationally. With just a few breaks for holidays and important national events, this rate of media engagement continued until the parliamentary vote.

Figure 6. Record of press coverage discussing drug liberalization (June – Nov. 2012)

	Favor liberalization	Oppose liberalization	Neutral
June-July	23	6	10
August	8	7	19
September	5	1	19
October	13	2	17
November	11	2	16
Total	60	18	80

One of the views presented consistently was that the role of the law is to reflect the desires of society which, in this case, was total abstinence. Proponents of this dissuasion argued that reduced penalties would inspire people’s interest in drug use, therefore penalties for drug possession should be steep. Consistently with Kowles’ notion that individual has the power and responsibility to maintain his or her own health, *Rzeczpospolita*, a Polish daily affiliated with the conservative party, in the early days of the debate, argued that hidden behind the appeal for a rational drug policy is an attempt at social engineering. The aim of this engineering is not a drug-free society (which should be the ultimate goal), but a society that offers drug users a peaceful life. The authors opposed harm reduction, suggesting that it was a concept created by the left-wing agenda without scientific evidence or value. *Rzeczpospolita* concluded that since, “no one

dies of withdrawal,” there is nothing wrong with leaving drug users to deal with their addiction, in prison and on their own (Bazak, 2009). Similarly, Catholic publications consistently came out against the proposed legislative changes. *Gosc Niedzielny*, a conservative weekly promoted during, and sold after the Sunday mass in churches, argued that the proposed amendment sends the wrong signal about acceptance of drug use (Gruszka, 2009). The Catholic Church opposed Poland’s European Union membership in 2004, arguing that integration threatens Christian values. It used the proposed change of legislation as an opportunity to prove that the European influence is undermining Polish morality. The Catholic press presented an image of a model catholic citizen who opposed the communist government, had helped Poland survive years of foreign oppression, was forced into economic obedience towards the European Union, and whose children are now threatened by a liberalized drug policy.

A year after the Commission made its recommendations and the debate began, Andrzej Czuma, was appointed as the new Minister of Justice. Czuma is a lawyer who spent a significant part of his career in the United States and who was best known for his lobbying efforts to relax gun laws in Poland. While he maintained the view that the law needs to change, his public explanation was far from the original intent. In his interpretation, charges against the accused would only be lifted if the detainee disclosed information about his or her supplier. This iteration caused significant discussion on both sides of the debate. One of the leading progressive journalists in Poland expressed concern: “Current Polish drug law sends to prison young people caught with small amounts of drugs. It is absurd and it should be changed. The trouble with the current proposal is that it proposes to substitute one absurdity with another; he possibility of dropping the charges if a person who is caught reveals the source of the drug. Small dealers are usually part of larger

underground structures. Will the state be able to ensure the safety of the people who gave out the name of a dealer?” (Zakowski, 2009) At the same time, a Catholic paper, *Nasz Dziennik*, warned the minister that he was opening the doors to police corruption, and appealed for criminal law that consistently prohibits citizens from possessing any amount of drugs, pointing to the Netherlands as a terrible country where “nothing is forbidden” (Czachrowski, 2009). By the end of 2009, Deputy Minister Krzysztof Kwiatkowski was promoted and replaced Andrzej Czuma as the Minister of Justice. Minister Kwiatkowski, in his public statements, held the view that punitive drug laws violate civil liberties and that using criminal justice tools, especially prison sentences, are ineffective in deterring users and, in the long term, destroy young people’s lives. He disagreed with law enforcement’s claim that focusing on petty users leads to the apprehension of serious offenders, and argued that the 2000 law distracted the police from pursuing serious dealers. Minister Kwiatkowski used the following data, often referred to in public debates, to support his claims, “In the 10 years since the 2000 drug law was put into place, the number of arrests for personal possession increased by 1,500% while the successful prosecution of dealers decreased by 100%.” The debate was not limited to government experts. Chart topping Polish singer and a songwriter, Kazik Staszewski, spoke out in *Machina*, a popular music magazine. He argued, in agreement with Minister Kwiatkowski, that Polish drug policy is ineffective because it criminalizes the users, distracting law enforcement from addressing the more detrimental crimes of dealing and drug production (Staszewski, 2009). A letter to the Speaker of the House signed by 72 personalities from the news media and the art world pointed out that criminalizing personal possession marginalizes young people, and that having a criminal record denies them access to jobs and other opportunities (Polish Drug Policy Network, 2011a).

The print media was not the only space for public debate. TokFM, the largest talk radio station in Poland, followed the issue closely. The Polish Drug Policy Network and Krytyka Polityczna created dynamic and engaging websites. In a letter to the Speaker of the House, the Polish Drug Policy Network stated: “Ten years of the current drug law shows that this amendment has neither helped to decrease levels of drug use, nor reduce the amount of drug-related crime. In fact, it has done more harm than good... Research shows that it is mainly young people, with no links to organized crime, who are being punished for possessing small amounts of marijuana.” The letter was signed by 30 national and 76 international groups and activists (Polish Drug Policy Network, 2011b). A blog about drug policy run by a lecturer of law, Mateusz Klinowski, was nominated for the prestigious Blog of the Year award (Klinowski, 2011). A Facebook campaign, *Apelujemy*, created by young professionals, collected over 60,000 signatures in support of the new law and used various new media tools to engage young people. Along with ongoing Facebook discussions, it also posted video statements made by international experts, one of them Ernest Drucker:

“We can say from many, many years of experience in the U.S.--where we now have two and half million people in prison because of these laws--that they make everything more difficult to do, they use money on enforcement that should be used on prevention, education and treatment... and there is plenty of evidence from the United States, from Canada, from Australia, from Great Britain, that the more successful, effective way to deal with drug problems is to keep them away from the criminal justice system as much as possible.” (*Apelujemy*, 2011)

In December of 2010, draft legislation made its way to the Parliamentary Committee on Human Rights and Justice where it was attacked by the conservative party *Prawo i Sprawiedliwość* or

PiS (Law and Justice) as well as the Chief Prosecutor whose office was integral to the long negotiating process. *Gazeta Wyborcza* suggested that the change in the prosecutor's office may be the result of internal discussions pointing out the increased amount of time required of prosecutors on each case (Siedlecka, January 2011). The majority party, Platforma Obywatelska or PO (Civic Platform) was fully present at the next committee meeting and the draft proposal made its way out of the committee and onto the list of projects waiting for a parliamentary vote. The Polish Sejm voted to adopt the new drug legislation on April 1st, the Senate voted in favor on April 28th, and the President signed it into law at the end of May 2011 (HRI, 2012). The effort, while limited in scope, may have been successful for a few reasons. First, the data, which showed the unintended consequences of the 2000 law, was produced by a leading Polish University and was embraced by the Minister of Justice who had been appointed by the ruling party and who had a historical relationship with the Jagiellonian University and the study's author. Around the same time, international funding was made available to a few newly founded advocacy groups including the Polish Drug Policy Network which became important partners with the media, participated in parliamentary expert groups and was generally visible. The more liberal media, not only covered the Polish debate, but also increased coverage of the discussion in the international arena in support of the Polish argument for liberalization. It is highly questionable as to whether a bolder amendment would have passed the legislature. Since the proposal was originally initiated by the ruling party, Platforma Obywatelska, it stood by this very minor change during the parliamentary vote. With relatively broad support from the liberal media, it would have found itself in a complicated position if it had voted against its own proposal.

The history of illicit drugs in Poland, throughout these three years, shows that policy making and implementation has always occurred in a highly politicized context and is, as a result, somewhat unpredictable. The most recent policy change is consistent with the literature suggesting that evidence is used by policymakers when researchers engage them directly. It was the criminal justice study by Professor Krajewski that inspired the Ministry of Justice to take action. Several sources in the literature also show that the likelihood of success is increased if evidence is explained through stories that resonate with key decision-makers, and if the evidence is used to influence the values and beliefs of decision-makers (Buse, 2011). Numerous letters, advocacy by civil society, and outreach to the popular and academic media were also helpful in prompting change. Public health officials were not engaged, and possibly because of this, public health considerations had limited influence over the debate about drugs in Poland.

Chapter Four: Drug Treatment and Harm Reduction in Poland

Treatment of drug dependence in Poland began in the early 1920s and was administered in psychiatric facilities. The first patient to be admitted for treatment of drug dependence was recorded in 1921 at the Dziekanka psychiatric facility. Seven years later, there are 85 such records from psychiatric institutions around the country, increasing to 295 admitted in 1933 (Bielewicz, 1988). There are also a few records of sanatorium stays, but these were expensive and rather rare. A heated discussion about the need for mandatory treatment occurred in late 1920s. It was instituted for those who broke the law while intoxicated as a compromise between what was perceived as a lenient judiciary and those who advocated for a more severe punishment (Bielewicz, 1988). In 1964, 165 persons were admitted to psychiatric institutions for drug dependence. The number of those treated remained steady throughout 1960s (Frieske, 1987).

Abstinence-Based Drug Treatment

Psychiatric institutions were the only option for drug treatment in Poland until the end of the 1970s. Numerous attempts were made to include drug dependent patients in alcohol treatment facilities, but these were, for the most part, considered unsuccessful. As described by a drug treatment provider, “You have to understand that psychiatric units were not popular places in the seventies. We were all watching *One Flew Over the Cuckoo’s Nest* and thinking of our patients, young people locked up in psychiatric institutions, sedated and sometimes tied to beds. Often,

these young people, young drug users, were there because they were perceived by the government as a nuisance. They were there for no other reason, really.” The first psychiatric unit to specialize in drug treatment was run by Ewa Andrzejewska in Garwolin. She is often described as a being maternal figure to patients and staff alike. A number of professionals concerned with the increase in drug use and dissatisfied with the standard treatment methods, started flocking to Andrzejewska’s department (Jump’93, 2011). Among them was Marek Kotanski, a charismatic psychologist who founded the first therapeutic community in collaboration with the Garwolin psychiatric hospital in 1978. A rundown estate with many acres of farmland was transformed into Poland’s first therapeutic community in Gloskow near Garwolin. This was the beginning of MONAR. The Polish socialist government had a number of mansions that it had confiscated from the owners after World War II. They were used for various purposes, but with time, lacking the resources to maintain them, they became severely run down. A second therapeutic community, Majdan, was organized under very difficult circumstances on another dilapidated estate with no running water, sanitary facilities, or central heating. The facility’s patients did all of the renovations necessary to make the space habitable (Cekiera, 2010). As Kotanski’s approach to drug treatment grew in recognition and popularity, the government handed over other such destroyed buildings to MONAR and young drug users, predominantly male, provided the free labor needed to rehabilitate what became a network of facilities across Poland. With the confidence of the socialist government, Kotanski managed to assemble the physical and political infrastructure that made MONAR the influential institution it is today; Poland’s largest drug treatment provider with 32 long-term rehabilitation centers making up 40% of all rehabilitation beds in the country (Poradnia, 2011). Currently, there are a number of regions in Poland where MONAR’s rich resources and infrastructure make it

impossible for other organizations interested in providing drug treatment to compete. All of the people I interviewed, when asked to list drug treatment organizations in Poland, listed MONAR as the first and the most significant one. All of MONAR's centers, along with six Catholic Therapeutic Communities, KARAN, receive half of Poland's national health budget dedicated to drug treatment (Jump'93, 2011). A study by the Institute of Neurology and Psychiatry illustrates the imbalance: 15% of all those in need of treatment and using the therapeutic community model use up to 60% of the national treatment budget, while half of all those in treatment and using the ambulatory method are allocated only 10% (Moskalewicz, 2010).

While the organization has evolved over time, MONAR's overall objective is to provide drug-free residential treatment and all of the services offered by the network support this goal.

Consequently, the aim of MONAR's outreach is to entice users into detoxification programs that are then followed by residential treatment. The homeless shelters for drug users run by MONAR also aim to bring clients into the fold of drug-free residential treatment. The treatment philosophy of MONAR is based on the premise that while addiction is a disease, it is a disease of the soul (Kotanski, 2003). To provide an effective cure, patients require clear structures, a daily routine filled with physical labor, and a nonnegotiable set of rules. Those who do not comply are punished in various ways and those who break their abstinence are immediately expelled.

A set of rules and guiding principles established by Kotanski thirty years ago continues to be applied in MONAR's therapeutic communities today. They were also adopted by a number of other implementers of this approach, such as KARAN. In short, as described by one of the drug

treatment experts associated with the drug treatment establishment for over two decades “The assumption was that treatment had to hurt. So even people who tell you that they favor treatment over prison, believe that treatment will be appropriately punitive.” Drug dependence was perceived as a fatal infectious disease and expulsion from treatment was seen as the only option for someone who was breaking the rules -- the health and safety of an entire group could not be sacrificed for the comfort of one, failing patient. “To increase the likelihood of therapeutic success, the ‘cancerous’ cells must be removed brutally, without concern for the pain the process will cause for the young person,” wrote Kotanski in 2003 when explaining the requirement for absolute abstinence and his nonnegotiable, “treatment intervention” of immediate dismissal of patients who broke abstinence. Treatment centers established internal “mini police squads,” made up of more experienced patients, whose job it was to check their fellow patients every three hours for pupil dilation and injection marks (Osipczuk, 2010). Such a view of drug dependence justified a number of punitive interventions including head shaving, prison-like uniforms, humiliating signs worn on a patient’s chest or back, and an extreme institutional culture where the majority reigned over the interests of the individual. This approach was consistent with the values of the ruling political party at the time when MONAR was established – individualism was undesirable under the socialist regime. A discourse of sacrificing individual needs for the good of the group was not unusual and may be one of the reasons why MONAR’s philosophy was widely publicized and quickly recognized as the only successful treatment option, even without any data. MONAR organized public spectacles with patients, dressed in prison-like uniforms, cleaning public toilets. This fit the common perception of drug use and drug users – drawing clear moral boundaries. It may be that MONAR received support from the government at the time, exactly because of its approach to treatment, rather than the

government's concern for increasing drug use. At the same time, heavily addicted young people found a sense of community there. According to one former client and currently an outreach worker, "While being at a sort of work camp was not meant to be fun, during the communist 80s, this was the only place welcoming to someone who was an addict and we appreciated that." The medical establishment, pleased to have rid itself of these complicated cases of drug dependence, kept silent thus allowing for MONAR's approach to remain unchallenged for decades. In most Polish cities today, if a person presents himself or herself to a psychiatrist and reports drug use, they will often be sent to a therapeutic community. As reported by a drug treatment provider, "I cannot tell you how many young people were sent to me with serious anxiety problems and depression, but only incidental use of cannabis. Having any drug experience made them ineligible for psychiatric care. This is changing slowly, but we have a very long way to go."

Another source stated, "While I have a number of issues with Kotanski's megalomania, I always felt that he was truly committed to the cause and in the face of evidence, could be flexible. If you sat and had a real conversation with him, a change in his thinking slowly became visible. When he died in a car crash it was a great tragedy for the drug treatment world in Poland. The people who took over for Kotanski are much more rigid in their approach. It's as though, in Kotanski's memory, they are more committed to his early goals than he ever was. Poles always try to be holier than our Polish Pope. Today MONAR is more Kotanski-like than Kotanski was himself." It was only in 2008 that an article critical of MONAR titled, "With Face in Manure," was published in the popular press. The article began, "To rehabilitate junkies, 30 years after its establishment, MONAR still uses extreme methods. Haven't cleaned the pigsty? Spend the night with the pigs. Didn't wake up on time? Cold water over your head." (Olszewski, 2008) After visiting one of the centers, the author described the system:

The daily routine at a MONAR rehab center near Opole, in Western Poland, hasn't changed since 1982. Starting their day with a two-kilometer run at 6:30 a.m., patients work hard all day on the farm. They meet twice a week in the evening to discuss plans for the center and decide on punishments for colleagues who have not followed the routine. Methods to break-in the newcomers these include wearing signs around their neck. There is a long list of rules; sexual abstinence (couples are not allowed to meet after 11 p.m.), no television, three coffees a day maximum, no swearing, etc. Life here is similar to other rehab centers where patients are taught that *a proper way of life* includes hard work, meals, sport, sleep, and sometimes a holiday. For several years, a sign hung in the common room stating, 'Love the grayness of life.' An example of 'provocative therapy' was witnessed when a therapist screamed at a female patient, 'You are fat, ugly, you have cellulite, everyone laughs at you behind your back.' The girl, with tears in her eyes asked 'Why are you telling me this?' The therapist replied, 'Because that's the truth. Do something with yourself.' The therapist explained that these methods are used in MONAR, 'because otherwise we wouldn't manage.' (Olszewski, 2008)

A former client recorded a similar experience in a book,

At the community meeting therapists assigned work for everyone. It was important to follow the rules because any violation had serious consequences. If someone broke a rule, he or she had to admit it during the community meeting and was assigned a punishment, called *dociazanie*. If you fell asleep with the lights on, you had to wear a light bulb around your neck for 24 hours. These penalties were important because they taught you to take responsibility for your behavior. Junkies are very imaginative when it comes to inventing punishments for others. After breakfast it was time for work, with a break for lunch. Care was taken so that junkies were not bored. Novices were forbidden to stay alone in the room, because it usually causes destructive thoughts. Therapeutic Community is a session where all members gather. This is a time when being offensive and judging others is not forbidden. There was usually an avalanche of hurtful words. You could really be humiliated, but it served a positive purpose – as a junkie, we can really stick to our denial. (Osipczuk, 2010)

Such treatment is in stark opposition to Article 7 of the International Covenant on Civil and Political Rights (1966), “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.”

In the Polish facilities using the model of therapeutic communities little actual drug treatment takes place. Instead, every activity, from peeling potatoes to working the land and morning exercises is considered therapy. It should also be noted that not all therapeutic communities are alike, “The oldest communities, where directors of the organization had themselves been through this sort of treatment in the 1980s, tended to be the most problematic, usually had a bad reputation and many empty beds.” (Osipczuk, 2010)

Until the political changes in 1989, having established a network of therapeutic communities, Poland considered itself a leader in drug treatment, among the Soviet Block countries. It's this self-perception of Poland's advancement in comparison to its neighbors that might have worked to Poland's detriment. As the political changes took hold and the national borders opened, the neighboring countries, recognizing their own limited experience, looked to the West for examples of effective treatment. Over time, various approaches were introduced in the Czech and Slovak Republics and Hungary while Poland persisted with its widely practiced abstinence-only method. Much more pragmatic, and secular Czech Republic was especially welcoming to the harm reduction approach which continues to be a strong pillar of its drug policy. It is also the first country in Central Europe to legislate access to cannabis for medical purposes. In Poland,

the introduction and expansion of other approaches, such as drug replacement therapy and harm reduction, has been very difficult, met with strong opposition, and has not flourished.

Methadone availability has been low and the number of needle exchange outlets and exchanged equipment has seriously decreased over the last decade, after peaking in 2004. The report of the United Nations Special Rapporteur on Health and Human Rights, following his visit to Poland stated:

Trends indicate that, while substitution treatment is available, a drug-free treatment regime is still prevalent within the country. This is of particular concern, as studies demonstrate that substitution therapy is a more efficient and less costly way to treat drug dependence. Studies have indicated that patients under methadone maintenance treatment and buprenorphine substitution therapy are more likely to discontinue or considerably decrease their use of illegal psychoactive substances. Furthermore, harm reduction interventions are well supported and promoted by UNAIDS, WHO and UNODC in their best practice guidelines. (Grover, 2010)

The Current State of Drug Treatment in Poland

Poland has two different systems for treating addiction; one for alcohol dependence and the other for drug dependence. Treatment for dependence on alcohol is supervised by the State Agency for the Prevention of Alcohol Related Problems and the National Bureau for Drug Prevention oversees the treatment of drug dependence. The network for alcohol treatment consists of 400 outpatient centers and 111 inpatient facilities. All facilities are part of the public health care system and the National Health Insurance (NFZ) or the Ministry of Health covers the cost of treatment for alcohol and drug dependence when a person is not eligible for NFZ coverage. Drug dependence is treated by fewer than 100 outpatient centers, 20 inpatient detoxification

programs and 60 inpatient facilities, most of which are run by non-governmental organizations (IATPAD, 2009). During the process of political transformation, the number of people seeking psychiatric care, including drug and alcohol dependence, increased significantly. An increase of 70 percent was recorded between 1990 and 2003. The number of people admitted for drug dependence is smaller, but the rate of increase is greater (IATPAD, 2009). Drug treatment in Poland is voluntary, with only two exceptions; when a patient is under 18 his or her guardians can make the decision or when the patient is an inmate and then admission is done on the directive of a prison physician.

A multi-country study in Europe that interviewed clients of alcohol and drug services in Poland concludes that drug treatment patients were much less positive about their experience than the patients treated for alcohol. Waiting lists, cumbersome bureaucracies where a patient must spend days retrieving information about previous treatment from various cities throughout the country, descriptions of random admission procedures, the sense that personnel are unfettered, the stress from feeling that the constant requests and instructions are senseless, a two hour commute to the “closest” treatment center, and poor facilities described as resembling a movie set, were some of the problems identified (IATPAD, 2009). Most of these comments refer to therapeutic communities as they are the predominant service.

In 2009, the Helsinki Foundation for Human Rights monitored 18 therapeutic communities (over 20% of the total in Poland) located in 6 voivodships. In addition, in-depth interviews were held with seven former patients currently in the care of outpatient clinics. Among the monitored

centers, 7 were run by MONAR (39%), 5 by other non-governmental organizations (28%), 4 by the local government (22%), 1 by a Church organization and 1 by a private enterprise. Four centers admitted minors and 3 housed mothers with children. Most conducted long-term therapy of 12 months or more (70%), and a few promoted a stay of up to 24 months. Short-term therapy, for up to 6 months, was offered by three centers, including one for a period of 8 to 9 weeks.

The Helsinki Foundation's report noted no concerns in the observance of fundamental human rights; the right to information, protection from degrading treatment, privacy, contact with relatives and loved ones, the right to lodge a complaint, and to access education. It did however, observe the following problems: lack of clarity about the need for stripping and body searches at admission, unjustified restrictions regarding contact with relatives and others, lack of clarity about penalties imposed by the community and staff. Access to stationary treatment was deemed satisfactory but a concern was noted that patients often treat their stay at the center as an opportunity to improve their physical condition, survive the winter, wait out a difficult time in their life, and not necessarily as an opportunity to treat their dependence. Terms such as "treatment tourism," or a need to "get a grip on oneself" were not unusual. Data regarding patients who fail to complete the course of treatment (approximately 70 to 75%) and then return to another facility were not unusual and were troubling, both in terms of the effectiveness of the treatment and the costs incurred by the Polish National Health Fund (NFZ). The maximum number of long-term treatment stays by one person was 12 (Helsinska Fundacja, 2010). The Central Bureau of MONAR objected to monitoring by the Helsinki Foundation. The centers that accepted the monitors did so on their own volition, which puts into question the generalizability of the findings.

The shorter-term treatment centers have more therapeutic activities in the strict sense, while the long-term therapy programs involve various types of work, often referred to as *ergo therapy*. There was no evidence that those who stay at the facilities for 1.5 to 2 years undertaking various types of community work are better prepared for independent life after release. No standards and mechanisms for evaluating the effectiveness of drug treatment for individuals were identified.

Even though MONAR has been in existence for over 30 years and it uses large amounts of public funding, there has been no formal institutional evaluation. There are a few masters degree-level papers that assessed individual treatment centers cited during the celebration of MONAR's 25th anniversary at the Catholic University in Lublin. Evaluation of the effectiveness of treatment was assessed by interviewing 30 former residents who completed the program and had maintained abstinence from drugs for at least one year. They were asked questions about their current and retrospective self-image. The author concluded that those who successfully completed treatment could be characterized as needing permanence and stability, and possessed a desire to help others, a strong need to understand others, diligence, high energy, initiative, tolerance, and forbearance in interpersonal relations. Another attempt at evaluation concluded that the community home creates a unique atmosphere of sincerity, security and responsibility. Friendships that developed during treatment are of paramount importance for people treated for drug addiction. The feeling of community and responsibility for one another and striving for the same purpose is critical to the effectiveness of rehabilitation in MONAR. A third evaluation effort summarized the following outcomes of a study without explaining how the study was

done; 27% of the residents state that the center is nice, 20% positively evaluated education efforts, 13% felt that MONAR is effective, 50% believed that they can live a sober life, 20% felt that they are learning honesty, and 17% felt that MONAR gave them hope for a drug free life. Seventy-seven percent stated that the treatment system at the center is helpful (Cekiera, 2010). It is clear from these small evaluation efforts that a number of drug dependent individuals appreciate the service they receive, they value the opportunity to be a part of a community and that this is where they find acceptance and friendship. With no long term follow up of patients initiated into treatment; its efficacy is impossible to measure. The first evaluation, for example, mentioned only those who completed treatment and said nothing of people who entered but dropped out. According to Helsinki Foundation 75% never complete the course of treatment. This is consistent with data from the US where outcome studies of abstinence-based treatment showed 15%-35% retention at 12 weeks (Kellogg, 2007; Marlatt 1998).

Substitution Treatment

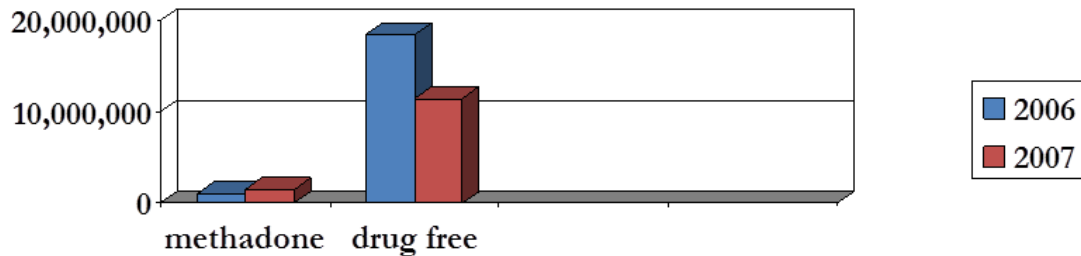
A pilot substitution treatment program established in 1991 at the Institute of Psychiatry and Neurology in Warsaw was one of the first of its kind in the entire Communist Block. It created much debate, and, as in many countries (Ambekar, 2012; Drucker, 2012; Newman, 1983), when it began it mobilized substantive opposition. Professor Zielinska, for example, a well-respected AIDS physician, in an interview with the press stated, “Providing methadone turns a blind eye to the fact that someone is a drug addict. In fact, it sentences this person to a slow death. It is clearly unethical because by prescribing it, physicians show the patient that no further effort will be made to rescue him or her.” Arkadiusz Nowak’s view was that methadone may offer an

alternative, but only for a few: “We cannot allow it to be available to anyone who wants it. Humanitarian reasons allow for methadone to be provided to drug addicts with AIDS and those with a very long history of use and many failed attempts at treatment. When very little life remains.” And finally, Marek Kontanski said, “The doctor’s job is to *treat* drug addicts. Instead, they tell them that they can live, thanks to methadone. They give them the drug and create a philosophy to go along with it. They basically condemn them to a life of addiction. But people who take methadone do not live a full life. That is fiction. It is a fiction promoted by medical professionals.” (Montgomery, 1998) As recalled by a harm reduction provider and a former drug user, the greatest opposition to substitution treatment comes from the providers of abstinence oriented drug treatment, “ I too was very suspicious of this model. What changed my mind, really, was a friend who, out of frustration, after another failed attempt at treatment, tried to commit suicide by jumping in front of a train. I can list people who are no longer with us who could have been helped if treatment providers were more open to this possibility.” The first program outside of Warsaw, also as a pilot, was inspired by an infectious disease physician in Chorzow who identified the need for substitution treatment in support of drug users’ adherence to HIV treatment. This model was supported by Arkadiusz Nowak as it aligned with his view that people with AIDS should have access to this modality, as a palliative intervention. When the pilot phase ended and methadone was approved for treatment of opioid addiction, for reasons that continue to be unclear, the most expensive form of it, produced by an Italian pharmaceutical, Molteni, was registered in Poland. This has had long term implication to availability of methadone treatment since high price of the medicine is often quoted as an obstacle in expansion of programs.

Though MONAR has adopted a harm reduction philosophy, one major difficulty remains. It amended its constitution to state that none of its centers can be associated with substitution treatment because it goes against the organization's drug-free philosophy. This is a disappointing development since, with its extensive network of programs throughout the country and decades of experience, MONAR is perfectly placed to advocate for and deliver much needed substitution treatment services. A number of European countries, including Switzerland and Italy, have managed to open their therapeutic communities to welcome methadone patients. This, however, is not currently possible in Poland. Interestingly, a MONAR drop-in clinic in Krakow, under the direction of a long-time harm reduction advocate, is providing buprenorphine to clients who are unable to abstain from opiates. This is a pilot program that has been functioning quietly and does not seek attention.

Despite rich literature on effectiveness of substitution treatment (MacArthur, 2012) and an increasingly favorable policy environment for this form of treatment, the number of drug users receiving substitution treatment has remained low. Slightly over 2,000, or 8% of the estimated number of dependent opiate users, are receiving substitution treatment. In comparison, there are 70,000 methadone patients in neighboring Germany (Golz, 2006), which represents roughly 40% of Germany's illicit opiate users. In Switzerland, 18,000 out of a population equal in size to Poland's 25,000 opiate dependents are receiving methadone treatment (Csete, 2010). In neighboring Lithuania, which began substitution treatment at a similar time and under similar conditions as in Poland, approximately 15% of people dependent on opiates receive substitution treatment (I Can Live, 2009).

Figure 7. Funds allocated by NFZ, in PLN, to methadone & drug-free treatment in 2006/2007



For active drug users, adherence to the HIV treatment regimen is a challenge documented throughout the world (Oppenheimer, 2003; Carrieri, 2006). To enroll and keep drug users in care, substitution treatment, such as methadone or buprenorphine, is used as an adherence support (Villalbi, 2004; Altice, 2006). Since antiretroviral medicines often interact with methadone, it is important that HIV clinics and methadone programs develop collaborative relationships (Cholewinska, 2004). With this idea in mind, infectious disease clinics in Chorzow, Wroclaw, and Warsaw introduced onsite methadone substitution treatment. This initiative has been successful and warrants expansion.

Though Poland has made substitution treatment more widely available, the programs are not necessarily based on the principles of harm reduction or the desire to empower people who are drug dependent. In fact, treatment is most often delivered by way of authoritarian medical institutions. Methadone patients have reported frequent urine tests, threats of expulsion, underdosing, and strip searches for evidence of ongoing injection (NGOs: Wyzwolenie and Jump'93).

One of the foremost authorities on HIV treatment for drug users published the following observation, “Specialists in the treatment of addiction must objectively differentiate between actual withdrawal symptoms and manipulation typical of drug addicts seeking to obtain higher methadone doses.” (Cholewinska, 2004) The suspicion that patients are abusing the “privilege” of therapy pervades Polish drug treatment and HIV services.

As methadone programs mature, patients are becoming more aware of their needs and empowered to express them. Wyzwolenie, an organization of methadone patients in Krakow, was formed in response to an announcement by program staff that the methadone dose for each patient will be reduced with a goal of complete detoxification within days. As stated by the organization’s representative, “We felt that no one cares about our needs and that we were being pushed back to the place we struggled to get out of – back into uncontrolled addiction.” (Wodowski, 2006) One of the goals of Wyzwolenie is to help methadone patients reintegrate into society by completing high school, obtaining employment, and reconnecting with family. It also advocates on behalf of patients who are in trouble with the treatment program and are at risk of expulsion. Jump’93 (National Polish Association of Drug Users and Substitution Patients), based in Warsaw, is another organized group of methadone patients. In addition to supporting patients in the capital, they also do advocacy work in cities where methadone is unavailable. Even though drug user movements are present across Europe (Curtis 2004, Michels 2012), methadone patients are the only voices of drug users in Poland.

Various national frameworks regulating and encouraging the expansion of substitution treatment are firmly in place; the National Health Program from 2007 to 2015, the National Psychiatric Care Program, and the National Program for Drug Prevention from 2011 to 2016 are all approved by the Polish parliament. One of the objectives of the National Health Program is to increase the number of ambulatory clinics for drug treatment, including substitution treatment programs. The National Psychiatric Care Program, even more specifically, is mandated to create substitution programs throughout the country wherever there are a minimum of 30 potentially opiate dependent persons. Finally, the National Program for Drug Prevention, has to provide at least 25% coverage of all substitution treatment given to opiate dependent persons in all regions of Poland.

Since the introduction of substitution was controversial in Poland and required a number of clear and restrictive legislative measures that stipulated the basis and conditions under which opiate dependent persons may be treated with methadone, a number of amendments were enacted. The 2005 Act stated that methadone may be provided within the framework of a therapeutic program by a healthcare facility licensed by the provincial governor and on the recommendation of the Head of the National Bureau for Drug Prevention. Following are the admissions criteria: the patient has been addicted to opioids for at least three years, is 18 years of age or older, abstinence-based treatment attempts have failed, the patient commits to abstain from narcotic and psychotropic substances, and expresses written consent to enter into such treatment. Methadone is the basic substitute drug used and enrolled patients must participate in counseling for at least two hours per week (Rozporządzenie, 2007). A more recent amendment removes most of these restrictions. Under strict conditions, it even makes it possible to enroll a person

that is below the age of 18. The criteria to show multiple failed attempts of abstinence-based treatments was also removed as heavily addicted patients were traveling the country in order to enter a residential program only to discharge themselves a few days later. It is noteworthy that while the Drug Prevention Bureau can be credited with successful efforts in relaxing criteria for methadone treatment, it is somewhat slow in its efforts to expand the number of medicines available for substitution, yet another manifestation of neoliberal practice of Polish institutions, as described by Hausner (2007). MONAR opposed the amendments relaxing the treatment criteria. Its center in Gdansk went on the record stating their concern that young, drug dependent persons will maintain their addiction by taking methadone financed by public funding, rather than strive for abstinence. In their view, such treatment should only be available to pregnant women and people with serious medical conditions. A similar statement was issued in 2008 by the entire organization suggesting that the current criteria was too lenient and advocated for an increase in the number of years of opiate use and the number of failed attempts at other forms of treatment.

While most European countries use multiple pharmaceutical products for this purpose, for example, Germany has 18, Poland only uses methadone. Buprenorphine, the second most administered substitution medicine in Europe is currently only registered in Poland as a pain medication, with a very few exceptions where it is prescribed, somewhat illegally, as replacement therapy the cost of which patients must cover in full. Slightly more than 2,000 people, or 8% of those who are estimated to be opiate dependent, have access to substitution treatment. Despite its early adoption of this form of treatment, Poland now has the second lowest number of substitution patients in all of Europe (Jump'93, 2011).

While formal restrictions on substitution treatment have been relaxed since the first programs came into existence, many program directors continue to enforce some of the outdated rules making most of Poland's substitution high-threshold. In addition, funding calculated by the NFZ is such that it is more profitable for the program to have a client show up for his or her medicine every day, clients have to make an extra effort to be allowed to take their treatments home. Generally, the spirit of most of the methadone programs resembles the overall drug treatment culture in Poland. A six month wait is required to re-enter a methadone program if someone left of their own will or was expelled. No other form of treatment exists in Poland, where it would be legal to require a patient to wait half a year to receive medically necessary medication. "Methadone is not considered medicine by the very medical staff who provide it," states one of my interviewees. "If it were, all these practices would have no justification. They think of their patients as bums and losers. How else could you justify withholding medical treatment from someone who needs it?" One of my interviewees, a drug treatment provider, when speaking of substitution programs said: "It is as though we are running a relay race. Methadone programs continue what started in the therapeutic communities. We no longer cut off people's hair, now we cut off their balls." A former methadone patient and now an active advocate for substitution treatment has a similar observation: "Only a few days ago, 14 people were drug tested and crossed off the list in one day. None of them were provided reduced doses to get them off methadone. In the last year, we had a few of those 'black Tuesdays.' Rotation at the programs is high. On an annual basis, roughly one third of patients get thrown out and immediately replaced by others waiting to be admitted."

Throughout the 2000s there have been various forms of advocacy for the expansion of substitution availability. The objective has primarily been to guarantee access to substitution in all the large Polish cities. Gdansk, the home of MONAR's current leader, Jolanta Koczurowska, has been especially resistant. In mid-2011, local authorities finally made 650,000 PLN available for the renovation of a facility (Katarzynska, 2011). However, by the end of the year, the program was still not in operation. The public debate is visible as evidenced by a number of press articles in the last three years, the most recent of which quotes several local officials and specialists opposing the availability of substitution. Mr. Dubiel, a deputy chair of the regional National Health Office states: "I do not understand why methadone therapy should be covered by the national health insurance. Especially at a time when we lack funding for a children's hospital." Another, Ms. Dominiczak from the voivodship social service bureau states, "If this program begins, we will do all we can to make sure that only the most infirm have access to it." Finally, Mr. Kowalczyk, the local treatment specialist and an advisor to the Wojewoda (governor) states, "If methadone cured addiction, whoever invented it would have received a Nobel Prize." (Gromadzka-Anzelewicz, 2011) A physician from the neighboring city, Bydgoszcz, inspired by the pleas of patients, activists, and ongoing media reports, set up a temporary satellite facility out of his own clinic and now provides treatment to 30 individuals from Gdansk.

During his mission to Poland, the United Nation's Special Rapporteur visited Gdansk, where he met with representatives from local Government and civil society. His summary of these discussions follow:

Despite the fact that the 2005 Act on Counteracting Drug Addiction provides for the establishment of substitution programmes, drug-free treatment - the therapeutic community model based on total abstinence theory - is the norm in the tri-city region of Gdansk, Sopot, and Gdynia. There are nearly 310 places in the region for those in need, including both inpatient and outpatient treatment centres, and the regional government has allocated up to 7 million PLN (approximately 2.5 million US\$) to such drug free centres. As the therapeutic community model remains the standard in Gdansk, it is difficult for people requiring methadone treatment to receive the care they need in the area, and they must travel to Warsaw or Krakow to receive it. The Special Rapporteur commends the decision of the local Government to start a methadone maintenance programme in Gdansk by September 2009, but regrets that, as of March 2010, the programme has not yet been established.

Tensions between the advocates of the drug free, substitution, and harm reduction treatments are high in Poland. These are illustrated by the outcomes of a round table discussion that took place in April 2011 organized by the Polish Drug Policy Network, an association of methadone patients called JUMP and the the Ombuds for People Who Use Drugs (a position created by an NGO). The purpose of the meeting was to discuss the availability and quality of drug treatment services among 23 participants representing 12 institutions. The group produced a letter to the Council for Drug Prevention identifying the following concerns:

- The preference for abstinence-only treatment undermines the availability of substitution treatment.
- While more than half of those seeking treatment are in outpatient care, the intervention is severely underfunded and receives less than 10% of national treatment funding.
- Poland has more therapeutic communities than any other country in Europe. Seventy-five percent of total funding for drug treatment from the National Health Fund is dedicated to this modality leaving few resources for other options.

- In many regions large monopolistic organizations refuse to expand the scope of services provided and exclude substitution treatment and harm reduction.
- Post-treatment must be undertaken in settings where people can also access jobs, education, and other opportunities. Isolating those who have completed treatment in remote and inaccessible locations is counterproductive.
- The deficit of physicians willing to administer substitution treatment is a problem that needs urgent attention -- only 25 such physicians could be identified in all of Poland.
- The only comprehensive, city-wide program that has been responding to drug users needs for two decades in Krakow was dismantled with little intervention from national bodies.

The following recommendations were issued:

- The availability of substitution treatment must be expanded.
- Capitalizing on the amendments to the criminal law that strive to reduce imprisonment, cooperation needs to be established between the judiciary and drug treatment providers.
- Physicians must have access to in substitution treatment training.
- Local governments must pay more attention to homeless drug users who receive little support and are vulnerable to HIV infection.
- Antimonopoly actions should be initiated against treatment providers who intentionally block others from expanding their range of services.
- Case management should be introduced as a method for controlling public expenditures and understanding use of services. The only successful holistic model of treatment in Krakow should be reinstated.

Harm Reduction

In 1988, when the first drug user infected with HIV was identified in Poland, there were no syringe exchange programs in place. A legal regulatory framework allowing for methadone maintenance therapy was not to be adopted until almost 10 years later, in 1997. By then, the

average HIV prevalence among communities of injecting drug users in Poland was at twenty percent, and in some voievodships (states) the rate was as high as forty percent. Hepatitis B and C are common among drug users: in a study of 133 HIV positive patients treated in the Department of Infectious Diseases in Krakow, eighty-four percent of drug users had HIV, Hepatitis B and C concurrently, as compared to eight percent of non-drug using HIV patients (Kalinowska-Nowak, 2004). A town near Poland's eastern boarder, Bialystok, reported HCV rates of 90% among drug users (Cook, 2008).

It was in the context of the drug-free treatment environment that, in 1989, after the first drug user who happened to also be a MONAR client, was diagnosed with HIV, that MONAR began intermittently making needles and syringes available. The initiative was inspired by the availability of syringes through donations from Sanitation and Epidemiology Stations and the Red Cross. This was the most significant effort ever undertaken to make syringes available to drug users in Poland. Rarely, however, did the syringes satisfy the needs of users who complained that they were of poor quality and the wrong size. It has been estimated that from 1989 until 1995, approximately 1 million needles and syringes were distributed throughout Poland, roughly 125,000 per year (Wodowski, 2005). By comparison, a Chicago-based NGO, exchanged 2.6 million syringes in 2006 alone for a population of drug users that was less than twice as large (Chicago Recovery, 2007).

Currently MONAR, though formally engaged in harm reduction efforts, has only two needle exchange programs, one in Krakow and the other in Warsaw. In other cities, needles and syringes are available sporadically, but are not distributed with a strategic focus.

Needle and Syringe Programs

Like most of Europe, Poland's National Program of HIV Prevention introduced needle and syringe exchange programs in the late 1980s (Drucker, 2011a). However, coverage has been negligible since a budget was not allocated to support the program. This is still the case today. When the first discussions about implementation took place, medical personnel rejected the idea of making needles and syringes available to drug users claiming that such services would encourage drug use. It is worth noting that at that time, hospitals and medical clinics were struggling with a shortage of medical equipment. In the beginning, given the lack of proper budgeting, shortages in conventional medical settings and the novelty of harm reduction, none of the government's medical providers were persuaded to offer needle exchange (Kulka, 1998). However, a year later, a small number of sexually transmitted infection (STI) clinics and public health offices began to offer needle distribution. Many rejected the provision of free condoms, consistent with the Ethical Commission of the Chamber of Physicians, which publicly declared that the promotion of condoms is "shameful" (Hendriks, 1991). As happened in France, where physicians united in opposition to some forms of treatment (Nathanson, 2007), Polish doctors played a counterproductive role by stating views that were at odds with conventional HIV prevention and evidence-based drug treatment. The Ministry of Health offered financial incentives to medical staff working with HIV positive drug users, including salary increases of

up to 200% (Johns, 1991). By 1993, 75% of voivodships in Poland reported having at least one needle distribution site, many of them implemented by MONAR (Kulka, 1998). The Open Society Institute² made external funding for harm reduction services in Poland available in 1997 (OSI).

The only national study of needle exchange and distribution in Poland was carried out in 1996. Of the 254 questionnaires that were sent out to MONAR, STI clinics, psychiatry clinics and ambulatory health services, 65 were returned. The study concluded that no matter how limited or unprofessional the syringe distribution or exchange was, it enabled initial contact with active drug users and thus a way for workers to distribute HIV educational materials. For drug users not interested in pursuing drug treatment, the distribution point for free needles and syringes became the only opportunity to engage with a health care or social assistance setting. For many providers, distribution of injecting equipment became their first opportunity to offer a service that was not coercive, was assessed as helpful, and did not place clients in a disempowered position. The following problems were reported by the respondents in the study: the lack of funding hindered the distribution of syringes and often resulted in breaks in service; the poor quality of injecting equipment donated by various institutions; difficulties with police who

² The author is currently an employee of the Open Society Foundations, previously, Open Society Institute

confiscated needles and syringes from outreach workers or clients; the recycling of returned equipment; the lack of drug-user-friendly medical services often requested by clients. A study of the relationship between HIV rates and the number of needles and syringes distributed between 1992 and 1995 indicated a significant inverse correlation between the rate of distributed injection kits per drug user and the number of new infections (Kulka, 1998).

At the end of 2011, the European Monitoring Center for Drugs and Drug Addiction, in cooperation with the European Center for Disease Prevention and Control jointly released a set of guidelines for European Union member states, *Seven Ways to Reduce Infections Among People Who Inject Drugs*. The recommendations are:

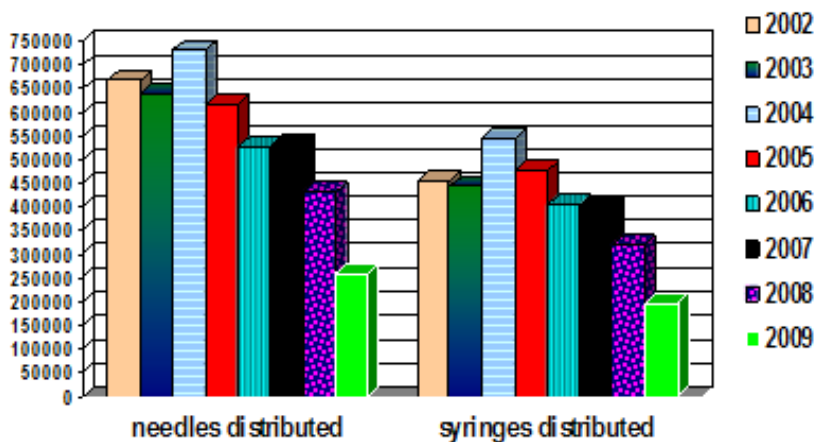
- Provide free access to clean drug injection equipment, including sterile needles and syringes, as part of combined multi-component prevention, harm-reduction, counseling and treatment programmes.
- Offer vaccinations for infections for which effective vaccines exist, such as hepatitis A, B, tetanus and influenza. For HIV-infected individuals, the pneumococcal vaccine is also recommended.
- Provide access to treatment, in particular substitution treatment, for opioid users.
- Grant access to testing for HIV, hepatitis C and hepatitis B and other infections, including tuberculosis; ensure the link to treatment.
- Provide antiviral treatment as clinically indicated for HIV, hepatitis B or hepatitis C-infected. Tuberculosis treatment is recommended for active cases, while prophylactic therapy should be considered for latent cases.
- Provide health promotion focused on safer drug use and sexual behaviour to enable people to increase their ability to control and improve their health.

- Offer a range of services, delivered according to user needs and local conditions, such as drug treatment, harm reduction, counseling, testing and referrals to other medical services.

There is no city in Poland that meets all of these guidelines. Warsaw comes the closest, but it lacks the vaccinations recommended for people who inject drugs. In all of Poland's existing harm reduction programs, four vaccinate staff against hepatitis A or B (2010 National Report). None of the programs offer vaccinations to their clients.

As presented in **Figure 8** below, there has been a significant decline in the number of needle exchange outlets in the country and the number of needles and syringes exchanged. There are currently 12 such programs in the entire country.

Numbers of needles and syringes distributed in 2002 – 2009.



Centrum Informacji o Narkotykach i Narkomanii KBPN

The greatest number of needles (731,832) and syringes (545,738) were distributed in 2004. The greatest decline, 259,220 needles and 196,960 syringes, was in 2009. The number of needles distributed per user fell to 80 pieces a year while in 2008 it had been approximately 140 (2010 Raport).

The UN Special Rapporteur on Health and Human Rights commented on this decline:

There is a need for improved harm reduction measures to treat drug dependence in Poland... It has been indicated that there has been a decline in the number of available needle and syringe programs over recent years. For example, while there were 21 needle and syringe programs available throughout the country in 2002, only 13 such programs existed in 2008. The total number of people being treated by these programs has significantly decreased and as of 2008, only 432,720 needles and 318,054 syringes were distributed in the country (Grover, 2010).

The shift from national to local planning and implementation of drug related services had a detrimental effect on harm reduction. The effect was compounded by the fact that this shift took place when Poland became a member of the European Union and international funding assistance for Poland began to decline. As municipalities and other local authorities became the primary funders of harm reduction, the programs began to wither. Today, Warsaw, with a functioning needle exchange and multiple methadone programs, is the only exception. While expansion of substitution treatment is complicated and has met with severe opposition, various national strategies for health, psychiatric health, and drug prevention clearly state the objectives that localities should attempt to adhere to and provide important advocacy tools. This is not the case with needle exchange as national documents do not provide concise implementation guidelines for municipalities or local governments.

The harm reduction professionals I interviewed had divergent views on the dramatically decreasing number of needles and syringes exchanged. On the one hand, there is agreement that foreign funding was instrumental in getting programs started as well as for scaling up and professionalizing those services already in existence. It also increased much needed flexibility. The programs have always been locally based with little opportunity for sharing information or collaboration between cities. Staff are reporting an increased difficulty now that local funding does not allow for collaboration and limits the possibilities for outreach. As explained by one source: “Since we are funded by the municipality, we can only work in the area of the administrative city. If we learn of groups of drug users situated immediately outside of the borders of the city, we would not be allowed to assist them.” Attempts were made to create a Polish Harm Reduction Network to facilitate collaboration and advocacy across the country, but the project failed to secure funding. With the end of international support, many programs either scaled down or closed. Other sources report that in mid-2000, even with foreign money in place, programs were not reaching many drug users because the numbers of injectors were decreasing. Yet another explanation offered was that increasing arrests due to the implementation of the punitive drug law atomized the drug user communities, forced the disappearance of gathering places, and inspired people to use mobile phones to arrange for as-needed exchange. While structural interventions were never strong in Poland, the new law shifted the burden of HIV prevention entirely on drug users themselves without any recognition of social conditions as fundamental causes for illness. Newer drug users, who began drug use after the introduction of the 2000 law, never tapped into the support network that was available before and are now, for the most part, functioning underground out of the reach of harm reduction programs. A harm reduction worker from Warsaw reported meeting 40 “newer users”

in 2011, each had begun by smoking heroin and then progressed to injection. In the absence of a public health campaign, they learned about the needle exchange program from their dealer.

An alternative view was offered by a harm reduction worker from the south of Poland. They believed that the decline in the number of harm reduction programs was due to the decreasing number of opiate users. As the drug dealing industry became more established, tensions between users and dealers became so significant that they inspired people to detox. In the past, many drug users were part of a network in which drugs were produced by a group of friends and then distributed to others. The violence associated with buying from a dealer was new to many older users in Poland. The first case of a person whose arms were broken because of a debt they could not pay off caused serious commotion in this community. Others I interviewed disagreed with the notion of a communal and friendly drug production network. They stated that while such situations occurred, there were always dealers who produced drugs for commercial gain and the possibility of getting in trouble with them was always a possibility. While they agreed that small drug using networks might have been somewhat affected by the drug market issues, they doubted that they served as inspiration for a significant reduction in opiate use and doubted that such reduction occurred on a national level. Consistent with this view, Poland's drug markets have always been uneven and vary from city to city. There is some evidence, for example, that smokable heroin, also known as brown sugar, was most popular in Olsztyn, Zielona Góra, Warsaw, and Wrocław while *kompot* is the most prevalent opiate in Głogów and Zgorzelec (Osipczuk, 2010). During my discussions in the south of Poland, it was confirmed that *kompot* continues to be the drug of choice among opiate users in Krakow and Katowice. Consistent with my findings in Warsaw, a harm reduction staff member in Krakow reported that they were

reaching fewer injecting clients than they had 10 years ago and that the *bajzels*, where drug users gathered, exchanged, bought, sold, and used illicit substances, are no longer in existence. As in Warsaw, outreach has, for the most part, stopped in Krakow. Clients who do access the services are usually older, have a long history of heroin use, have multiple medical conditions and legal problems, and they access services not only to exchange needles and syringes but also for comprehensive case management now available in Krakow. The decline of needle exchange in Krakow is also attributed to the decline in the number of opiate users and the punitive law that puts self-identified drug users at risk of arrest. Service providers are concerned, however, that there may be groups of injectors in Krakow that are not visible to them. A few times a year they do hear of small, insular groups, that are unknown to any of the staff or the older clients. The most recent report from the National Drug Prevention Bureau states that there is no clear evidence that the number of injecting drug users is falling and that the classification used in medical statistics makes it impossible to determine the actual number of injecting users (2010 National Report). Varied views were expressed about the impact that the increasing numbers of methadone patients had on the use of needle exchange. Some felt that clients of methadone programs are indeed abstinent from other substances and no longer needed needle exchange, hence they contributed to the decreasing need for such services. Others saw the situation as more complex – methadone patients indeed are cautious to admit to drug use since this may cause them to be discharged from the program. Some methadone clients are themselves outreach workers for needle exchange programs; some clients of the needle exchanges are wait-listed to enter a methadone program and are feared to report on others, etc. All of this complicates the degree to which people on methadone have access to needle exchange programs. While methadone clients are tested for the use of opiates and limit their opiate use, there are other

injectable substances that are undetectable by the drug tests in the clinics. For example, as reported by the staff of harm reduction programs, legal pharmaceuticals that contain ephedrine can be altered and injected for an amphetamine-like effect.

The staff of harm reduction programs consistently state that while their programs were created to provide services to clients functioning in a relatively open drug scene, that reality has changed dramatically. As stated by one of my interviewees: “No one had the knowledge and the experience to redesign their programming and to respond to the changing environment. Many of us felt that our case was an exception rather than a symptom of what was occurring nationally. Left to our own means, with the constant struggle to fundraise for existing programs, we find our own service inadequate and those at the national level do not provide any tactical support. Yes, we do participate in meetings sometimes, but these meetings are not really for strategic thinking. They are more for the National Drug Prevention Bureau to gather information from us for their publications.” The regions of Poland that never had harm reduction services for people who inject drugs, persist in their lack of action, justifying their course by declining number of exchanged needles and services elsewhere.

Needle and syringe distribution began in Poland in 1986 in Jelenia Gora at the MONAR counseling center and was replicated by other MONAR offices throughout Poland. HIV among drug users had been identified and the number of new infections was increasing. Marek Kotanski was the first person in the country to speak against the discrimination of HIV positive persons while holding an HIV positive child in his arms on national television. The scale of this

needle and syringe distribution and the attention paid to these public health efforts were not significant -- counseling centers were not set up to accommodate recurring client visits. Their primary purpose was to refer those who needed long-term treatment to appropriate MONAR facilities. As one of the harm reduction providers explained: “This was all about ‘fishing.’ You would go into the street and see what you could ‘catch,’ always with an aim to enroll people in treatment. It really took us a long time to learn that being so invasive and prescriptive does not help us develop relationships with drug users on the streets.” Outreach was limited and the quality of equipment did not meet with the client’s expectations. The size of the needles and syringes were, for example, often different from those used by clients and there was limited outreach work, if any (Wodowski, 2005). Despite these shortcomings, the idea of making clean equipment available to active drug users became a part of the landscape. As the number of HIV infections among drug users grew, needle and syringe exchange became a higher priority for a few of the programs. MONAR Krakow and MONAR Warsaw become the largest providers of this service. At both sites, it was the initiative of individual staff members that led to the expansion of harm reduction services. In Krakow it was Marek Zygodlo, followed by Grzegorz Wodowski and in Warsaw, Jacek Charmast followed by Pawel Nasilowski. In 1996, at the urging of representatives from these two cities, the harm reduction philosophy was formally adopted by MONAR (Charmast, 2006). As recalled by an outreach worker who set up one of the early programs: “We were worried that being out there with needles and syringes, somewhat publicly, would result in an outcry and accusations of permissiveness. I expected, for example, that senior citizens would be yelling at us in the park, but none of that happened.” More robust needle exchange programs followed as the concern over HIV and hepatitis increased. The human rights of drug users became a subject of discussion. This was an important contribution as

it fit well with the political changes taking place in Poland during the 90's. In a few of MONAR's centers, clients became partners rather than being subject to coercion or humiliation into sobriety. The role of outreach workers became more precise, with goals that were clearer and more client-friendly. The interactions between drug users and outreach workers were increasingly supportive, and the push for abstinence became less of a priority (Charmast, 2006). Over time, however, MONAR Krakow and Warsaw came under tremendous pressure from management and the board of director. By 2011, Zygadlo and Charmast, catalysts for the expansion of harm reduction services, had been removed from MONAR. Since financial irregularities were given as reason for departure in one case, and working against the interest of the organization in the other, it was difficult for others intent on pursuing harm reduction at MONAR to speak out in support of the two men.

Drug Use and Treatment in the Prisons

The 2000 drug law that criminalized possession of any illicit substance affected Polish prisons. Among four studied Eastern European countries (Estonia, Hungary, Lithuania, and Poland), Poland has experienced the most significant increase in rates of incarceration. Almost half of the inmates (49%) reported lifetime drug use before entering prison. By comparison, federal studies in the US estimate that 60 to 83 percent of prisoners have used drugs at some point, twice the estimate for a general population (Drucker, 2011b). This ratio is similar in Poland. 20% reported drug use during their prison stay, 3% reported injecting while in prison. As outside of prisons, abstinence-only treatment predominates with a few, scattered methadone programs in jails for select individuals. In a survey, 20% of respondents evaluated drug treatment as good

and 80% qualified it as bad. Reported needle sharing in prison was higher in Poland than in the four other countries (Thane, 2011). While discussion about access to methadone treatment in prison is ongoing, its availability is limited and sporadic.

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment (CPT) visited Poland in December 2009 and issued a report that states:

Practically no progress had been made as regards the care of inmates with drug-related problems, the services offered to them, or the development of a prevention policy. Methadone substitution programmes were not available in the establishments visited, with the exception of Poznań Prison Hospital where a few prisoners were being treated with methadone. Further, none of the establishments visited had in place harm-prevention measures (such as, for instance, the provision of bleach and information on how to sterilise needles, needle-exchange programmes or the supply of condoms).

The CPT wishes to stress that the management of drug-addicted prisoners must be varied – combining detoxification, psychological support, socio-educational programmes, rehabilitation and substitution programmes – and linked to a real prevention policy. It goes without saying that health-care staff must play a key role in drawing up, implementing and monitoring the programmes concerned and co-operate closely with the other (psycho-socio-educational) staff involved.

The CPT reiterates the recommendation made in its 2004 visit report that the Polish authorities develop and implement a comprehensive policy for the provision of care to prisoners with drug-related problems (European Committee, 2011).

NGOs in the Drug Field

For the most part, the people I interviewed did not agree with the director of the National Bureau for Drug Prevention, Piotr Jablonski, that the objectives of the national program implemented almost entirely by NGOs are a measure of Poland's success. As reported by the Helsinki Foundation, directors and therapists from the monitored drug treatment facilities presented a troubling lack of cooperation and there was often competition between inpatient and outpatient treatment facilities. All of my sources, many affiliated with NGOs, concurred with this assessment and reported that the civil society environment in Poland is such that the lack of cooperation and sense of competition is a serious problem for most of the NGOs. One offered the following analysis: "Poland is somewhere between the West and a post-Soviet East: while organizations are allowed to exist, they exist to provide a clearly defined function, a service. People rely on their own financial survival providing these services so they do not see a need for cooperation with the competition. For example, why would they let others know that a new grant competition is taking place? They are also not able to be critical of local or national institutions because these are the funding sources that sustain their organizations." Much was said about MONAR as a monopolist and its total isolation from others, "Their structures and internal relationships are so old and interdependent that they would not want outsiders to see their internal systems." As an example, a number of years ago a meeting was organized by Marek Kotanski to create a joint platform for drug treatment organizations. This was a welcome idea since a number of staff at MONAR were concerned with the organization's isolation and those newer to the field welcomed an opportunity to collaborate. After the meeting took place, Kotanski's interest in collaboration declined. The meeting clearly established that MONAR was the largest and most powerful organization and collaboration with others was perceived as

unwelcome power-sharing. It was recognized that: “The role taken on by many NGOs in the West, that of advocate and government watchdog, is totally utopian for Poland. Our government partners are not interested in progress. They are interested in self-preservation: keeping their own jobs and keeping the peace. This is how their relationship with the NGOs is determined.”

NGOs find it impossible to be critical of the local and national government, since they all receive funding from one or all of the responsible government entities. As one source stated, “It is inaccurate to call us NGOs – we are at the service of the government.” Another pointed out that, though the 2005 legislative changes of the drug law allowed NGOs to operate substitution programs: “Not much has happened since then – two, maybe three programs were opened. This expectation by the government, that the non-profit sector will solve the problem and deliver services is not realistic. This is especially so, if the funding they are willing to provide is so insignificant and does not take into account our real needs.” Two of the persons I spoke with, from two different cities, described a situation where the municipal councils significantly reduced funding to NGOs working with vulnerable groups. They shared their disappointment and held a small meeting with colleagues from other programs to discuss a response, but they did not follow through. In one of the cases, the group could not reach consensus. In another, many felt so overwhelmed by what would be required of them to keep the programs afloat, and were concerned that the effort required will not bring about substantive enough outcomes. When discussing the power that civil society has to force government into action, the only positive example offered was that of international funding for newly emerging harm reduction programs in mid 1990s. “Since some local co-funding was required, and we really wanted to make these programs available, it forced us, and we in turn successfully lobbied local governments to

contribute. We made it happen. Then all the programs lobbied the National Drug Prevention Bureau to make money available for needle exchange. Before then, no local or national government had given money for needle exchange.”

While Poland has the longest history of responding to drug use in Central Europe, much of this response is based on a single approach. As the relationship between the state and its citizens changes and drug use diversifies, so should the interventions offered to people who use drugs. The process of diversification has been complicated and often undermined by the very organizations and individuals who were pioneers of drug treatment advocacy years ago. Public health implications are most visible in the spread of HIV and HCV and will be discussed in chapter five. It is worth noting that debates and tensions over the balance between harm reduction and abstinence treatment is not something that is exclusive to Poland. Neighboring Germany, for example, also struggled to establish an effective equilibrium for years. “Only abstinence-oriented services were regarded as the magic bullet and the 'gold standard' of treatment.” (Michels, 2012) Similarly, strong opposition to substitution treatment in France was overcome only when a sharp increase in the HIV infection rate among drug users was observed (Nathanson, 2007). The Polish evolution has taken much longer, and matters that seem to have been resolved by other countries continue to be a constant source of debate which, in turn, affects the availability of services.

Chapter Five: Poland's HIV Policy towards Injecting Drug Users and its Implications

Jonathan Mann, former head of the World Health Organization's Global AIDS Program, often said that the way we conceptualize and frame the question will determine the answer. The problem of HIV transmission among injecting drug users in Poland, and how it is interpreted and portrayed exemplifies this thinking. In a 2010 interview, on the 25th anniversary of HIV in Poland, Dr. Anna Marzec-Boguslawska, the Director of the National AIDS Center stated, "It should be emphasized that preventive actions are targeted and respond to the current needs of specific populations at varied degrees of risk, i.e. women, youth, heterosexual couples, men who have sex with men, prison inmates, and immigrants." (Kontra, 2010) It is remarkable that while drug users constituted close to 50% of all those infected with HIV at the time, Dr. Marzec-Boguslawska did not mention them nor talk about interventions appropriate for injecting drug users. The same is true of the National AIDS Center's most recent report, which describes the implementation of government activities (Work Plan, 2010). Though the language of harm reduction is used, it pertains to the prevention of HIV through sexual transmission in the context of a generalized epidemic. Referring to a "generalized" epidemic might be effective for rallying concern, but it distracts from those mechanisms that are most likely to be helpful (Des Jarlais, 1995; Wolfe, 2007).

Drug users, excluded from the discussion of risk, are not identified as targets for prevention and HIV treatment efforts in Poland. An outreach worker from Warsaw observed, “The HIV education materials for drug users that I have seen are almost 10 years old. That is probably also when we last received funding from the National AIDS Center. From the perspective of our officials, this is when the problem was solved. It’s as though they do not know that each day I see a few new people who inject, as though they do not know that our country has changed, our laws have changed, people use drugs differently, and use different drugs.”

HIV in Poland

At the end of September 2012, Polish authorities reported 16,053 HIV cases, placing Poland in the category of low prevalence countries. Of these, at least 5,930 persons were infected through injecting drug use. Injecting drug user has been strongly established throughout the world as a risk factor for HIV infection (Rhodes, 1999; UNAIDS, 2005; Mathers, 2008). It has been documented that because of the unique way in which *kompot* is prepared, shared and sold, that this risk is potentially even greater. Limited evidence exists that HIV was identified in the substance itself, after a number of users drew it in from a common receptacle (Kala, 1997).

Today, many older users know about the risk posed by this method and often take the precaution of re-heating their dose before injecting in order to reduce the risk of viral infection but smaller, isolated groups may not be fully aware.

With the first HIV infection identified in 1985, the number of HIV cases peaked in 1990 with 809 registered new cases, declined to 384 in 1993, and has increased slowly since then, reaching a new peak in 2011 when the highest ever incidence was recorded. Since data comes in with

some delay, it is expected that the actual number of new infections during 2011 will be between 1,210 and 1,290 (Rosinska, 2012). In 2009, 939 HIV cases were diagnosed in Poland constituting a 10% increase over the rate of infection in 2008 and a 33% increase over the median rate recorded between 2003 and 2007 (Werbinska-Sienkiewicz, 2011). There is some discussion over the 30% increase in HIV infection in 2011, as compared to the year before. A psychologist implementing voluntary and confidential HIV testing (VCT), questions whether this 30% increase does not fall within the range of estimated infections in Poland (25,000 – 35,000). “Since we test so little and the number of tests slowly increases, maybe we are just discovering old infections. We have to know when these people got infected to draw any conclusions.” According to a drug counselor, also engaged in HIV prevention: “Sitting between Ukraine and Western Europe puts Poland in an interesting position. There are now hundreds of thousands of drug users infected with HIV in Ukraine and Russia. Poland’s numbers are encouraging in comparison, but not so positive when you compare our infection rates to those in Western Europe.”

Data on HIV and Testing Among People Who Inject Drugs

Surveillance of HIV and AIDS is carried out by the National Institute of Hygiene which is currently transforming into the National Institute of Public Health (NIPH-NIH). Its mission is, “To protect the health of the population through actions taken in the field of public health, including research and training. NIPH-NIH offers its expertise to the government, NGOs, and civil society in the fields of public health, risk assessment, and avoidance.” All national HIV prevention and treatment activities in Poland are outlined in the National Program for Combating AIDS and Preventing HIV which is approved by the Prime Minister and coordinated by the

National AIDS Center. The ministries of Education, National Defense, Health, Internal Affairs, and Justice, as well as several non-governmental organizations, and scientific associations are responsible for the National Program. Compliance with the National AIDS Program, even though it is approved by the Council of Ministers, seems to be a low priority for most of the ministries since expenditures for specific components consistently fall short of the plans contained in the approved document. Medical care for HIV-infected individuals in Poland is provided by 14 specialized reference centers often based at University Hospitals. This helps with the quality control of HIV treatment, but it concentrates HIV knowledge in a few, select locations, leaving the majority of physicians in Poland uneducated about symptoms and treatment (Jablonowska, 2007). A physician I interviewed suggested that the level of knowledge about HIV among general practitioners is declining. During her academic interactions with family physicians she often hears that they are not motivated to expand their knowledge of HIV because relatively few cases present in their practices.

Though Poland held the 2012 Chair of the UNAIDS Program Committee Board, the UNAIDS slogan ‘know your epidemic, know your response,’ an appeal to put evidence at the center of national AIDS planning, is far from being implemented in Poland. It is important to note that since relatively few HIV tests are performed each year in Poland one can expect that the actual number of Poles living with HIV is higher than the government reports. From 2003 to 2004, 3.2 HIV tests were performed per 1,000 inhabitants. At the time, in the majority of European Union countries, the rate of testing was greater than 20 per 1,000 inhabitants (Rosinska, 2007). In 2006, EuroHIV reported that Poland, together with Albania and Georgia, had the lowest testing rates in the WHO European region, conducting fewer than 5 tests per thousand inhabitants

(ECDC, 2006). In 2009, with 5.6 tests per 1,000 inhabitants, Poland remained one of the three countries with the lowest test rates (ECDC, 2009). By 2010 the trend persisted with only 4.9 tests per 1,000 - significantly lower than its European Union neighbors. The rate in Slovakia is 20.1, in Czech Republic it is 33.6, and in Latvia it is 26.2. European countries with the highest HIV testing rates are: France at 76.9, and Belgium at 60.1. It is estimated that 70% of Poles who are HIV positive do not know they are infected (Sytuacja, 2010).

Some of my interviewees have speculated that the low rate of testing for HIV in Poland reflects a conscious policy decision. It was suggested that, because of the budgetary difficulties, many policy makers would prefer not to know the actual prevalence rates because Poland could not afford comprehensive treatment for all who need it. These observations are consistent with the overall trend by the international AIDS establishment to show success, as evidenced by “Getting to Zero” and “Treatment 2015” strategy papers (2010, 2012). As critiqued by the UNAIDS Reference group -- statements about the world being “on the brink of ending one of the worst pandemics of our time” falsely raise expectations to believe that the HIV epidemic may soon be over. Such statements take away from the hard messages that should be at the center of UNAIDS advocacy. A senior policy maker in Poland offered similar comments on the country situation, “At the government level, difficult issues are not seen as something to be discussed and solved. They are always the cause of conflict and as such as hidden in bureaucratic, unhelpful language. If you are a governmental institution, your primary strategy is to avoid conflicts. So any activity that threatens the status quo is to be avoided, at all costs. If there is no public debate about this and other issues, then there is no incentive to do anything about it.”

This same policy maker also expressed concern for the overall passivity of Polish society towards taking responsibility for their own health, including high smoking rates and alcohol consumption. He suggested that blame for low HIV testing rates should be shared among those institutions responsible for making tests available and Poles themselves, who are generally inactive and disinterested in preventive efforts. He also referred to the persistent effects of a now defunct socialist law, on the Polish consciousness. All employed individuals (meaning all Poles, since employment was mandatory), had to present a health certificate to their employer and update it regularly, depending on their profession. In a situation where people were legally required to comply with certain medical procedures, many perceived as absurd, there may have developed a distrust of any government supported health “propaganda,” and, alternately, planted the expectation that a signal will come from above, if there is a true public health concern. When the law changed, no policy efforts were made to encourage greater personal responsibility.

This observation of a senior Polish health official is concurrent with data on mortality rates in Europe. While mortality has improved in the West over half a century, it is in stark contrast with the decline in the East. As argued by Bobak (1998), social and economic conditions play a significant role in the speed how rapidly the society can leave the unfavorable phase of transition. Life style, behaviors and diet seem to have the most substantial impact on these health outcomes, with smoking and alcohol having the largest impact, According to Peto (1992), about a half of the East-West gap was caused by smoking and Leon’s data (1997) shows that much of Russian mortality is due to alcohol. Several studies identify negative health lifestyles as the primary social determinant of the decline in life expectancy in the former socialist nations, with Russian male life expectancy as the most dramatic illustration. In 1965 it was at 64.0 years

and decreased to 61.7 by 1980. Gorbachev's three year anti-alcohol campaign inspired some improvement, reaching 64.9 years in 1987. Since then however, there has been an accelerated decline showing male life expectancy in Russia to be 58.9 in 2000 (Cockerham, 2002).

In Poland, among those who do test for HIV, the routes of transmission are mostly unknown. In their 2011 reports, the European Center for Disease Control (ECDC) and the World Health Organization (WHO) excluded two European Union countries, Poland and Estonia, from their analysis of European trends. More than 50% of the data on transmission modes was missing in both cases (ECDC, 2011). As noted by the National Institute of Hygiene, since 2000, there has been a consistent increase in reports of new HIV cases identified as having an unknown route of transmission. All the people I spoke with were convinced that this high rate of "unknowns" is a serious problem since it does not allow for the planning of strategic and targeted interventions (Walichowska, 2010). Their views as to the reasons for the current state of affairs were divergent. Some felt that the National Institute of Hygiene is not doing its job in more actively soliciting information. Others, that it is the job of the National AIDS Centers to provide technical guidance to the laboratories, to train them, to explain the importance of gathering information in order to design targeted prevention efforts. Still others felt that maintaining the status quo is simply comfortable for all involved.

According to an epidemiologist monitoring HIV data in Poland, there seems to be a confluence of factors that are responsible for incomplete reporting. First, the new Infectious Disease Law passed in 2001 significantly relaxed the expectations placed on medical providers and laboratories to gather information about routes of infection. Names could be replaced with

identifier codes, if patients wished to remain anonymous. I was able to confirm this by locating reporting forms (separate for HIV infection and AIDS diagnosis) attached to the 2001 Infectious Disease Law. Only the form reporting an AIDS case asks about possible routes of transmission, no such form exists for HIV reporting. One of the HIV physicians I corresponded with views this as an oversight: “When the parliament was approving the legislation, it all happened very quickly. The omission of this form was a mistake and it appears that it was never corrected.”

Second, as the Polish health care system changes, and with the increasing availability of private laboratories aiming to maximize profits, there is little interest in gathering additional information. The reporting to the National Institute of Hygiene relies heavily on the good will of various institutions, laboratories, and individuals. Some reports are submitted with a delay of six months or more. Finally, as health care system reforms began in early 2000, and severe pressure was exerted to cut costs, various “additional” services, such as HIV testing at detox units and other treatment centers, were removed. This assumption was confirmed by people I spoke with who work at the VCT centers. Many are referred for a test by a methadone clinic or detox program, or pregnant women undergo a test at the request of their obstetricians. These patients, in principle, are under the care of medical facilities that are saving scarce resources by referring their patients to VCT clinics instead of providing the testing service themselves.

It is important to stress that, since the first HIV diagnosis during the socialist period and up until 2000, all reporting was meticulous and included names, addresses and other personal information. This raised serious confidentiality issues and was opposed by many individuals and organizations. The system was considered outdated and potentially abusive. I referred to my notes from a 1998 meeting about the need to change data collection. People who favored this

level of information gathering argued that if names and addresses were not requested, it would send a message to people trained in the socialist system where detailed reporting was a norm, that reporting itself was not important and that information flow would break down. As it turns out, their concerns were largely ignored; no trainings or specialized communications were put into place to prevent incomplete reporting when the law changed in 2001. Recognizing problems related to incomplete data, the law was amended again in 2008, but it still awaits instructions on implementation. Until these are created and adopted, the 2001 instructions still apply.

Even though the data has been incomplete since 2001, reports of the National AIDS Center and comments from its director continue to state that injecting drug use no longer contributes to HIV infections in Poland (Redlinska, 2010; Kontra, 2010; Glazewska, 2011). While acknowledging that injecting drug users were most affected in the first 10 years of the epidemic, after 2001 all subsequent publications and statements suggest that the trend was successfully reversed.

However, a different picture from the one portrayed by the National AIDS Center emerges when analyzing HIV incidence rates among those who identified injecting drug use as the route of infection (Malinowska, 2013). As figure 9 shows, although the number of tests performed among injecting drug users between 2000 and 2009 (18,783) was less than one-third of the number of tests performed between 1988 and 1999 (72,832), HIV incidence was still higher in the years 2000 to 2009.

Figure 9. HIV among Drug Users

Years	Number of HIV tests	HIV incidence
1988 – 1990	13, 401	6.17 %
1991 – 1993	22,582	4.1 %
1994 – 1996	20,620	4.6 %
1997-1999	16,229	5.93 %
2000-2002	8,684	8.75 %
2003 – 2005	5,988	11.0 %
2006 – 2008	2,935	9,3 %
2009-2011	2,717	5,7%

All data is based on reports from the Polish Institute of Hygiene.

The European Center for Disease Control (ECDC) was less convinced by the 2006 Polish data than were the Polish government representatives. In its report it states:

The apparently injection-driven epidemic in northeast Poland near the Kaliningrad border suggests possible links with the Russian outbreak. However, because the transmission route was not reported for many of these cases, this data must be interpreted with caution. The gender distribution of cases with an unknown transmission route (72.4% males, 27.6% females) parallels that in IDUs (74.2% males, 25.8% females), indicating that injecting drugs could play an important role in the group with an unreported transmission route. Among the cases with a reported transmission route, the proportion of IDU transmissions was the highest in the two northeastern regions – 89.3% in Warminko-Mazurskie and 88.1% in Podlaskie. (ECDC, 2006)

The report of the Polish Minister of Health makes a similar observation: “In the last five years, there was a significant increase in new infections in the region of Poland that neighbors the Kaliningrad region of Russia which has the highest HIV rates in Europe.” (Minister of Health, 2011) There was no attempt, however, by Polish officials, to offer an analysis of how the situation in Kaliningrad might affect Poland with regard to HIV transmission among injecting drug users. The ECDC also listed Poland, along with Estonia, Latvia, Lithuania, and Spain, as countries with ongoing HIV transmission among young IDUs (under 25) with prevalence levels above 5% between 2005 and 2010 (ECDC, 2011).

I asked a number of my interviewees about the assumption that HIV among drug users is no longer a problem and most did not agree. Some felt that the incompleteness of the data does not allow for such statements. A counselor at a testing center in Warsaw, for example, suggested that the number of diagnosed HIV infections among drug users in her center is low, but so is the number of drug users who come in for testing. She could not explain why their center predominantly attracts people who are concerned about potential sexual transmission. Even though she finds data from the VCT sites reliable, she does not consider them particularly useful for understanding HIV infection among people who inject drugs. In 2010, 333 persons tested for HIV at the VCT centers identified injecting drug use as a probable route of transmission. That number represents 2% of all clients at the 29 VCT centers in Poland. Among these, 8.1% were HIV positive. Each year, injecting drug users constitute a diminishing group of people tested at the anonymous testing sites. In 2004, they made up 4.7% of the VCT centers’ clients, in 2007 they were down to 3%, and in 2010 still further decreased to 2%. Two drug treatment providers from two different cities in Poland offered somewhat similar explanations for the low

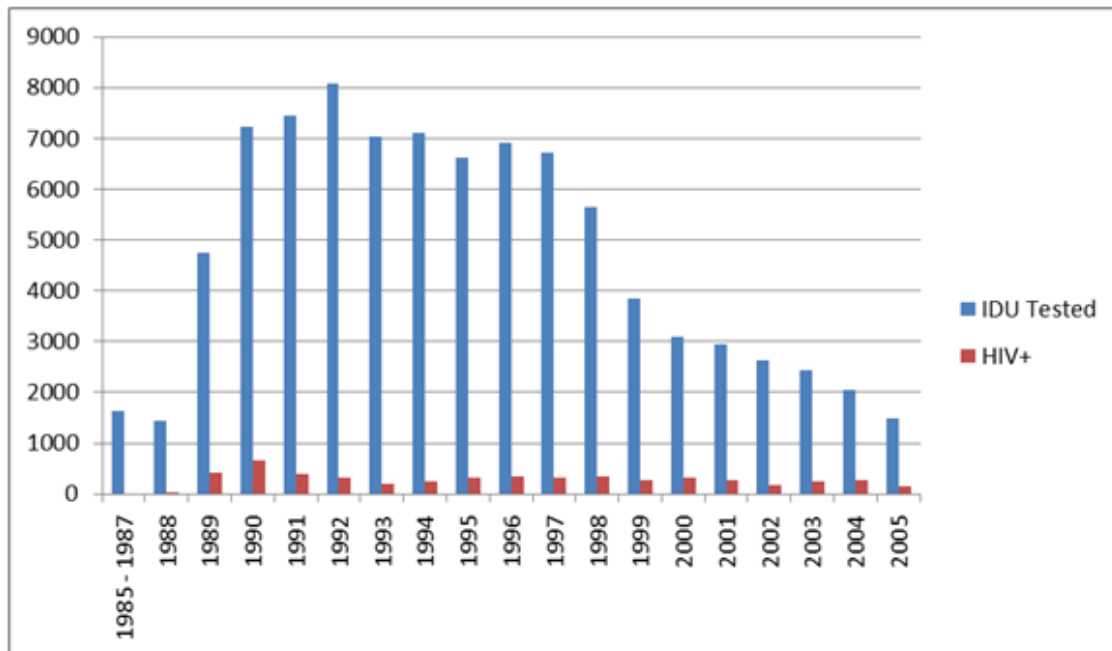
interest among drug users in accessing HIV testing. One provider felt that drug users have little faith in institutions they are not familiar with and that they are unlikely to walk through the door of an unknown, formal and intimidating building. Similarly, the second provider pointed out that drug users have long lists of grievances towards the medical establishment so unless something really hurts, they will avoid any contact. There was agreement that IDU clients only come in for an HIV test when it is requested by an outpatient drug treatment facility. Since these facilities are scarce and not always appealing, so is HIV testing of drug users.

Anonymous and voluntary testing sites began operating in Poland in 2001. In 2010, 26,118 persons were tested. The most comprehensive report, based on 2005 data, was published in 2006 and showed that less than 4% of people who came for testing have a history of injecting drug use (ARC, 2006). Somewhat surprising, in a report from 2010, is that 8% of clients tested were pregnant women (Minister of Health). This may be because in that year a ministerial instruction was adopted mandating provision of HIV testing to pregnant women. As explained by one of my interviewees, since cost cutting is a top priority for nationally funded health care clinics, obstetricians are suggesting that their patients get tested at the free VCT clinics rather than deplete the scarce resources of their healthcare provider.

The HIV epidemic among IDUs was first observed around 1990, when this population represented more than 80% of all HIV infections in Poland. It was a group more frequently tested than any others (Szadkowska, 2003). As described by one of my interviewees: “When I think about it now, I am horrified. All drug users were told they had to test. There was no

treatment, no one asked if they wanted to know, and no one gave them the choice to opt out.” As Figure 10 shows, until 2000, the number of tests of this population were consistently high. What is not clear is whether the number of tests among drug users after 2000 declined significantly or if testing continued, but the results were absorbed into the growing group of tested individuals classified as having an “unknown” transmission route. In 2009 76.5% of all infections, and in 2010 80.9% were attributed to an “unknown” route of transmission. In 1992 8,000 tests among injecting drug users were recorded, ten years later, in 2002, that number dropped to 2,500. It is also unclear what effect the criminalization of the personal possession of drugs had on HIV testing. What we do know is that former gathering places of drug users, where information was exchanged, and outreach workers were able to offer information and assistance, disappeared. It is possible that, just as men who have sex with men who do not identify as gay maybe difficult to reach, dispersed drug users are now no longer a part of a network that supports information and advice about testing.

Figure 10. The Number of Drug Users Tested for HIV and HIV Infection Rates



HIV Prevention and Drug Users

Studies from 2004 and 2009 of five locations show infection rates consistent with the trends noted in Figure 10. The 2004 study had 426 participants from three different sites in Poland and recruited subjects from various modalities of intervention (detox, drug treatment, and needle exchange). Among the participants in this study, the overall HIV prevalence was 11% (Rosinska, 2004). A smaller study, carried out in 2009 with 193 participants recruited from low threshold programs, reported that 8.1% of their clients were infected with HIV in Gdansk and 11.9% in Krakow (Rosinska, 2009).

Poland is one of the European Union countries that spends the least on prevention, – 0.05 Euros per person. From 2005 to 2010 there has been a continuous decrease in spending (Minister of Health, 2011). As a senior policy maker explained: “It seems that during the socialist times public health was more of a priority. One might question whether the tools were effective, but the will was certainly there. It is not the case now. It is enough just to look at the very low mammography screening rates in Poland as compared to those in the rest of Europe.” Currently, 96% of all government resources for HIV related efforts are spent on HIV treatment, only 4% is allocated to prevention (Minister of Health, 2011). The UN Rapporteur on Health commented on this imbalance after his visit to Poland: “Although HIV was not a focus of the mission, certain observations that were made need to be noted. In this context, the need for improved harm reduction measures remains of significant importance in Poland. . . .There is a significant concern that people do not take seriously the risk of being infected with HIV, that infections are often diagnosed too late, that there is a permanent necessity to enhance the availability of ARVs,

and that there are few and limited financial resources allocated to HIV prevention. As a result, there are few voluntary counseling and testing (VCT) centers and severe limits on the ability to finance programs implemented by NGOs.” (Grover, 2010)

The absence of comprehensive HIV prevention efforts for injecting drug users and the structural risk related to the punitive drug policies have been detailed in Chapter Four: Drug Treatment and Harm Reduction and Chapter Three: Drug Use and Drug Policy. Here, I intend to discuss the evolution of the priorities of the National AIDS Center responsible for coordinating prevention activities throughout the country.

Zofia Kuratowska, a physician and member of Solidarity, the opposition party during the socialist government, was the first public figure to speak about HIV in Poland. She published the first book about it in the mid-1980s and continued her advocacy when she became the Vice-Marshall of the senate. As described by one of my interviewees, “When talking about AIDS she always spoke as a physician, she was very rational about it and lacked any political motives.”

The first person to be appointed by the Ministry of Health as an advisor on AIDS was a physician, Maria Dzedzic. She held the post from 1986 until 1988, leaving over a disagreement with the Minister on prevention priorities. In an interview, Dzedzic recalled the discomfort caused to various civil servants when gay visitors came to the Ministry and the fact, that this was the first community to reach out to the Ministry of Health asking for support; many unanswered letters sat in the files until her arrival. During her time at the Ministry, in collaboration with the Polish Red Cross, the first brochure about AIDS was published. Ten million copies were meant

to be sent to all households. According to Ms. Dziejcz, less than a quarter reached their destinations and it is unclear what happened to the rest. A researcher and an advocate specializing in sexuality and HIV matters recalls: “Maria knew exactly what needed to be done. She understood the nature of the problem, but the Ministry was not ready.” Another advocate remarked that Dziejcz’s affect was profound because she was the first person in the ministry to deal with AIDS in a professional, nonjudgmental manner. She felt that Dziejcz set a standard that was later followed; she managed to couch HIV in the domain of biomedical and sociological issues, rather than one of pathology. Marek Kotanski, the founder of MONAR, was another proactive figure often evoked in discussions of the early days of the HIV epidemic. While many of the staff at the MONAR centers were afraid of HIV and resigned in haste as their clients learned of their HIV status, Mr. Kotanski insisted on accepting people with HIV for drug treatment. “Whatever you might say about Kotanski,” said one of his MONAR colleagues, “he was one of the first to understand HIV and drug use and to really want to do something about. It was a bit about publicity and spectacular actions, but it worked to the advantage of the fight against AIDS.” Kotanski’s colleague referred to the frequent criticisms of Kotanski’s charismatic style and, in some eyes, self-indulgent public appearances. His name is still widely recognized in Poland, even among the youth, who only learned of the issues after his accidental death in 2002.

From the beginning of the epidemic, drug users were subject to stigma and discrimination:

“Drug users who are suspected of being HIV infected are generally denied treatment by doctors, surgeons and dentists, and instead (are) referred to emergency units. In addition, the management of emergency units issued an order prohibiting ambulances to be used to transport drug users. In

some emergency departments, routine HIV antibodies testing has been introduced contrary to national and international guidelines” (Hendriks, 1991). In these early years, the director of one of Warsaw’s two detoxification centers decided not to admit HIV positive drug dependent patients because they presented a “danger” to other patients and staff. The explanations were that hospitals did not have enough latex gloves and disposable syringes, patients might use each other’s toothbrushes, and patients and staff use the same bathroom and kitchen appliances. According to the director, caring for HIV patients required the following additional procedures: disinfecting the water after washing the patient, and scrubbing and disinfecting walls, doors, floors and windows when the patient leaves (Jedrzejewski, 1989). As first the HIV infections were detected, identifying medical entities that would take responsibility for treatment was extremely difficult. The first ministerial staff in charge of HIV recalled that she attempted to interest tropical disease specialists, “I thought, at the time, that since AIDS came from Africa, it would make sense. Well, they hated the idea all together. What I learned later is that such specialization did not really exist in Poland. For the most part, these were just general physicians that were given an additional salary for adding this responsibility. To be honest, I am not sure if they hated me for discovering this or for trying to hand over AIDS treatment to them.” The few people who were infected with HIV through blood transfusion were cared for by the hematology departments. Hematology was not willing to take on HIV care for anyone else. The first infectious disease physician who finally agreed to care for HIV positive patients was Professor Lidia Babiuch at Warsaw’s Infectious Diseases Hospital.

Krystyna Sienkiewicz, the Vice Minister of Health from 1989 to 1992, was responsible for the Ministry’s HIV portfolio. At this time the first halfway house for people living with HIV and a

history of drug use was established. There was much resistance by the local community, including two attempts at arson. The second of these was so severe that the house had to be vacated and, for a number of days, its residents found shelter in Minister Sienkiewicz's office in the Ministry. The halfway house was one of many institutions run by Marek Kotanski who invited a young catholic priest, Arkadiusz Nowak, to help him respond to the local community's resistance and who, during these efforts, developed a close collaboration with Minister Sienkiewicz.

In the early days of the HIV epidemic, during and immediately after the political transition of 1989, a number of halfway houses were created for people living with HIV and for drug users. Every one of these evoked strong opposition from their local communities. One interviewee suggested that the opposition was not just to people living with HIV, but also due to the perception of drug users as irresponsible, dangerous, and malicious. The conflation of HIV and drug use created, in the minds of potential neighbors, an unacceptable level of risk. In 1989, having only just emerged from decades of central planning, there was no practice of consulting with local residents when institutions, industrial or otherwise, were placed within communities. Residents learned of the changes as they were being instituted. In this manner, the halfway houses were established without consultations in their new neighborhoods. A remarkable post factum "educational" campaign took place after protests erupted following the discovery that two HIV positive children lived in a local halfway house. The response was to rain HIV information pamphlets on the protestors from a helicopter. One of my interviewees was present at one of the homes when a protest began. He remembered the reactions being extremely violent: "They came in with sticks and axes. I really thought that we might die there." When another of my

interviewees, a psychologist, was recalling these events she was struck by the lack of strategy at the time, but also recognized the influence of people such as Zofia Kuratowska who stepped in and publicly associated with the cause, with positive effect. With a few exceptions, despite the initial opposition, these homes have managed to survive and are still in existence today. In many instances, the assumption was that HIV positive drug users would live in these establishments until they died. A number of them, in fact, were transformed into hospices. It is important to recognize the political context of this period. As transformation was gaining speed, inflation was dramatic, jobs were lost, services were cut, many felt disoriented, and a climate of fear was the norm. What was perceived as bringing HIV and drugs into often isolated, small communities, with no consultation and education, was a dramatic oversight. Showing people's reaction on national television, ridiculing their ignorance, and making them look like "village idiots" further exasperated the difficulties.

In the early 1990s, Minister Sienkiewicz recruited Arkadiusz Nowak to run a new home for HIV positive drug users under the purview of the Ministry of Health. Later, between 1995 and 2002, Nowak served in the formal capacity as an advisor on AIDS and Drugs to three separate Ministers of Health and oversaw the National Bureau for Drug Prevention and the National AIDS Center. He became a broker between the sphere of public health and the powerful institution of the Catholic Church. As the unchallenged moral authority in Poland, since 1989 the Catholic Church has vigorously instigated and emerged victorious from the discourse on abortion and sexual health in the schools. Nowak's influence over the National Bureau for Drug Prevention was limited. Its first director, Olaf Mejer Zachorowski, a charismatic psychologist, carved out a large independent space for the activities of his office. Apart from Mejer

Zachorowski's political skill, it is likely that the church was just not as interested in drug-related matters. That was not the case with the National AIDS Center. Nowak's influence over this institution was vast and for a number of years, after his post as Advisor to the Minister on AIDS and Drugs was terminated, he remained its salaried consultant. He appointed the current Director, Anna Marzec-Boguslawska, as well as her two predecessors. My interviewees were divided over the current role played by Arkadiusz Nowak in the HIV landscape today. Some felt he exerts no influence while others were convinced that he is significantly engaged in decision making. An ethnographer from the University of Kentucky researching HIV prevention in Poland who was aware of the importance of the church was surprised by the church's lack of direct engagement in AIDS work. She was also frustrated at not being able to interview Nowak during the fifteen months of her field research. At the same time, as she tried to understand why HIV prevention is never explicit, she heard of the importance of not angering the Church or the conservative parliamentarians because they had the power to eliminate the National AIDS Center (Owczarzak, 2007). A similar view was presented by a psychologist specializing in drug treatment: "When I talk to people at the margins of various meetings, colleagues I work with, it is clear to me that everyone understands their role and the church-delineated boundaries. No one is brave enough to go outside of these. In the area of drugs and alcohol, the tacit objective is clear, 'blessed sobriety.' That is what we are to work for. Anything short of sobriety is unacceptable. The only reason there has not been a real fight around HIV or harm reduction is that no one is willing to test that boundary – certainly not government institutions such as the Drug Centers and the National AIDS Center." Ms. Owczarzak reported that an NGO seeking support for educational materials for MSM that reflected a content standard consistent with West European publications, was told that they were too graphic for the government to endorse (2007).

Another NGO had a similar experience when it sought governmental endorsement of a publication for drug users offering guidance on safe injection practices. As recalled by one of my interviewees, use of condoms by heterosexuals, was the only acceptable publication to be supported by the National AIDS Center as long as it was couched in the context of advocating monogamy and abstinence. The ABC strategy, Abstain, Be Faithful, use Condoms, was, for example, its flagship campaign. Throughout all the prevention discourses taking place in Poland, none factor in the social and economic context that makes people vulnerable to HIV infection. The limited prevention efforts in Poland align closely with the approach described by Adkins where vulnerability to HIV infection is viewed as a matter of individual action and responsibility for prevention is located entirely with the individual who is expected to adopt certain lifestyle choices (2001). In the Polish paradigm, no narrative of structural interventions as a matter of government responsibility emerges.

In a 1990 interview in a Catholic weekly Nowak encourages mercy and support for those already infected, but at the same time, he clearly emphasizes the primacy of morally appropriate behavior. It also reflects his limited enthusiasm for harm reduction, “You cannot be sympathetic towards drug users. . . . You cannot feel bad for them or be friendly towards them. The love you offer has to be tough. . . . You cannot trust them. Drug users are best at manipulating and it is my job not to let them.” As defined by Harm Reduction International, a highly respected, UK-based international advocacy group: “Harm reduction refers to policies, programs and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs.” The

premise of Nowak's approach is complete abstinence, including sexual. For example, to qualify for housing in any of the institutions under his supervision, one must comply with this requirement. In the interview, Nowak went on to say: "At the root of AIDS often lies immoral behavior, or sin, but it does not mean that we have the right to judge. I will say, however, that once infected they have to deal with the consequences of their immoral behavior. . . . If you do bad things, it is very likely that they will end badly. . . AIDS is not about punishment but it is about justice." (Okonski, 2000) Five years later, in an interview with a women's magazine, Nowak restated his position that AIDS is not God's punishment for moral corruption and offered his thoughts on prevention of sexual transmission. He explained, for example, that condoms are not the only available HIV prevention since they do not address the change in values needed for HIV prevention, and they do not guarantee full protection. According to Nowak, adhering to the Christian value of fidelity and abstinence until marriage is the only effective prevention since one can never know for sure if a potential sexual partner has HIV and because condoms do not guarantee full protection (Domagalik, 2005). These statements are consistent with his interview in 2000 when he stated, "God gave us rules, and they certainly do not include acceptance of promiscuity." (Okonski, 2000) This narrative of acceptance and support for people living with HIV was present during the time when Nowak oversaw the National AIDS Center and continues to be the case. Prevention technologies such as needle exchange and condom use, on the other

hand, have never been the priority of Father Nowak or the National AIDS Center. The United Nations Development Program³ (UNDP) became active in the area of HIV in Poland in 1995. UNDP headquarters approved the appointment of 22 HIV officers to be placed in national field offices around the world. Since Poland was one of the two countries in Central Europe with the highest HIV rates (along with Romania where an HIV epidemic among children broke out), one of these 22 posts was assigned to Poland. The UNDP forged an agreement with Nowak to lead prevention activities, in a cost-sharing fashion. During this time, and with the support of the Open Society Institute (OSI), a number of needle exchange programs as well as methadone programs were initiated. Condoms were also purchased and distributed. A number of people I spoke to referred to the UNDP project as useful for institutionalizing support for an emerging and difficult issue. For example, its training project for medical staff engaged HIV positive drug users as formal trainers. The first gathering of people living with HIV was also funded at this time. It was hoped that the United Nations would provide a certain level of protection against any opposition that might emerge in response to these approaches. However, this hope was not entirely realized. Several years later, in 2005, a heated discussion ensued over a leaflet produced in the context of the UNDP project, designed for MSM. A Lambda representative, who was distributing the leaflet at a training about homosexuality organized by the Krakow municipality, had her HIV educator certificate revoked following complaints made by the local, conservative

³ Author initiated UNDP's AIDS program in Poland and was its coordinator from 1995 until 1998

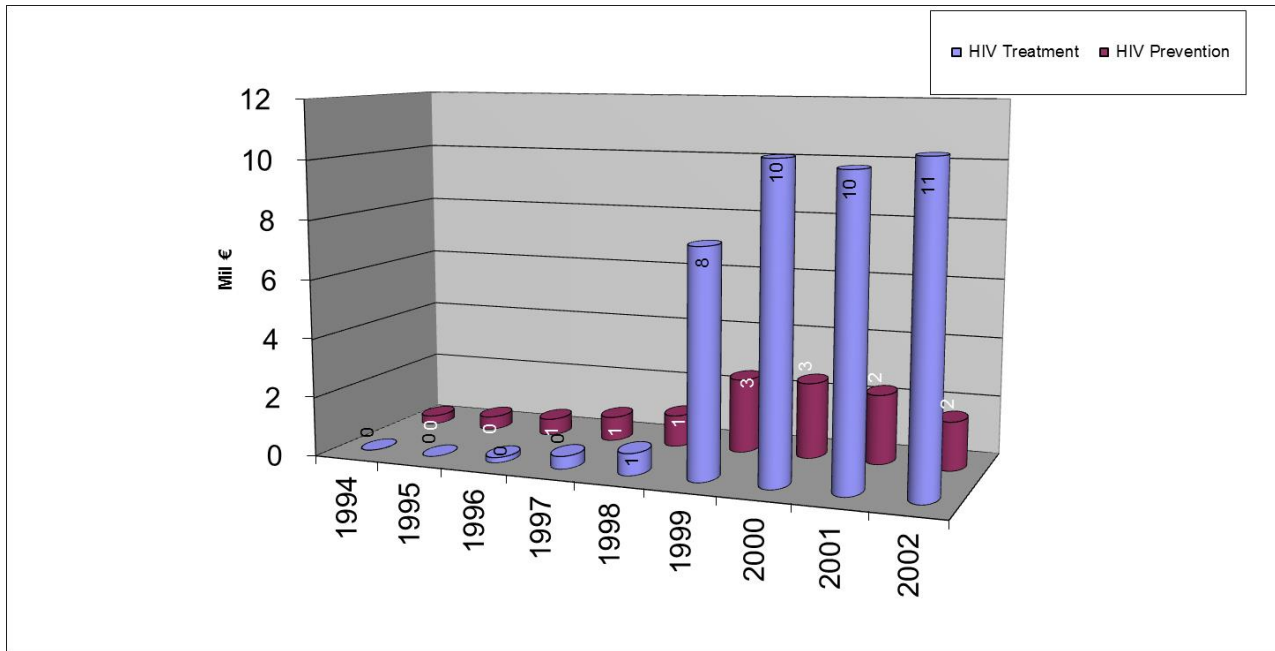
party. Her HIV educator certificate had been awarded and was then revoked by the National AIDS Center.

While Nowak's moral and religious principles helped to reduce some anxiety related to the presence of people living with HIV in Polish society, they also fueled the lack of clarity in national prevention efforts. Furthermore, his goal of "normalizing" people living with HIV and presenting them as "regular," rather than portraying them as drug users and homosexuals, may have contributed to the highly generalized discourse on the epidemic that omits drug users and men who have sex with men from prevention efforts. Poland has never had a national prevention campaign that clearly endorses condom use and/or needle exchange. By the time that drug possession was criminalized in Poland there was already abundant international evidence that criminalization drives drug users underground, making access to and use of effective prevention technologies difficult (Kerr, 2004 and Room, 2012). Neither the National AIDS Center nor Nowak spoke out against this legislation. Moreover, Nowak recently opposed liberalizing punitive drug laws, arguing that such a change would send the wrong moral message. When discussing his engagement with a number of my interviewees, most had a positive view of his overall role. While some agreed that he had a complicated relationship to the prevention effort, they did think that he did all he could in his capacity as both an advisor to the Minister of Health and a Catholic priest, to advance an open debate about HIV in Poland. One interviewee reminded me that when Nowak first became engaged, the church was at the peak of its "power grabbing" following the political transition from the socialist system: "There was no better person than a priest to advocate in support of HIV positive people. No one else would have been able to be effective in this environment." Finally, a senior policy official felt that it really did not

matter who was installed in Nowak's role. At the time, and to this day, the political climate did not allow for open, transparent, and explicit messaging related to sexuality and drug use.

The National AIDS Center, a government agency funded by the Ministry of Health and established during the time Nowak was an advisor to the Minister, is responsible for coordinating the national response to the HIV epidemic in Poland. The responsibilities of this structure are broad and include: preparation of the National Program for Combating AIDS and Preventing HIV Infections, and coordination of its implementation and monitoring; initiation and implementation of various HIV prevention efforts as well as improvement of the quality of life of people living with HIV and AIDS (including the promotion of social inclusion); initiation and implementation of various trainings and certifications; oversight and implementation of analysis of HIV-related research; procurement and distribution of HIV medication as well as the monitoring and coordination of its use in medical centers; collaboration with national consultants on infectious disease, laboratory diagnosis and epidemiology and other national institutions; provision of technical assistance to local authorities; initiation and implementation of international cooperation; analysis of various legislation that may impact HIV programing; and coordination of the activities of the Red Ribbon Chapter, an award given to individuals and institutions whose actions improve the quality of life of people living with HIV or the quality of prevention programs (Rogalewska, 2007). While the Center's mandate is extensive, its budgetary allocations do not match the comprehensive scope of responsibility. Figure 11 compares the Center's expenditures on prevention to those on treatment from 1994 to 2002 (Daniluk-Kula, 2002).

Figure 11. HIV Expenditures 1994-2002 (Prevention and Treatment)



Since 2002, the imbalance between funding for prevention and funding for treatment became even more dramatic. In 2010, 96% of the national HIV budget was spent on purchasing and distributing HIV medication for 14 treatment sites. The remaining 4% was allocated to prevention, and this included the support for HIV testing sites (Minister of Health, 2011).

During 1995, with Nowak's engagement, some harm reduction activities were supported with AIDS funding. However, this support ended in early 2000. It is unclear if this was the result of a shift in priorities related to the purchase of medication or for the other reasons explored. A few of my interviewees mentioned a serious conflict between Akradiusz Nowak and Marek Kotanski and there is suggestion that this conflict might have contributed to the decision. Others have suggested that there has been an overall increasingly conservative trend in the decision making of the National AIDS Center. Over the last ten years, the National AIDS Center has become

more bureaucratic and cautious, focusing on the mechanical processes of medication procurement and distribution, data collection, and gathering information on the implementation of the National AIDS program. This gradual bureaucratization is a reflection of both, 's notion of administering an epidemic (2000a), and Housner's concept of avoidance of decision making among the employees of the Polish government (2007). One of my interviewees pointed out that in 1949, the medical schools in Poland were removed from the universities and established as independent entities – Medical Academies. Graduating high school students were immediately immersed in their medical instruction without any exposure to sociology, psychology, and the humanities that are typically offered in places of higher education. He used this analogy to explain the transformation of the National AIDS Center in the 1990s, from a socialist-style public education organization devoted to counting infections, and producing and distributing educational brochures to the medical institution it became in the 2000s, predominantly focused on treatment. With its singular focus on the medical aspects of HIV there is little reflection as to who is becoming infected, what puts them at risk, and what are the ways in which effective interventions can be inspired and supported.

Even though all the funds for HIV treatment flow through the National AIDS Center, there is little information that is gathered by this institution, for the purposes of policy making. As expressed by one of the AIDS physicians: “The Center knows exactly how many people are treated, how many dropped out, how many new clients came in, how many therapy regimens had to be changed. Yet, I have never seen any published analysis of this information, or guidelines to assist us with adherence. The reason for this, in my view, is the ongoing conflict between various treatment units and the Center itself. What exists is a transaction of providing and absorbing

medicines. Each treatment center owns its own data and the National Center, even though it has access, cannot publish it.” This illustrates, as do many others, the various conflicts within the HIV community and the great resistance to collaboration, which has led to many missed opportunities for practice improvement.

When discussing the expenditures of the national AIDS budget my interviewees shared various perspectives. One felt that since Poland is “terrible” on prevention overall, and since public health is a nascent field in Poland, the expenditures for implementing the National AIDS Program simply reflect a trend in the Polish health system’s overall expenditure and is a symptom of a larger “Polish problem.” The majority felt that moving the purchase and distribution of HIV medication from the protected area of the National AIDS Center and incorporating it into the national health scheme would be a mistake. Various examples were offered with HIV diagnostics, when the National Health Fund limited payments for necessary procedures, including cutting the number of methadone patients that a given site was able to treat. Poland was recently ranked 27th, at the bottom of Europe, in the 6th edition of the Euro Health Consumer Index and it is continuing to deteriorate (Björnberg, 2012). At the same time, some frustration was expressed with the status quo: “It is not normal, really, that the Director of the National AIDS Center, with tears in her eyes, thanks the Minister of Health for providing money for AIDS medications at the plenary of a National Conference. It is as though he is doing this as some kind of favor. This is the tenor of our discussions about AIDS in Poland.” Another interviewee noted the persistence of the hierarchical bureaucracy inherited from the socialist system and its current impact. The way people relate professionally is always perceived through rank, and the lower ranking staff are always considered an applicant, never a partner. Thus it

follows that the NGOs are considered applicants of the National AIDS Center and the National AIDS Center is considered an applicant of the Ministry of Health. Two NGO representatives shared a distinctly different view on the AIDS Center's role in the purchase of medicine: "The National AIDS Center is huge, I think it has five accountants. It is hard to understand its purpose. It does not do prevention. All it does is pay for medicine and its distribution. Why is there such a huge infrastructure for such a basic activity? Yes, in the beginning, it was tough. Everyone was worried that there would not be any medicine, and that no one would stand up for people with HIV. Today, years later, HIV medication should be handled by the national health system, as with all other illnesses. The National AIDS Center should be about policy, prevention, problem solving." Another interviewee was even stronger in his view: "It is absurd that the only technical agency that should be helping us implement successful programs is spending all of its resources on HIV medicine. That should be a part of the regular health care system." While most of my interviewees felt that safeguarding HIV treatment was important, they also expressed frustration over the lack of investment in prevention and strategic initiatives. Through these discussions, a theme emerged that suggested a conscious choice had been made by the staff of the National AIDS center. In a conservative, Catholic country such as Poland, it is easier and far more admirable to be a person who saves lives and provides medicines, than to be someone who deals with sexuality and drug use. As one interviewee said, "Why would you want to use words such as condoms, semen, vagina, safe injection, and anal sex every day when you can be spending your time negotiating lifesaving medication with pharmaceutical agents? Why do you think we have the same director for over ten years? She does not use these words." Another, a provider of drug treatment, agreed with this view and felt that treatment serves as a "shield" which protects the senior staff from dealing with issues that would potentially put them in

conflict with key contacts in the government. Another interviewee pointed out: “The AIDS Center came up with a way to pay for AIDS meds by maneuvering the system so that moral judgments and economic considerations would not interfere with treatment. Even though I am pleased for those who have access to medication, I find this somehow to be wrong.” He went on to explain that as more people need treatment, the less sustainable the current model will become. So called “protected” systems are costly because they are isolated from the established healthcare delivery system and thus require a separate infrastructure and that, as the operations continue in their present form, will miss opportunities to evolve and integrate with other areas. Ideally, we want HIV treatment to be available to all who need it as the result of a transparent decision made by those mandated to make such decisions – the National Health Insurance. Otherwise, HIV treatment will remain on the periphery of the larger health system.

HIV Treatment as Prevention

The public health approach to HIV frames HIV treatment as prevention: the less infectious the person is, the less likely they are to pass the virus on to others. After years of intense international debate over the value of investing in prevention or treatment, and almost 10 years after the establishment of the Global Fund to Fight AIDS, TB and Malaria (the leading funder of HIV treatment worldwide), the matter was largely put to rest. During the 2011 AIDS Conference in Rome, Anthony Fauci, Director of the United States’ National Institute of Allergy and Infectious Disease (NIAID) pronounced, “The idea of the tension between treatment and prevention, we should just forget about it and just put it behind us, because treatment is prevention.” Fauci was commenting on the results of the Prevention Trials Network study

showing that antiretroviral drugs (ARVs) reduced the risk of heterosexual transmission by 96% (Cohen, 2011 and Cairns, 2011). The head of UNAIDS subsequently stated, “This breakthrough is a serious game changer and will drive the prevention revolution forward. It makes HIV treatment a new priority prevention option.” (UNAIDS, 2011) As discussed widely at the Conference on Retroviruses and Opportunistic Infections (CROI) 2012, while there are ongoing concerns about the practical implications of these findings, such as achieving good adherence, maintaining a long term undetectable viral load, and a constant supply of medicines (Fowler 2012 and The Lancet, 2011), inspiring drug users to test and be treated with antiretrovirals could have an additional benefit of HIV prevention.

Though the National AIDS Center is primarily focused on the delivery of HIV treatment, I was unable to locate any information about the strategic effect of these new findings on the Polish HIV policy. Furthermore, as stated by one of my interviewees, “On paper, HIV treatment is available to people who inject drugs if they meet the clinical criteria, but if there are no supports in place, they will not be treated. We all know that, for the most part, these supports do not exist in this country. So, as with many other things, the papers look great, but the practice is entirely different.” Another person, an advocate of methadone patients had a similar observation, “Most of the HIV positive people were told that they will not get ARVs if they do not go on methadone. A number of those on methadone were told that they have to be on it for a while, to prove that they will be responsible with their medicines. There are others who were told ‘no’ once, and would therefore not return. These are the ones I worry about the most. What tops the cake is the fact that people can only apply for housing available to those who are HIV positive after they are. . . methadone free.”

When discussing the silence on the topic of people going untreated, the most marginalized members of society, one of my interviewees responded, “Drug users in Poland have a tradition of taking drugs quietly, of occupying dark corners in dark buildings, of getting sick and dying quietly.” This silence on HIV treatment among drug users is present in the statements of the National AIDS Center: “Since antiretrovirals became available in Poland in 1996, all persons who meet the medical criteria receive these medications without charge. Those who are eligible include the uninsured, prison inmates, and the homeless (Redlinska, 2010). Among the 274 AIDS cases that were identified within three months of HIV diagnosis between 1999 and 2004, IDUs represented 31.8%, suggesting that drug users may have been tested very late in the process (ECDC, 2006).

IDUs have successfully started antiretroviral medication in at least 50 countries where they have enjoyed significant benefits from HIV therapy. Furthermore, the studies show that virological resistance does not differ between IDUs and other patients (Mathers B, 2010; Wolfe, 2010). The World Health Organization issued clinical protocols detailing regimens for IDUs and stated that active injecting drug use should not be a criterion for exclusion from HIV treatment. As described by HIV physicians (Carrieri 2006; Altice 2010; and Cholewinska 2007), a number of adherence supports are available to assure that active drug users can be effectively treated with HIV medication. The range of support interventions is diverse and includes cues and reminders, adherence counseling, contingency management, supervised therapy, medication-assisted therapy, and integrated health services delivery (Altice, 2010). A physician describing her

efforts to begin a discussion of HIV treatment for drug users in Poland related: “My efforts only got me in trouble. My colleagues do not think that our job is to assist our patients with adherence. They told me that our job is to treat patients who want to be treated.” This approach is very similar to the drug free philosophy for drug treatment. A drug treatment provider reported that for a number of years the HIV physician requested that his HIV positive drug using patients bring a note stating that they were promising to undergo drug treatment, before being enrolled on antiretrovirals. He fears that the practice ended only because new drug users are no longer being enrolled in treatment due to funding limits and swelling numbers. Another AIDS physician stated that her community is divided: there are doctors who do their best to treat HIV in active drug users and then there are those who believe it is a waste of funds. “In my view, this is not a discussion that has come to a conclusion. A number of years ago, it was on the agenda and as a result, a few centers initiated methadone provision. Then it got quiet and no one has made an effort to come to a consensus on this. It is important to acknowledge that active drug users in Poland do drop out often, but let’s be honest, what sort of adherence work is done to keep them enrolled? For the most part, the answer is, very little or none. There is not one person who lobbies for HIV treatment on behalf of drug users.” The two programs mentioned by my interviewee are in Katowice and Wroclaw. Both were established because of the efforts of infectious disease doctors who noticed a high number of active drug users at their HIV clinics, wanted to provide treatment, and felt that a methadone program will aide in that goal (Gasiorowski, 2007 and Beniowski, 2007). Even earlier, an outpatient AIDS clinic in Warsaw made a methadone program available to its patients, as did the infectious disease hospital (Cholewinska, 2007). It did so in a closed ward for HIV positive drug users where until today, patients are not allowed to have visitors. An anonymous, voluntary survey of 95 patients,

reported that most are homeless, receive no social services, have no income and have no relationship with their families (Piekarska, 2004). The study offered no explanation for patients being locked in or forbidden to receive visitors for the duration of their hospital stay. The closed ward was discussed by a number of my interviewees as an inexplicable phenomenon. Some asked if I had ever seen such a set up in other countries. One NGO representative shared an illuminating experience: “We had guests from the Ukraine once and we took this visit very seriously – there is a high level of HIV in Ukraine. We took them to visit NGOs, they travelled throughout the country, saw needle exchanges, methadone clinics, and various HIV treatment centers. Then they visited the Helsinki Foundation for Human Rights. While there they asked about the human rights of the HIV positive drug users who were locked-up in the Warsaw hospital ward. We all just looked at each other and did not know what to say. It’s always been there. I guess we all got used to it and no one really asked questions about its existence.”

A number of countries have used the provision of HIV medications as an opportunity to motivate members of various vulnerable communities to come forward for testing. The availability of treatment makes it worthwhile, even if discrimination is still a problem. Poland is missing this opportunity among its drug users. People whose infection resulted from intravenous drug use still constitute more than a half of all those diagnosed with AIDS (45% in 2005, 52% in 2006). In 88% of the AIDS cases reported between 2004 and 2005, patients had not received antiretrovirals before their AIDS diagnosis (Rosinska, 2007). Four years later, the percentage of late presenters, defined as those with a less than 3 month period between HIV and AIDS diagnoses, is still reported to be high and makes up 56.1% of AIDS cases. This suggests that a significant proportion of AIDS incidence could be prevented with improved testing rates. The

largest group among patients with AIDS are also males aged 30 to 39 years old. Of these, 40.2% of were likely to have been infected through unsafe injecting drug use (Wierbinska-Sienkiewicz, 2011).

As stated by an HIV physician I interviewed who recently participated in a multidisciplinary workshop on HIV for non-HIV doctors, it was surprising how limited their knowledge was about HIV treatment. They had no idea of the existence of anti-retrovirals, of the fact that people with HIV can live for a long time, and that their expertise, for example in cardiology, may be useful for patients with HIV who are aging, as is the case with the rest of the population. Such lack of interest and knowledge may help to explain the great delays in HIV diagnosis which continue to be a problem in Poland; family physicians unfamiliar with the risks and symptoms may not offer HIV testing to their patients. Examples of dramatically late AIDS diagnosis were shared by a number of my interviewees. Recently, a 23 year old man was hospitalized and bed ridden for eight months with multiple AIDS-related symptoms before receiving an HIV test – a day before he died. A scientific body, the Polish AIDS Society, was seen by a number of persons I spoke to as a potential solution to the lack of knowledge about HIV and AIDS held by so many physicians. For the most part, however, they concluded that there is little interest in reaching out to others and that the members are very focused on issues internal to their group.

An important piece of international advocacy – treatment activism – has not made its way to Poland. Polish treatment discussions contrast strongly with the treatment activism of the International Treatment Policy Campaign (ITPC), HealthGap in the United States and the AIDS

Treatment Action Campaign in South Africa. In all of these instances people organized around the lack of access to HIV drugs, not only for themselves, but also for those who were invisible and powerless. The ITPC, for example, brings together activists that engage not only in single communities and countries, but also across continents. In Poland, the financial pressure is felt and much anxiety is shared when a new budget is approved each year. This anxiety, as expressed by many of my interviewees, is over ensuring that those people who are currently on treatment, continue to receive it. Little concern is expressed over newly identified cases or larger groups, such as drug users, who may be consistently excluded. Securing funds for the purchase and distribution of medicine within the policy and decision making bodies may preclude such advocacy. During the last gathering of people living with HIV that I was invited to, I was struck by the congratulatory tone of the event towards the Ministry of Health and the National AIDS Center. After a while I came to understand that all of the event's attendees already had access to HIV treatment.

Non-Governmental organizations

Civil society, as defined by political scientists, is the matrix of institutions and associations that, “Fill the space between family and state.” While Buchowski (2001) states that civil society can be defined differently, depending on the political context, he argues that it is inappropriate to try to understand post-communist civil society by comparing it to the West. In mature democracies, the non-governmental sector frequently fills in where the state ceases to meet the needs of its citizens. NGOs have played a pivotal role in maneuvering HIV and AIDS onto government agendas and forcing appropriate action and funding. For this reason, it is hard not to look at Poland’s AIDS organizations without some expectation that they adopt the methods that worked for others in the West. The ACT-UP model, a United States based organization of middle-class gay men committed to policy change and willing to do civil disobedience when necessary to obtain it (Nathanson, 2007), or any of its other advocacy tools, was never adopted in Poland. In fact, the French organization AIDES, following its mission to Poland, reported:

...most of the very limited funding for NGOs comes from the state. Criticizing the institutions responsible for AIDS funding is, therefore, definitely not advised—unless you’re willing to risk your organization’s survival. In any case, none of these organizations take such risks; any problematic political positions or demands are stifled before rising to the level of conscious thought. Only the occasional request (usually regarding a special case) discreetly reaching government ears through well-placed friends is likely to get results. Their precarious situation is made worse by the fact that government funding does not cover the organizations’ administrative costs (such as rent, telephone, and electricity).” (Wasson, 2006)

While there are a number of NGOs that focus on HIV and drug use in Poland, they all provide services, are project-based, and rely heavily on funding from the state and the local governments. These factors limit their ability to advocate on behalf of their constituency. A physician with a history of working with HIV in both the governmental and NGO sectors stated, “People choose to engage where they know there will be profit. Much of the international funding available to the non-profit sector before Poland entered the European Union is no longer available. In the fall of 2011, when Poland held its first Presidency of the Council of the European Union, it placed drug-related matters on its presidency agenda. At a conference held in Warsaw, in support of this priority, the head of the National Drug Prevention Bureau delivered a speech in which he encouraged other European countries to follow Poland’s example, in which eighty percent of drug prevention and treatment is delivered by NGOs. A number of my interviewees were puzzled as to why this heavy reliance on the non-profit sector is considered a measure of success. In fact, many felt that most of the NGOs have serious governance issues, poorly trained staff, and are severely underfunded. They also felt that these institutions are poor substitutes for the role that the government should not abandon. Over dependence on project-oriented government funding transforms potentially powerful civil society advocates into an informal arm of a stagnant government. Tensions between various civil society organizations are high and there is little evidence of cooperation. Since both sectors, drugs and AIDS, are small, everyone knows one another and any serious conflicts may result in exclusion. As one of my interviewees pointed out, “No one can afford an open conflict. People know that once you are out, there is no way to get back in because everyone knows everyone else.” As a result, the current atmosphere within the NGO community is one of ongoing tension with no sign of resolution.

As shared by an NGO representative: “It is difficult to criticize the people who can chose, or not, to finance your program. What we clearly lack in Poland, is a think tank that can do research, provide independent recommendations, and to carry out effective advocacy.” What is striking, when assessing the Polish NGO scene, is that there is no leading AIDS organization. For the most part, they are service oriented and, more precisely, they provide various amenities to the government as implementers of components of the National AIDS Program. Advocacy is a small component of their work, if at all. When describing the relationship to the government, another of the NGO representatives stated: “As I think about all these years of AIDS work in Poland I am amazed at how much we have managed to do despite the government. It is hard to remember one instance when the government institutions took the lead on any one of the issues. Furthermore, the initiatives that NGOs cannot tackle on their own such as epidemiology, HIV treatment for drug users, and scaling up substitution treatment have been inadequately addressed. If one wants to discuss any of these issues, our shamefully incomplete data, for example, there is really no one to address.” When government grants are paying for NGO salaries, they do not fund posts, but pay per deliverable. This makes planning very difficult for civil society groups and leaves little room for the leaders of organizations to be compensated for overall coordination, grant writing, etc. A staff member of a harm reduction program recounts: “When we have visitors from Canada or Western Europe, they are always surprised that I have five jobs. They exchange needles and syringes five days a week and can live on their salaries. I would not be able to feed myself with what I make here, never mind paying rent and covering other expenses.”

MONAR, registered in 1981, had to suspend its activities during the period of Martial Law. It started again when Martial Law ended in 1982. It was the only non-governmental organization dealing with drug users in the 1980s and was the first to notice HIV infections in this population and to talk about this issue. The first HIV-specific NGO was established in 1989, the same year that Poland's political and economic transition occurred. Maria Malewska, a psychologist with a long history of working with drug dependent persons, founded the non-governmental organization, You Are Not Alone, to provide support for HIV positive individuals. Along with delivering psychological assistance, the newly formed group also provided food, holiday packages and other necessities. Malewska operated out of her home and fundraised through TV appeals which she had easy access to. She also travelled throughout Poland conducting HIV education sessions that instructed on proper condom use, a novelty in a newly post-communist country. Malewska's organization, however, has not managed to sustainably establish itself in the Polish HIV scene. The next group to come into existence, also in 1989, was Solidarni "PLUS" which was dedicated to supporting the social reintegration of marginalized individuals, including drug users living with HIV. One of their activities is running an eco-farm. The Social AIDS Committee (SKA), registered in 1993 with the support of parliamentary players as well as the Helsinki Commission. Its portfolio has diversified and developed over the years and currently includes training services, counseling and testing for HIV, outreach to sex workers and advocacy. When the Social AIDS Committee was accepted as a member of the European Civil Society Forum in 2005 it subsequently issued to all HIV NGOs in Poland a request for information about their work, needs, successes and challenges. Several groups replied. Badz z Nami, which came into existence in 1993, is mostly composed of people living with HIV. They run a 24-hour hotline, a program of volunteers who assist people living with HIV, and organize

various support activities for people living with HIV. Most of their activities are centered in Warsaw. Bez Granic, an NGO operating in Southwest Poland where HIV infection rates have historically been high, also provides various forms of assistance, including the identification of employment opportunities. Międzynarodowego Stowarzyszenia Studentów Medycyny is an organization of medical students whose primary activities are pro-bono educational efforts. Krakowskie Stowarzyszenie Pomocy Uzależnionym (KTPU), based in Krakow, provides a wide range of services to support people who use drugs. Lambda is an organization focused on supporting men who have sex with men and runs outreach to young sex workers and at dance events. Other HIV NGOs include Siec Plus, a network of people living with HIV that organizes annual gatherings for its members, and Res Humane, founded by Arkadiusz Nowak, runs trainings, a hotline, and administers the annual AIDS conference of the National AIDS Center. Pozytywni w Teczy, is a support group for men who have sex with men. With one exception, none of these Polish organizations have a significant advocacy or campaigning mandate. The exception is SKA, which, for example, attempted to coordinate a Polish NGO report to a review by the United Nations General Assembly Special Session on HIV/AIDS (UNGASS).

Recent opportunities for NGOs to talk about the challenges they face in their work revealed many serious threats that include the lack of: funding, publications and educational materials in Polish, and opportunities for exchange and learning from others in Europe. During my interviews, there were several accounts of effective knowledge transfers from organizations in other countries. NGO cooperation with the Dutch, Germans, Austrians, Swedes, and French was mentioned. None of these have continued into the present. The list of difficulties also included poor communications with national government entities, local governments, and NGOs

themselves. Budgetary planning has been marred by nepotism, difficulties in accessing funding networks, the lack of long-term contracts. Additional challenges are the constant manipulation of NGOs by making them compete for “pennies,” the poorly defined priorities of key decision makers that are not based on evidence, the limited capacity of NGOs and lack of resources to increase capacity, and limited access to high-speed internet due to budgetary constraints. The lack of inter-organizational cooperation has resulted in the largest NGOs acting as monopolists, while all of the smaller organizations, having insufficient funding to specialize and excel, do a little of everything, usually poorly. National grant givers treat NGOs like potential thieves and make them jump through time consuming hoops. The National Centers (AIDS and Drug Prevention) lack interest in making international documents available in Polish and language barriers to communicating with groups outside of Poland make it impossible to collaborate. Poorly educated medical practitioners are causing harm to people living with HIV and drug users. There is very little information sharing or collaboration among the groups. Their small size and lack of cooperation are a serious obstacle to accessing funding from the European Commission which prefers large grants with established and collaborative partners. No assistance in accessing international funding is provided to the NGOs by the National AIDS Center or the National Drug Prevention Bureaus for help with proposal writing, identifying opportunities, or bringing partners together to discuss potential international collaboration.

When talking to various HIV NGOs about the lack of prevention strategies for drug users in the early days of the epidemic one narrative emerges— MONAR was a well funded, highly visible organization specializing in drug treatment and the assumption was that it was taking care of all drug user needs, and represented all drug user interests. MONAR began needle and syringe

distribution in the mid-1980s and in 1989 passed a bylaw formalizing the procedure. This assumption about MONAR was somewhat flawed since MONAR was a treatment organization and was reaching only those drug users seeking treatment assistance. As stated by one of my interviewees: “Getting sterile shooting equipment was not easy. Before receiving your needles and syringes, which, by the way, were of terrible quality, you had to have an entire conversation about why you take drugs, about not wanting treatment, etc. So as you can imagine, this was not an attractive offer to people who wanted to shoot-up immediately.” None of the people I interviewed could recall any prevention activities for the community of active drug users until much later, in the mid-1990s, and most of these efforts were enabled by the external resources of the Open Society Institute. As in the United States, seven years passed in Poland between diagnosis of the first HIV positive IDU and the establishment of the first formal needle exchange for active drug users. It took even longer for any government funding to start flowing into this area. The two regional leaders in harm reduction efforts were the MONAR offices, first in Krakow and then in Warsaw. As described in an earlier chapter, the leaders of both programs were later dismissed from their posts because of conflicts within the larger MONAR network.

In an interview on the twenty-fifth anniversary of HIV in Poland, the director of the National Center for HIV Prevention stated: “One of the most important factors that determined the shape of the epidemic in Poland was the quick cooperation of the government with people living with the virus, that is, with civil society. This cooperation continues to be one of our main pillars.” (Kontra, 2010). At the same time, the NGO representatives I spoke with seemed dissatisfied with their relationship the National AIDS Center: “If we want to do something, we just do it. Government agencies have little expertise, and provide no information. International sources are

the only ones to rely on.” According to AIDES, most of the NGOs providing direct prevention and support services remain vulnerable financially. “Private funding is extremely limited; an appeal for donations sent to 10,000 people by Res Humanae netted a total of 10 replies and only three of these contained checks. The primary source of funding, albeit limited, to NGOs is the national government” (Wasson, 2006). My interviewees agreed on one aspect of civil society engagement – that there was not only a lack of cooperation, but there existed open hostilities. The reasons given for this state of affairs varied. Some blamed the previous political system; the pervasive fear of informers and therefore the need to keep information close to ones chest. Others talked about scarce resources. Some felt that increasingly scarce funding created a constant feeling of competition and that the few funders that do exist, for the most part governmental, manipulate organizations to prevent them from creating a common front. A physician I spoke with, suggested that I should not perceive this as a problem of civil society: “Doctors do not like to share information with other doctors because they want to feel that they are the most competent. They do not even publish, which might be a Polish phenomenon. Government agencies have no interest or habit of informing and consulting others they collaborate with. Why should NGOs be different?” When asked about collaboration between NGOs and the medical establishment another physician stated that no such efforts exist and that no institution ever tried to forge such partnerships. “Doctors do not really trust NGOs. I doubt they would know how to work together or how to set a common agenda. There is no institution here that ever attempted to facilitate such a discussion.” Another pointed out: “This is something that has to be learned in a classroom, in a community. No one ever invested in teaching us cooperation.” A number of people I spoke to made the point that Polish culture precludes coming together to solve a common problem, especially across various sectors. The head of a

think tank offered the following observation: “During the communist time nothing was safe. The government that was shooting at workers was certainly something to stay far away from. This experience remains in the minds of many. Now, competition is so deadly that we have another reason not to come together.” Another person stated, “Look at our national agencies. Since we began talking about AIDS in the mid-1980s different bureaus were created for AIDS, alcohol addiction, and another for drugs, and a separate office for public health education was established at the Ministry. Everyone wants to be the director of their own office with a secretary and a computer. The same is happening with the NGOs. It’s not about us coming together, but rather about everyone getting her or his own cake and being a director. I do not recall even one moment when the worlds of AIDS and drugs came together to discuss HIV prevention and treatment for people who use drugs.” Another NGO representative confirmed this view: “It seems that the National AIDS Center and the National Bureau for Drug Prevention divided the territory. As a result, the AIDS groups do not talk to the Drugs people and Drugs people do not talk to the AIDS NGOs. There are very few spaces for collaboration in Poland.” None of the HIV positive people who collaborate with the National AIDS Center are drug users. While drug users in Europe have been organizing around their shared identity since the 1970s, with Rotterdam Junkiesbund in Holland, and continue to be active throughout the region, they have never done so in Poland. Unlike in the United States where the critical role of activist interventions was confirmed, there has been no advocacy for needle exchange in Poland. The organization of methadone patients, Jump’93, comes the closest. While methadone patients try to advocate for expansion of the very limited availability of substitution treatment, they have not managed to organize successfully to voice their concerns over the gradual disappearance of other services.

A number of people mentioned that working with HIV in the early days of the epidemic was easier because it was not a business yet. Rather, it was a group of “fantastic” people who were moved by the issue and really wanted to do something about it. This is no longer the case. They observe that now it is simply just one of the many ways to make money and that relationships within and between organizations are tense and often unpleasant. A few expressed a concern over young people joining civil society organizations: “It is really hard for them now. There are all these old timers that are in place with no opportunities for them, no additional funding coming in, so there is no room for all of these young, enthusiastic people. That is a real shame because many are highly competent, speak English fluently, and could make a significant contribution. We are doing ourselves a great disservice by not finding ways to welcome and retain the next generation.”

While the global discussion of HIV vulnerability is increasingly understood as a matter of social and economic justice, most Polish prevention efforts have focused entirely on personal responsibility. Without acknowledging the structural risks, the inadvertent assumption is that every citizen has the knowledge and resources to opt into a drug-free lifestyle, choose and practice sexual abstinence, or always use condoms or clean syringes and needles. The criminalization of personal possession that removed drug users from public view, a phenomenon proven throughout the world to hinder the delivery of harm reduction services, was never discussed. Strategies were not put in place to ensure that drug users, increasingly receding from public spaces, would continue to have access to necessary services. Furthermore, no efforts were made to track the levels of HIV infection among injecting drug users since they make up a diminishing percentage of those people tested for HIV. Although, HIV prevalence close to 10%

is consistently shown among those drug users who come forward to test, the government has effectively removed them from the epidemic's narrative and focused exclusively on the theme of general transmission. In so doing, the Polish government removed drug users from HIV prevention and treatment efforts, from safe spaces that confirm their human dignity and protect them from structural violence.

Chapter Six -- Crucial Issues for the Future of HIV in Poland

Without effecting long term changes in the structures of society and in relations of power, there can be no hope for ending the HIV epidemic (Parker, 2000a). Based on gathered data, there are seven crucial issues that require immediate action if Poland is to manage HIV prevention and care for people who use drugs in a manner consistent with the international standards. The areas requiring action are: a change in the drug policy, expansion of needle and syringe programs that includes expansion into the prisons, improved data collection and an increase in the availability of HIV testing, scaled-up substitution treatment, improved quality of other forms of drug treatment, greater investment in civil society organizations, improved access to HIV treatment, and educational and training efforts that encourage greater attention to HIV related matters across disciplines.

Drug Policy Change to Create an Enabling Environment

As discussed earlier, the current drug legislation is at the very heart of the challenge to mounting an effective response to HIV among drug users in Poland. These inadequate and unreliable policies greatly undermine public health efforts and encourage continued human rights violations. Public appearance trump public health strategies and drive the problem underground. The removal of drug users from public spaces, such as the central train stations in Warsaw, Krakow, Katowice, and Chorzow, makes it difficult to reach them with public health interventions. As

stated by a methadone advocate, “Users got swept under the rug. When they come out, they are immediately harassed and picked up by the police. One might think that someone did their job really well –drug users are now invisible.”

Furthermore, these actions set the wrong tone – one that clearly suggests that criminal justice, along with the quest for total abstinence, are the only appropriate paradigms to follow – a message that spread rapidly among the population. As one of my interviewees pointed out, during the 1990s, whatever you did for drug users in one city, was immediately known in another. This was a very communicative and mobile community. He suggested that even if needle exchange programs were not widely available, and not everyone knew about the ones that did exist, the discussion about not sharing needles was noticeable as there was much buzz across Poland about the existing programs. Drugs move as fluidly as information, some of which may be contaminated and can be very dangerous, as made evident by recent reports of anthrax deaths among drug users in the UK (Health Protection, 2012). In the past, information about a few bad experiences in one city quickly made its way across the country. But with the atomization of the drug user community, under police persecution, much of this information sharing has been reduced. Poland’s law enforcement professionals need to understand the detrimental consequences their actions cause to public health interventions, as well as the implications of the law and order approach for the tone set in drug policy debates in Poland. Former Minister of Justice, Krzysztof Kwiatkowi, when discussing the positive amendments to the existing drug law in 2011 at an implementation meeting a few months later, stated that he felt he could only shepherd through the Parliament those changes he felt were possible.

It needs to be pointed out that the criminal justice representatives are not in agreement, and do not speak with one voice about the effectiveness of their anti-drug efforts: 48% of surveyed police officers and 60% of prosecutors did not find criminalizing personal possession to be an effective tool in apprehending drug traffickers, and 66% of prosecutors, 58% of probation officers, 46% of judges, and 51% of police officers did not think that criminalizing personal possession deterred potential drugs users (Kuzmicz, 2010). Now that the debate has begun again and includes new allies, such as former President Kwasniewski, rather than continue the process of ongoing amendments to poorly designed legislation, a new drug law is needed. This new law should consider support to public health efforts and compliance with human rights goals among its benchmarks of success. The discussion of legislative changes and amended engagement of criminal justice should be guided by the Office of the High Commissioner for Human Rights (OHCHR) and UNAIDS, “States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted against vulnerable groups. . .” And, “Criminal law should not be an impediment to measures taken by States to reduce the risk of HIV transmission among injecting drug users and to provide HIV-related care and treatment for injecting drug users.” (2006)

Needle and Syringe Exchange and Changing Patterns of Drug Use

The patterns of drug use have clearly changed in Poland: the proportion of opiate users as compared to users of other substances has declined. During the 1980s and 1990s injected heroin was the predominate substance, today, relative to other drugs, its market and use is greatly

reduced. The risk factors have changed as well. The display of freedom during the Solidarity movement expressed by joining a counter-culture where drugs were injected is not the current experience of young Poles. The severe economic crisis of the 80s, and the lack of knowledge about HIV transmission, where a needle was used hundreds of times until it dulled, is no longer the case. But it is a mistake to interpret the changing socio-economic environment and patterns of drug use as justification to limit or decrease services, especially taking into account an established HIV prevalence of 10% among the clients of harm reduction programs. A harm reduction worker from Warsaw, for example, reported recently meeting approximately 40 new users who began by smoking heroin and, as their use progressed, switched to injection. They had received information about needle exchange from their heroin dealer. No public health information reached them through formal channels. Growing interest in cannabis use and the problems associated with it, does not absolve the responsible authorities from providing the necessary care to drug users who inject opiates and other substances. Otherwise, as in other locations where services are scarce, injectors, while currently constituting a small group, will continue to bear the greatest burden of the epidemic in terms of mortality and morbidity. It needs to be considered that Polish data, similar to that of Germany and Switzerland, reports opioid use to be low. However, Germany and Switzerland continue to invest in substitution treatment, injection rooms, and other facilities aiming to support people who inject drugs (Michels 2012, Csete 2010). Poland, on the other hand, uses the same low reported rate of injecting drug use, to justify its lack of scale. The dearth of data on the number of injectors in Poland is troubling. Clearly, opiates are not the only drugs administered through injection. For example, much anecdotal evidence exists about the injection of amphetamines. Every effort needs to be made to expand and professionalize harm reduction programming so that the

programs can respond to the needs of all injectors. The effort should be broad and address multiple problems, per the guidelines of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA,2011). All Polish cities must make available: robust outreach to drug users, needle exchange, HIV testing, condom distribution, STI testing, basic medical care, and social and legal assistance. The trend in declining availability of needle exchange is troubling and requires immediate attention. Efforts need to be made to understand this phenomenon and plan for an appropriate response. Innovative approaches to assure that drug users in smaller communities have access to services, such as mobile vans, need to be supported by the local and national governments. Finally, the designation of case workers may be considered by providers of harm reduction services. As stated by one outreach worker, “Our services really have to respond to people’s needs. They have so many complications in their lives that a useless service is not where they will be spending their time. Needle and syringe exchange is one option, but legal services, social services, and medical assistance are also needs we have to respond to all the time.”

While arrest and incarceration is now the default response to many drug users, prison based services are inadequate to prevent HIV. Needle exchange is not available to prisoners in any Polish prisons. According to the European Commission, “Harm reduction interventions in prisons within the European Union are still not in accordance with the principle of equivalence adopted by the UN General Assembly, UNAIDS/WHO, and UNODC, which calls for equivalence between health services and care (including harm reduction) inside prison and those available to society outside prison. Therefore, it is important for the countries to adapt prison-based harm reduction activities to meet the needs of drug users and staff in prisons and improve

access to services (Michels, 2012). Prison services need to consider making needles and syringes available.

Data and HIV Testing: Documenting the Problem of HIV

There is an urgent need to develop and employ confidential HIV testing and reporting – first for case finding and secondly to address the significant data gaps in Poland, especially among drug users . Between 15,000 and 25,000 people are currently estimated to be injecting opiates . In addition, 40% (50,000) of the estimated 125,000 problem drug users, as defined by the EMCCDA, are diagnosed with poly use (Category F-19). It is unclear how many of these poly users are injectors and require harm reduction services. The most recent report from the National Drug Prevention Bureau states that there is no clear evidence that the number of injecting drug users is falling (2010 National Report). It is equally unclear who is HIV infected in Poland. Evidence points to a decrease in HIV testing among drug users. Measures need to be taken to reverse this trend, keeping in mind that the current methods of delivery have proven inadequate for this population. The decision of the ECDC and WHO to remove Poland from the European trend analysis, because of its incomplete data (ECDC, 2011), illustrates the scale of this problem. Necessary procedures, including implementation of clear guidance related to legislative decisions on HIV reporting, must be implemented to assure that complete data on new infections is gathered, reported, and analyzed. Policy making needs to be instigated and guided by this data.

HIV testing urgently needs to be scaled up in order to better understand the incidence rate and to know who is HIV infected. It is also critical to enrolling those who need treatment as early as possible. Currently, in significant number of cases HIV treatment is offered very late, often when a person has become visibly ill. Limited data suggests that late diagnosis and treatment is especially prevalent among drug users. Improved testing practices would allow for greater access to, and more effective, HIV treatment. Since it is not possible to effectively prevent and treat HIV without sufficient testing and accurate data, these should be given the highest priority.

Recent reports from Romania and Greece show a significant increase in HIV incidence among injecting drug users. In Romania, as in Poland, while patterns of drug use appear to be changing, access to sterile syringes has been on the decline. In Greece, access to substitution treatment is limited to only a few sites in large cities (EMCDDA, 2012). The implications of these developments in Greece and Romania are very concerning for Poland in light of the fact that there is a high undiagnosed prevalence: a substantial proportion of HIV infected injecting drug users in Poland, especially recent injectors, are unaware of their infection (Rosinska, 2010); reported needle sharing behavior is at 40% among those tested at VCT sites (Walichnowska, 2012); and all of this is set in the context of an overall lack of enabling environment. The data from Greece and Romania and the parallels to the situation in Poland, point to the fact that HIV prevalence in Poland is likely to be much higher than is currently documented.

Substitution Treatment

The difficulty with Polish substitution treatment is not only that it is so scarcely available, with exception of Warsaw's six programs, but it is the spirit in which services are delivered. Many of my interviewees spoke of substitution being offered with the same punitive philosophy and contempt for drug users that is present at many abstinence treatment services. "The only change is the service itself." Further education of substitution providers is needed, including exposure to practices in neighboring countries as well as a roll-out of new programs. A substitution advocate argued that programs should be stratified: "There should be a low threshold mobile point, which would include needle exchange and treatment of abscesses; a medium level to offer social services and legal assistance; and a high threshold program which would provide psychological counseling, job training, along with legal and social services." Availability of substitution is especially important in the context of adherence to HIV treatment. A number of my interviewees reported that HIV care is often linked to substitution and only available to drug users enrolled in a methadone program. The examples of Chorzow and Wroclaw need to be followed, where substitution treatment was made available by infectious disease clinics. Access in small towns was on the minds of a number of people I spoke with: "There is a small group in Elk, near Bialystok, maybe 15 of them. They will just stay there, until they start getting sick and dying. Accessing services is practically impossible and no one is going to open a clinic for 15 people." Each city needs to offer substitution and consideration has to be given as to how to serve opiate dependent persons living in smaller communities. Prescriptions issued by local physicians should be implemented along with mobile outreach. As stated by one of my interviewees: "We need to 'free' methadone in Poland." There are a number of doctors who do not want to be labeled as addiction specialists, but who do, quietly, assist people who are drug

dependent. They usually quietly treat five, may ten patients with ‘underground’ substitution.“ Poland needs to standardize this practice, rather than relegate these physicians to potential conflict with the law. Substitution programs should also be much more flexible about take home doses, and it is important to put measures in place making sure that the lack of substitution does not impede access to HIV care. A model developed and implemented at Yale Medical School, where mobile outreach is made available for both purposes, substitution and HIV care (Bruce, 2010). This approach may be considered for smaller communities and more remote areas. As shown by Germany (Michels, 2012), expanding substitution by strictly offering it the settings of methadone programs is not possible. Urgent discussions are needed about registering buprenorphine as a substitution drug, and allowing its prescription outside of rigid program settings. “Expanded substitution treatment in Poland should not necessarily mean additional rigid methadone programs.” Buprenorphine, along with methadone, is included on WHO’s list of essential medicines. Medicines used in substance dependence programs include methadone and buprenorphine, and opioid analgesics, such as morphine (WHO, 2007) and should be classified as such in Poland.

When legislation was passed in 2005 expanding the number of entities allowed to provide substitution treatment, it was hoped that civil society groups would seize this opportunity. This, however, was not the case: only three, NGO-run programs were opened. One of my interviewees observed: “People who want to expand substitution availability are not interested in following the current model. Instead, they are trying things that are somewhere on the borderline of illegal, because, from their point of view, that is more effective, closer to the clients’ needs,

respectful of human rights, and they are probably counting on the fact that soon they will be able to do so legally.”

While a few jails offer methadone treatment, by and large, availability is limited. Reports of arrests of opiate dependent persons who then suffer in jails without proper medical support make their way to the few existing advocates. According to UNCHR, sick prisoners who require specialist treatment shall be transferred to specialized institutions or to civil hospitals (UNCHR, 1997). Finally, it needs to be formally acknowledged that some patients on substitution treatment will continue to inject drugs, at least for an initial period. Methadone programs need to make needles and syringes available rather than continue the current policy of expelling drug using patients. Continued use is often evidence of poorly administered treatment that needs to be adjusted, i.e. when a patient needs a higher dose (Newman, Raport 20011). A number of people I spoke to with were concerned about the emergence of new HIV infections among clients of methadone programs. Since people are fearful of being recognized at the needle exchange programs, and as a result, being denied substitution, they discontinue using this service and HIV infection follows.

Other Drug Treatment

While most of Europe offers outpatient drug treatment as a primary mode of delivery, the situation in Poland is reversed. The most significant budgetary allocations are for long-term, inpatient facilities and 70% of state funding goes to organizations that came into existence before 1989. Several observations were made by the Helsinki Foundation for Human Rights after it

visited 18 inpatient drug centers. The stationary treatment centers should admit those who have been subject to therapy at outpatient clinics and are clearly motivated to undergo treatment. This sort of regulation of access would not allow for a popular practice now – that clients stay at the center as a place of temporary residence and a way to temporarily “mend” their health. While not stated explicitly, they are not aiming to complete a full course of treatment. The effectiveness of therapy should be assessed, also in the context of the costs incurred, especially since they vary considerably. There is a need to upgrade addiction treatment standards based on modern knowledge (Helsinska Fundacja, 2010).

The absence of evaluations of the quality of services is another serious problem. As stated by the Helsinki Foundation: “In our view, there is a need to perform an assessment of the Polish model / system of drug addiction treatment. Evaluation and diversification of the inpatient treatment is clearly needed. Perhaps the long-term residence facilities, at which clean-up work occupies the majority of the residents’ time have a *raison d’être*, possibly as social assistance institutions under the Ministry of Social Welfare rather than as drug treatment facilities under the Ministry of Health. Undoubtedly, the range of therapeutic offers should be more diversified not only based on the duration of the stay. Finally, it is unclear if such a number of isolated, stationary centers is needed in Poland and if emphasis should not be shifted on development of a coherent system for outpatient treatment where such an important element as family therapy could be carried out.” (Helsinska Fundacja, 2010)

Since Polish drug treatment developed around long term inpatient facilities, outpatient services are low in number, often underfunded, and many require technical assistance. Investment in outpatient services is needed. Much has been said about MONAR as a monopolist. In order to diversify services, other entities must be empowered with special attention paid to short-term options.

Post-rehabilitation is another area that requires attention. As shared by one of my interviewees: “ It should be located in places where people can work, learn, where they can rent out a small apartment and try real living, with a real goal of re-integration. What we have instead, is a lengthened stay in a therapeutic community. An isolated treatment facility puts up an additional signboard, makes a few rooms available, and moves clients who have completed their treatment process next door. Local governments must address this and start supporting real post-rehab efforts.”

Non-governmental Organizations and Their Funding

Given these systemic and governmental obstacles to effective drug policies and programs in Poland a strong role of civil society is essential. Globally, civil society’s role in exerting pressure on governments and multilateral bodies for appropriate responses to HIV has been monumental. From local policy making to the creation of the Global Fund, NGO advocates played a crucial role. Attempts can be observed in Poland where, for example, the Social AIDS Committee began advocacy efforts to promote testing, and NGOs have quietly created injection rooms and prescribed buprenorphine hoping to inspire a positive policy response. By and large, however,

the successes of civil society advocacy in Poland have been limited by the same problems that have impeded governmental action. As argued throughout my paper, and consistent with the writings of the political scientist, Patricia Siplon, HIV and drug use has largely affected those without power. Even when the powerless organize and come together, those who do hold power are often able to diffuse their demands. They can force “non-decisions” by preventing grievances from developing into issues requiring decisions and change. The fundamental problem of HIV, she argues, is one of the configurations of power relationships among individuals, organizations, and nation-states (Siplon, 2007). One way this manifests itself in Poland is through the severe and haphazard underfunding of civil society organizations. None of them receive institutional support which would allow them to set an independent agenda. The salaries of staff, for example, are attached to individual deliverables: a project director receives a salary for a training, but only if he or she performs the actual role of trainer. None of the other costs, such as preparation, oversight, and office space, for example, are covered by state funds. And overhead costs are not allowed. NGOs, in reality, are the implementers of the national programs set forth by the government agencies, at extremely low cost. As stated by one of my interviewees: “There is little effort made to invite us to discussions about how to improve national policy. Rather, there are instructions for us, NGOs, for implementation of various pieces that have already been decided upon.” This approach is evidenced by the Polish proposal to the Global Fund to Fight AIDS, TB and Malaria submitted while Poland was still eligible before entering the EU. While the Fund required the establishment of a Country Coordinating Mechanism allowing all entities to engage in the process, the Polish proposal had one single component – HIV education for the schools of social work. When I asked NGO representatives how many weighed in on the process of identifying this as a priority, the answer was that none

had. A number of NGOs were asked, post factum, to sign the application that was prepared entirely by the government. The proposal was not approved by the Fund's Technical Review Panel⁴.

Not surprisingly, the advocacy that does occur on the part of civil society, happens on non-paid basis as an "add on" to various service delivery. As pointed out by a French delegation that visited Polish NGOs, they are very constrained by the funder-grantee relationship that the state and local funding institutions have with the civil society groups.

For a number of years, an alternative to state and local funding was offered by private foundations and small grants from the European Commission, as Poland was preparing to join the European Union. After Poland became a member of the EU, most of these financial mechanisms ceased to be available. There was no institution that took responsibility for preparing Polish civil society for this massive transition. The European Union funding opportunities available now are on a scale that is simply too large for the nascent and inexperienced Polish civil society. The funding requirements call for collaboration among many

⁴ Author served on the Global Fund's Technical Review Panel but consistently with Fund's policy, recused herself from review of the Polish proposal.

partnering organizations, ideally from at least two countries, proposals need to be submitted in English, co-funding is mandatory. All of these requirements make this form of funding nearly inaccessible.

Other obstacles, related to local funding, were identified as well. As explained by one of my interviewees: “Since we are funded by the municipality, we can only work within the boundaries of the city. If we learn of groups of drug users situated immediately outside the borders of the city itself, we are not allowed to assist them.” Attempts were made to create a Polish Harm Reduction Network to support collaboration and advocacy across the country but the project failed to secure funding.

Independent funding sources for civil society is urgently needed in Poland. Also, state and local agencies should make every effort to assist NGOs in obtaining European Union and bilateral funding. A service that helps to identify priorities, and assists with proposal writing and partnership seeking, could greatly strengthen the civil society sector and improve Poland’s response to HIV and drugs. The organizations themselves need to reach out to other, more experienced groups such as human rights and women’s organizations, to create partnerships and share resources. This would also allow them to learn about development experiences from others.

International experience sharing is important to the continued development of Polish NGOs. Connections with European organizations that, as a whole, have a long history of advocacy and service provision, must be established and nurtured. This may be possible through various small

collaborative initiatives supported by local embassies. While most embassies focus on commercial collaboration, there may be opportunities to explore civil society cooperation.

HIV Treatment: A Continuing Debate

While elsewhere in the world ARV treatment is now becoming a cornerstone of policy (including its use as prevention), in Poland much anxiety emerges when discussing access to HIV medication. First off, the model in which the only technical agency dedicated to HIV prevention, the National AIDS Center, spends 96% of its budget on HIV treatment is highly problematic. The Polish healthcare system, along with its financing, has been under constant debate since the political changes of 1989. However, no discussions are taking place to integrate HIV treatment into the national funding scheme rather than have it funded and administer it centrally by the National AIDS Center, as it's the case now. A thoughtful strategy is needed to move HIV treatment into the National Health Fund (NFZ), keeping in mind the need for continuous and uninterrupted funding for ARV medicines. While NFZ can be problematic, there are some sign of hope: a recent event where the supply of chemotherapy drugs was interrupted, but then immediately responded to by the Ministry of Health, illustrates the increasing maturity of the national system. One option to pursue would be to stage the process, with a built in mechanism, to assess the capacity of the National Health Fund to absorb the newly diagnosed patients. The “protective” mode, in which HIV medicines are considered by the National AIDS Center works to the long-term disadvantage of patients and dramatically limits the funding available for prevention efforts .

In this context, special attention must be paid to HIV treatment for drug users. While they make up the majority of those infected before 2000 and possibly later, and are most likely to have progressed in their HIV illness and require antiretroviral treatment, their numbers, as a percentage of enrolled patients, are ambiguous and appear to be small. In addition, they make up 70 percent of those with a late diagnosis, within one year of HIV infection (Rosinska, 2011).

Professional Education and Training

Currently, HIV knowledge is located only in a few specialized centers across the country. Medical educational institutions must expand their academic portfolios in the area of HIV and drugs at the level of physician and nurse trainings, and also at the level of continuing education. The majority of medical staff trained outside of these centers are therefore not privileged to the knowledge that would allow them to consider the possibility of HIV when diagnosing patients. As expressed by an AIDS physician: “If a person arrives at a general practitioners office, or any other doctor, with an acute fungal infection, they will spend months being treated without considering an HIV test. There will not be a discussion about lifestyle and risk factors because doctors do not talk to their patients. If drug use is not visible, it is likely that she or he will be diagnosed at the very late stages of AIDS.” This explanation is supported by data with late diagnosis of HIV. Polish medical academies and other establishments charged with medical education need to expand their curricula to provide fuller knowledge of HIV as well as an understanding of drug treatment. In both instances, special attention must be paid to physician supported adherence efforts, and the knowledge must be consistent with international standards and the recommendations of European and United Nations bodies.

Since 2002, training efforts have existed to standardize the capacities of those providing drug treatment in Poland. All drug treatment counselors undergo certification trainings by the National Drug Prevention Bureau. However, those who had practiced for at least 12 years when the process started, were granted certificates without the examination. This turned out to be problematic since, for the most part, counselors with the longest history in therapeutic communities are the most entrenched in the abstinence-only approach, and have little formal training and education (Raport, 2011) Alternative modes of furthering their competencies should be considered. The Czech Republic introduced a certification process for treatment centers, for example, which sets ongoing educational expectations for all staff.

This area of professional education must extend to a broader set of skills – including management, advocacy , and development . Polish NGOs have very few personnel that have been trained in administration, fundraising, or management. This presents a significant challenge to the effective running of organizations, work plans, budgeting, reporting, creating advocacy strategies, etc. Funding is greatly needed and should be made available by the state to strengthen the capacity of Polish AIDS and drugs NGOs in the areas of organizational development. Foreign language classes would also be greatly beneficial, especially in light of its membership in the European Union. Polish civil society groups have few partners outside of Poland.

A recurring theme in my interviews was the lack of opportunity to participate in international events. This is highly problematic since a significant number of academics emerged from Polish universities before 1989, and their expertise is often not congruent with the current Polish realities. Exposure to the practices of other countries would be useful to inspire discussions in Poland. There is no funding however, for civil society groups to take part in international meetings and conferences. Those who do travel are government officials with office budgets and physicians whose costs are covered by pharmaceutical companies.

Greater educational opportunities need to exist in Poland in the area of HIV. There is not one institution of higher learning where specialization in HIV exists in any of the fields. As a result, there are very few professionals in the area of psychology, sociology, social work, etc, that have any academic credentials in the area of HIV. One of my interviewees pointed out that the problem with the limited number of testing sites is that there simply are no competent people to provide HIV testing, especially outside of large cities. There are also no advocacy efforts targeting local governments to introduce or expand the availability of HIV testing. Various opportunities to expand the knowledge base in the area of HIV and drugs needs to be supported, from concrete skills around motivational counseling and HIV testing, to serious academic research.

Chapter Seven – Conclusions: Human Rights and Public Health

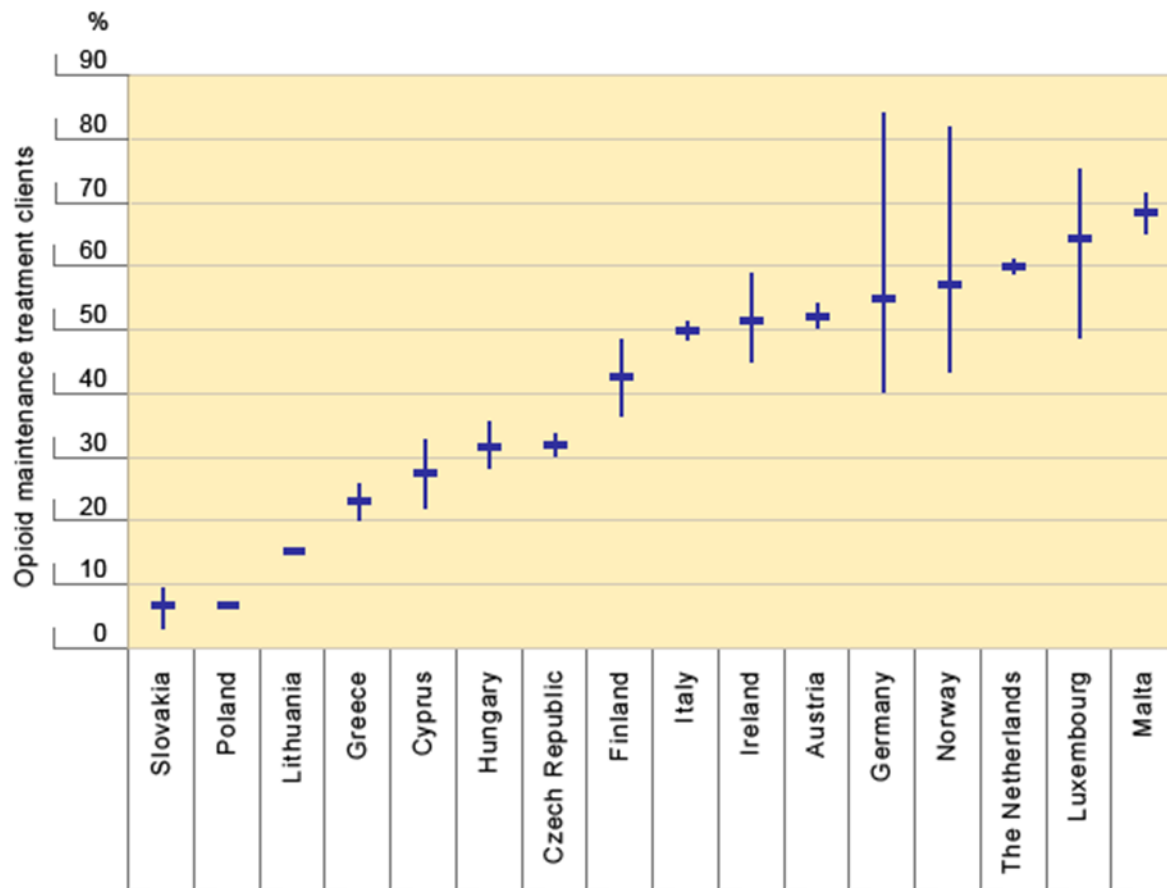
The lessons to be learned from the history and the current state of the HIV epidemic in Poland have general significance for specific epidemics of infectious disease globally, and for how public health is understood in the modern era.

Human rights violations, when ongoing and severe, are a major determinant of health. While social determinants theory does not specifically identify human rights, it talks about the economic and social factors contributing to poor health outcomes. When examining HIV prevalence globally, the greatest disease burden is closely associated with the most socially excluded including the poorest families and communities, who are most often the core of the drug user population (Grund, 1992; Rhodes, 2009; Reference Group, 2010). The inequalities reflect the forms of structural violence (Degenhardt, 2010) that lead to increased HIV vulnerability and mortality (Farmer 1996, Mann 1999). As discussed by Parker (2000), the spread of HIV infection has tended to uncover the fault lines of social cleavage, as well as capacity, or lack of thereof of political, cultural and social systems, to respond.

The Case of Poland

Poland entered the global HIV crisis in an unfavorable moment. As suggested by Bobak (1996), it is likely that the social environment existing in CEE and the fSU had a strong influence on psychosocial well-being of the region's citizens resulting in poor life styles. Social, political and economic factors have been influencing health behaviors. The problem of HIV among drug users in Poland is not a lack of knowledge about effective instruments for HIV prevention and treatment, nor a constraint on resources – Poland's economic development and per capita income are well above that of many societies in the region and likely to improve with EU membership. It now ranks 41 in the Human Development Index. When Poland was discovering HIV among its drug users in the late eighties, it could have been argued that the response was slow and cautious because the country, emerging from decades behind the iron curtain, was simply unaware of many new issues and focused on its early stages of modernization and economic achievement. This clearly does not apply today -- the evidence for engaging in HIV prevention efforts among people who use drugs is strong and the nation is fully capable of effective action. Access to the means of effective interventions are now externally well supported - by the International Red Cross; the Institute of Medicine; the UNAIDS, the Joint United Nations Programme on HIV/AIDS (UNAIDS); the World Health Organization (WHO); European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) the United Nations Office on Drugs and Crime and many others. Yet, the availability of the most fundamental measures to prevent HIV among the nation's drug users is wholly inadequate -- needle exchange efforts are declining and the number of substitution treatment programs in Poland remains well below the European average (Figure 12).

Figure 12. Substitution clients as percentage of estimated need (EMCDDA, 2013)



HIV and drug policy has been more about politics than evidence-informed public health. During the 70s, drug users perceived as a nuisance and a challenge to the system were put away in psychiatric facilities and remained there often heavily sedated and mismanaged. Similarly now, the quality of services is driven by, and responds to political contexts -- humiliation of clients at MONAR treatment centers, high threshold and frequent urine screenings of methadone patients, strip searches, serve as powerful examples. Why this is so and what forces continue to restrict

Poland's ability and political will to act effectively on its HIV and drug problems has been the subject of this inquiry.

I have argued that the heart of the problem is that drug users most fundamental needs and wants, in fact, their human rights have been ignored, rendering them invisible and powerless as individuals, communities, and as political actors at the national level. When MONAR was created almost 30 years ago, its intervention method very much aligned with the government's approach – the assumption was that treatment had to hurt. Mini police squads were established at its facilities and humiliation, shaved heads, were the norm. An ongoing process of political transition from socialism to democracy and free market economy and the many social tensions that emerged as a result, have sustained this state of affairs. The neoliberal governance based on the idea that the state should have a reduced role in the provision of public services is evident as one records the Polish state's response to both HIV and drugs. As argued by Buse (2008), Poland is an example of “Laws and regulations that continue to stand in the way of effective policies.” Various decisions makers, either actively, out of hostile intention, passively or both, block potential solutions to the drug problems that are all too evident.

An example from neighboring Germany provides an illustration of how ideology prevails over evidence where needle exchange projects in prisons that had been initiated and found to be effective were stopped due to political changes following election outcomes in which an anti-drug position gained power . “Neither the encouraging findings of scientific supervision, nor positive practical experiences played a role in this purely political decision. Out of seven

projects, only one in Berlin remainsOne of the lessons learnt is that syringe provision in penal institutions must be agreed to and accepted by all participants as well as by politicians. This acceptance must constantly be renewed in order for such preventive methods to be sustained. Only against a background of this specialized and politically firm rooting can one become immune to shortsighted, populist strategy modifications” (Michels, 2012).

While Poland can take comfort in being classified as a low prevalence country for HIV, there is no assurance that this will continue to be the case. And three decades of experience with HIV tell us that much needs to change in order to have Polish AIDS policies meet the public health needs of people injecting drugs. In 1987, Jonathan Mann wrote about the need to for inclusion, of bringing people into structures of social, psychological, and medical support in order to avoid driving the epidemic underground (Parker, 2000a). Two decades later Poland continues to be resistant to this call. Structural interventions are urgently required, including availability of a full range of services and a change of the national drug law which would allow drug users to access these services without fear and hesitation. In addition, deeper attitudinal changes are essential -- national and local policies must recognize that vulnerability to HIV goes far beyond individual choice and behavior, and acknowledge that such behaviors are the result of larger environmental factors that sustain high risk. These structural interventions must involve governments through their own policies in various sectors, and by not blocking actions undertaken by civil society (Altman, 2005; Rhodes, 2005; Dagenhard, 2010).

There is awareness of this issue among frontline health and social service professionals in Poland. When asked for his view on the current situation, a long-time outreach worker, stated: “First, it is important to cast doubt on the proclaimed success and ask for real proof and reasons. We are probably in ‘a success mode’ at all costs, and are trying to present only the best as we constantly compare ourselves to other European countries. . . For many years we felt incompetent and now we are going in the opposite direction: we are overstating our success. As a result, we are a little lethargic when it comes to problem solving. What we lack is a rational discussion. We need to ask: what are we doing, here are we headed and are the methods we use optimal or do they need improvement? . . . We need space for discussion. Not a space where we will criticize each other, but where we can problem solve. To date, when we talk, blood gets shed.” While this reflection was offered about a national situation in Poland, it strikingly resembles comment that were offered by the UNAIDS Reference Group on Human Rights to the UNADS secretariat on its recent report, as a learned in a correspondence with one of its members -- Statements about the world being “on the brink of ending one of the worst pandemics of our time” and other hyperbole in the beginning of the document falsely raise expectations to believe that the HIV epidemic may soon be over. The Reference Group advised UNAIDS to rethink its broader messaging and communications strategy to be much more balanced between achievements and the difficult work that remains to be done.

How may Poland move beyond this dangerous stasis?

Improved communication with others societies facing similar problems and within Poland:

Recently Poland served as Vice-Chair of the Northern Dimension Partnership in Public Health and Social Well-being's (NDPHS) Expert Group on HIV/AIDS and Associated Infections (HIV/AIDS&AI EG). With the financial support of the European Commission and various governments, Northern Dimension brings together ten Northern European countries, including Russia. Issues of drug use and HIV were often discussed and reported on since parts of Russia are heavily affected by drug related problems. Statements and recommendations related to drug policy and harm reduction are often published by the group, "Scientific studies show that harm reduction is an essential element in effective HIV prevention among IDUs, the policies should combine harm reduction programs with medical and social rehabilitation, implement harm reduction strategies in prisons, services should also include harm reduction measures to keep the patients attached to the treatment." (NDPHS, 2008) A review of the publications of the National AIDS Center reveals that none of these discussions and recommendations were taken up in Poland. Even though Poland also held a leadership role in the Program Coordinating Board of UNAIDS where drug use and HIV are often discussed, it has not resulted in "nationalizing" these conversations at the country level. Instead, government documents offer no specifics on how various agencies plan to address any of the complex issues and whatever actions are proposed are innocuous and bland. The Parliament-approved work plan lists and describes what various ministries and partners should be doing as a matter of routine, is filled with vague references to various partnerships and consultations that do not directly address the clear structural risks and social exclusion associated with human rights violations, and misses a crucial opportunity to be an urgent call for the social, legal and human rights solutions that will address the real barriers.

Limited information for transfer of knowledge between government and civil society is also a significant problem.

The only two systematic occasions in Poland for a national dialogue to take place are the National AIDS Conference occurring annually, in observance of World AIDS Day, and a newly organized drug treatment gathering of medical professionals specializing in dependence. But participation at both is highly fragmented. Outreach to different segments is needed in order for a variety of views to be included in these national events, as well as in smaller meetings that deal with substantive matters. One of the drug counselors I spoke with shared: “There is a great opportunity lost in Poland – we are denied the possibility to confront each other’s views and to dialogue. At each conference, we are patting ourselves on the back. No space exists to ask real questions, to point out errors. And then the dominant group, representatives of the therapeutic community, do not even show up.” Civil society’s limited foreign language skills and lack of resources for translation make it easy for the state to selectively disseminate information on the issues it deems to be a priority. Government-run newsletters published by the National AIDS Center and the National Drug Prevention Bureau, are the only organized source of information. In both cases, these are recent and limited initiatives. While civil society organizations have identified the lack of information as a problem, there is no NGO that has taken the responsibility to provide this service for others. There is not one listserv in Poland with the goal of information sharing among various AIDS NGOs and across the two communities dealing with HIV and drugs. One explanation that was offered during the interviews was that the constant lack of funding and high level of job insecurity makes it impossible for anyone to take on additional, long-term projects. Others worried that this would be seen negatively, as though

they are trying to coordinate everyone else. And finally, there was a real hesitation to share what was perceived as a scarce resource – information. In order to address communications difficulties, civil society needs support in the form of technical assistance and funding for roles that facilitate dialogue and information sharing. Other institutions, such as academia, should be approached and encouraged to contribute to knowledge dissemination throughout the country.

Leadership in HIV and drugs

When analyzing the factors that have led to the successful containment of HIV in other countries, a critical common denominator is the presence of strong leadership by an individual or a group that is clearly focused on the goal of HIV prevention and quality care for those already infected, and is not constrained by political or religious boundaries. In the Czech Republic, for example, Pavel Bem, a physician and the Mayor of Prague, spent his early years as a doctor working in the first needle exchange in his city. In Switzerland, President Ruth Dreifuss was so concerned and touched by the misery of drug users in Zurich injecting parks that she, along with local physicians, mobilized an emergency response which was, over time, institutionalized across the Swiss cantons. In Portugal, Joao Goulão, President of the Institute of Drugs and Drugs Addiction, with the backing of other political leaders, consistently advocated for moving matters of personal possession and use out of the realm of criminal justice and into that of public health. These are just some of the instances in which stronger leadership led to effective change (Csete 2010 and 2012, Domoslawski, 2011). While Poland certainly has had visible and long-lasting advocates such as Marek Kotanski and Arkadiusz Nowak, they were greatly limited by other personal and professional interests and alliances. Kotanski's primary goal was the survival of

MONAR's network of drug treatment centers and perpetuating his great commitment to the abstinence-only paradigm. Nowak's commitment was to the church's view on sexuality and morality as a prevention tool. While both were charismatic, media savvy, and dedicated, they fell short when it came to advocating for evidence-informed public health interventions. Furthermore, by virtue of their status and recognition, the narratives they promoted predominate years later and are difficult to alter. It is possible that Marek Kotanski's premature death deprived Poland of a leader who would have evolved and moved MONAR, and public opinion, towards greater appreciation of the efficacy of methadone and other harm reduction practices.

Polish government officials have been absent from all of the difficult and controversial discussions. Consistent with Hausner's analysis, they are non-inflammatory civil servants who oversee administrative processes and who are positioning themselves as Polish representatives in the international arenas. While the state institutions have produced evidence-informed policies and action plans, there is a lack of clear leadership. Much greater public engagement is needed to promote harm reduction at the national and local levels. Since 70% of the funding for prevention comes from local authorities, the national Drugs and AIDS institutions need to give guidance and monitor expenditures so that previous allocations, such as building soccer fields, does not become the main prevention effort. Bureaucratic processes and National Programs are important for framing what needs to be accomplished, but in and of themselves, they offer little support in advancing actions that are considered controversial. Robust advocacy must compliment the bureaucratic processes. A journalist who often covers the needs of marginalized communities made the following observation: "A few years ago, when Kaczynski, as a President of Warsaw, denied gay men the right to a parade, the number of supporters who came out to

protest in Warsaw was enormous. They included many moral authorities, such as people from the old opposition movement. Suddenly, they understood that there is a bigger issue at stake and they responded. This is what's lacking with AIDS and drugs: the inspiration for others to see the issue as theirs and to join in. “

The struggle to build leadership in AIDS work has been crippled by continued discussion in Poland about who “owns” the problem, yet to be resolved. Interestingly, this is similar to the situation in the United States in the early years of the epidemic (Nathanson, 2007; Drucker 2012) and can be linked to the continued high incidence of new HIV infections in America. The two government entities in Poland charged with responsibility for HIV, the National AIDS Center and the National Drug Prevention Bureau, must collaborate on assuring adequate services and become more visible in discussions on relevant legislation and other discussions with criminal justice officials. Dividing the territory, as it seems to currently be the case is detrimental to quality and coverage and the existence of an enabling environment. Switzerland and the Czech Republic, two countries that are upheld as models of public health in the area of HIV and drugs, pride themselves on the ongoing and close collaboration between the drugs and AIDS agencies, as well as among various other state and civil society bodies. Monthly meetings of various entities are the rule rather than the exception (Csete, 2010). Consistent with Buse's argument that policy emerges through interactions among institutions, ideas, and interests (2008), Poland's officials must make immediate efforts to inspire such collaboration in order to facilitate an understanding of these interactions and to identify and address the political barriers and opportunities that undermine evidence-based policy. It maybe that the Council for Counteracting Drug Addiction, chaired by the deputy Minister of Health, composed of

secretaries and undersecretaries of state from various ministries and representatives of local governments, with its mandate to shape national drug policy, including substitution treatment, and the efficacy of primary prevention, can fill the leadership void that exists in Poland in relation to drug use and HIV. Including civil society groups in this body may also provide the necessary inspiration for more active civic and grassroots engagement in public debates and policy making. One community worker interviewed in the course of this research had the following idea about what effective leadership would look like: “It should be a small office that continuously inspires action. It does not have to have a lot of money. If people are competent, they can always find money elsewhere. The point is that there would be a resource for others to come to for technical guidance, for support. Individuals and organizations with a problem could call and know that there is competence and a willingness to engage. “

Towards Ending The “ Paradox” of HIV Among Drug Users in Poland

This thesis began with the 2006, statement by the director of the Polish National AIDS Center “that injecting drug use no longer contributed to the HIV and AIDS crisis in Poland” , a statement that was re-iterated two years later by the Director of Poland’s National Bureau for Drug Prevention. My research has documented that evidence does not support this claim. But the fact that it is repeatedly expressed is vital to understanding the true nature and great depth of Poland’s HIV and drug problems. The consequences of such a statement by Poland’s drug and HIV policy leadership are profound as most of the dominant risks associated with HIV infection go unaddressed in policy and practice. As the accurate focus is removed from injecting drug use, the population of drug users themselves are subsequently neglected by HIV prevention efforts,

denied access to HIV care, and marginalized as human beings. On a practical level, various international guidelines on drug use related public health interventions and policy are being ignored. As a consequence many of the required steps for effective HIV prevention among drug users are very weak or altogether missing in Poland – including broad availability of needle and syringe distribution or exchange; outreach services with condoms and other paraphernalia; provision of STI and other disease screening and treatment; referrals to or direct provision of housing; substitution treatment; HIV testing and treatment, and overdose prevention – as well as a non-punitive policy environment that emphasizes public health rather than criminal justice. The interviews I conducted, as well as the review of the literature on drug and HIV policies and programs in Poland suggest that services are scattered, often unavailable, and that their number is stagnating, at best, and in some cases, even decreasing. With populist politics and the increasingly popular “law and order” paradigm the few services that are available are increasingly hostile towards public health goals. As these essential interventions remain unavailable or operate at a wholly inadequate scale in practice, it is highly likely that the HIV epidemic among drug users will worsen in Poland.

There are two opposing paradigms related to the global drug policy discussion today. First, represented by a call for drug reform by a number of Latin American states where drug- related violence gave an impetus for change along with a few Western Europeans invested in public health approach to drugs and second, by Asia and Russia standing in support of the international drug regime. Over the next few years Poland, along with a number of others, will need to take an important policy decisions as to what drug policy it will pursue. The upcoming UN General Assembly Session in 2016, dedicated to review of global drug policies, offers a useful motivation

for a long overdue national-level evaluation. In the meantime, Poland's drug users excluded from the discussion of risk, as described by one of my interviewees, "are the voiceless actors – the new 'disappeared' of the Polish society".

Appendix 1: Individuals mentioned and engaged in HIV and drugs debates

Babiuch, Lidia -- the first physician to care for HIV positive patients at Warsaw's Hospital

Balicki, Marek – a physician, twice a Minister of Health of the Social Democratic Party

Dziedzic, Maria -- first employee of the Ministry of Health dedicated to HIV control

Housner, Jerzy -- an economist and former Finance Minister

Jablonski, Piotr – current director of National Bureau for Drug Prevention in Poland

Jaruzelski, Wojciech -- the last Communist leader of Poland, a general who imposed martial law

Jolanta Koczurowska, current head of MONAR

Kotanski, Marek -- a psychologist who founded MONAR, the network of therapeutic communities

Krajewski, Krzysztof -- professor of law at Jagiellonian University, a drug policy scholar

Kuratowska, Zofia – a physician, Vice-Marshal of the Senate, one of the first HIV advocates

Kwasniewski, Alexander -- two term president of Poland, politician from Social Democratic Party, currently a member of Global Commission on Drug Policy

Kwiatkowski, Krzysztof – Minister of Justice who coordinated efforts to pass the 2011 drug law amendments

Marzec-Boguslawska, Anna – current director of the National AIDS Center in Poland

Mejer-Zachorowski, Olaf – first director of National Bureau for Drug Prevention in Poland

Nowak, Arkadiusz – a catholic priest, served as an AIDS and Drugs Advisor to three consecutive Ministers of Health, currently advises the National AIDS Center

Osiatynski, Wiktor -- professor of constitutional law engaged in public discussions about alcohol and drugs

Staniszki, Jadwiga -- prominent sociologist, professor at Warsaw University, engaged in various political debates

Zygadlo, Marek -- the former Head of Monar, Krakow, pioneer harm reduction practitioner

Appendix 2: Timeline of major events:

- 1978 – first therapeutic community opened by Marek Kotanski in Gloskow
- 1980 – massive anti-government protests and emergence of Solidarity
- 1981 -- martial law imposed
- 1983 – martial law revoked
- 1985 -- first HIV case detected in Poland
- 1985 -- first modern legislation dedicated to drug related matters
- 1988 -- the first HIV positive drug user identified in Poland
- 1989 – first modern, free, multi-party elections in Poland, fall of the Berlin Wall
- 1991 -- first, high threshold substitution treatment opens at the Institute of Psychiatry and Neurology in Warsaw, one of the first of its kind in the entire post-communist block
- 1993 -- the National Bureau for Drug Prevention was created
- 1997 -- Poland began the process of negotiations for accession to the European Union
- 1997 -- Drug Abuse Prevention Act is adopted making possession illegal but suspending criminal penalties for personal possession
- 1999 -- Poland joined the North Atlantic Treaty Organization (NATO)
- 2000 -- Article 62 to the drug law introduces criminal charges for possession of any amount of illicit substance
- 2004 – Poland joins the European Union
- 2010 -- Prime Minister Tusk, overnight, shut down over 1,000 shops selling “smart-drugs”
- 2011 – amendment to existing drug law allows prosecutors, in some specific cases, to drop the charges for personal possession

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