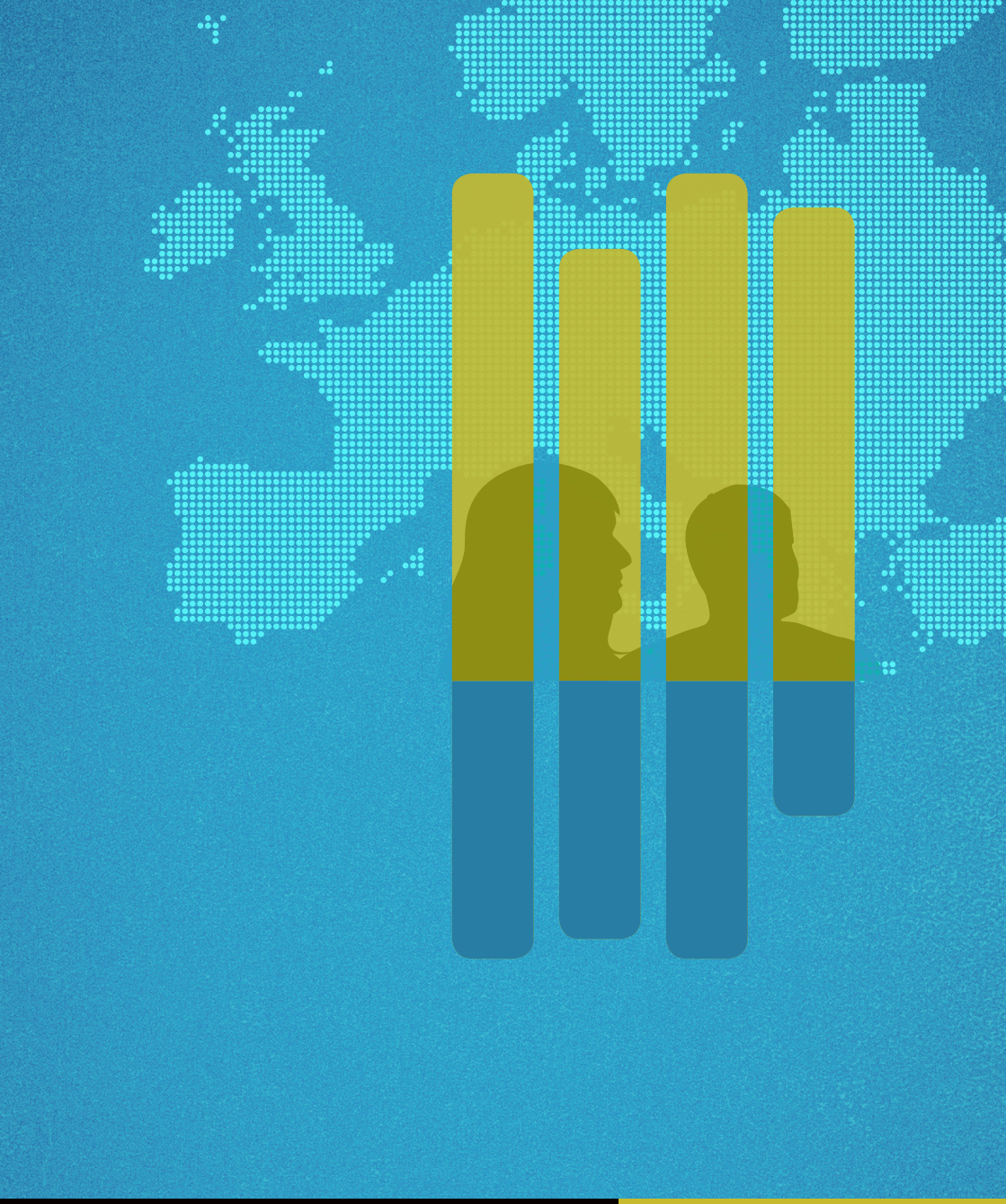

Improving Prison Conditions by Strengthening the Monitoring of HIV, HCV, TB and Harm Reduction

Authors:
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Piotr Kubaszewski

Mapping Report - Poland

HELSIŃSKA FUNDACJA PRAW CZŁOWIEKA

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This report forms part of the EU co-funded project "Improving Prison Conditions by Strengthening Infectious Disease Monitoring" implemented under the lead of Harm Reduction International in 2015 and 2016.

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CONTENTS

I. INTRODUCTION

1. Background and justification

The Human Immunodeficiency Virus (HIV), Tuberculosis (TB) and Hepatitis C (HCV) – are a major health concern in prisons, evidenced by the fact that prevalence rates tend to be substantially higher among prison populations than in the general population.

Prisons and other places of detention are high-risk environments for the transmission of these diseases. This is related to the over incarceration of vulnerable and disadvantaged groups who carry a disproportionately high burden of disease and ill-health; the criminalization of drug users and high levels of injecting drug use; overcrowded and substandard prison conditions; inadequate health care; and the denial of harm reduction services.

Several international, regional and national human rights mechanisms are in place to monitor and inspect prison conditions in order to prevent torture and ill-treatment – including the Subcommittee on the Prevention of Torture (SPT), under the Optional Protocol to the UN Convention against Torture (OPCAT), with National Preventive Mechanisms (NPMs), as well as within the Committee for the Prevention of Torture of the Council of Europe (CPT) and national bodies in a number of European countries.

United Nations human rights bodies and the European Court of Human Rights (ECtHR) are increasingly finding that issues relating to infections in detention can contribute to, or even constitute, conditions that meet the threshold of ill treatment of prisoners. It is therefore critically important for human rights-based monitoring mechanisms that have a mandate to prevent ill treatment to meaningfully examine issues relating to infections in places of detention.

2. About this report

This report forms part of the EU co-funded project “Improving Prison Conditions by Strengthening Infectious Disease Monitoring” implemented under the lead of Harm Reduction International in 2015 and 2016.

The project aims at to reducing ill-treatment of persons in detention and improving prison conditions through improved and standardized monitoring and inspection mechanisms on infectious diseases (TB, HIV and HCV).

The research component of the project includes a mapping the current situation relating to infectious diseases in prisons in seven European countries (Greece, Ireland, Italy, Latvia, Poland, Portugal and Spain) as well as a mapping of practices among monitoring mechanisms in target countries, with particular reference to infectious disease in prisons.

The project also mapped existing regional and international public health and human rights standards relating to infectious diseases in prisons and developed a user-friendly tool, including a set of key indicators, to generate better informed, more consistent, and sustained monitoring of infectious diseases in prisons by national, regional and international human rights monitoring mechanisms.

More about the project and its products can be found on Harm Reduction International website (www.ihra.net).

The current report, written by Marcin Wolny and Piotr Kubaszewski, presents the mapping situation in Poland.

3. Methodology

The report is based on a desk review carried out by employees of the Helsinki Foundation for Human Rights – Marcin Wolny and Piotr Kubaszewski.

Great attention was paid in particular to studies concerning drug dependence, and to a report prepared by M. Ksel – member of the CPT and former Director of the Health Service on the Central Board of the Polish Prison Service.[1]

The authors of the report also analysed statistics available on the Prison Service, National Institute of Hygiene, and the National Bureau for Drug Prevention websites. Whenever this information was out-of-date or incomplete, the authors asked for the necessary information on the grounds of the right of access to public information.

The conclusions drawn on the basis of this desk review were supplemented by interviews with representatives from the world of education, the Prison Service and doctoral students of medicine. As a result, the report not only highlights issues relating to infectious diseases in penitentiaries, but it also tries to place them in a cultural and socio-economic context.

In particular, this report contains many pages dedicated to Polish interventions concerning healthcare, including its legal and economic background.

The report also includes a comprehensive analysis of drug policy in Poland, as this has a considerable influence not only on people in penitentiaries but also on the spread of infectious diseases.

Special emphasis was placed on issues connected with accessibility to harm reduction programmes, including to substitution therapy and needle exchange, which reduce the proliferation of infectious diseases among injecting drug users.

II. NATIONAL CONTEXT

The political transformation that took place in Poland in 1989 had many social and economic repercussions. The political and legal system witnessed one of the most impressive transformations, with a re-orientation in the direction of respecting human rights. One of the elements of this change was the enhanced independence of the judiciary, in line with the "separation of powers" model. It has become an instrument used to keep the executive in check and ensure its accountability.

The increasing recognition of human rights had many reverberating effects, including the first democratic parliamentary election and the ratification of the European Convention for the Protection of Human Rights and Fundamental Freedoms.

Bodies responsible for the protection of human rights, including the Constitutional Tribunal and the Ombudsman, gradually started playing a more important role. In 1997 Poland passed a new Constitution that enshrined several human rights.

Ratified in 1997, the Constitution, specifically Chapter II, contains a catalogue of rights and freedoms which are owed to every human being. Several of them concern the situation of prisoners and guarantee, inter alia, a right to human and non-degrading conditions during detention.

The Constitution also enshrines many rights connected with healthcare services. Article 68 provides that everyone has the right to access to healthcare. Furthermore, the Constitution guarantees every citizen, regardless of his or her financial condition, equal access to healthcare services covered by the public budget. The Constitution also obliges public authorities to combat epidemic diseases.

The last cornerstone in the development of the Polish legal system (and its increased attention to the protection of human rights) was the accession of Poland to the European Union in May 2004. As a result, Poland decided to accept *acquis communautaire*, which obliges Polish authorities to an enhanced protection and promotion of human rights.

As far as statutory law is concerned, the issue of execution of prison sentences by public authorities is described in the 1997 Penal Enforcement Code[2] and in the decrees connected with it. In particular, they define the scope of rights and obligations of prisoners, listing among them the right to health services.

Issues connected with infectious diseases are regulated under the 2008 Act on Preventing and Combating Human Infectious Diseases.[3] It sets out rules and procedures for preventing and combating contagions and diseases, including rules and procedures for the recognition and monitoring of epidemic situations and for taking appropriate action against epidemic, and using preventive measures. The statute provides a catalogue of diseases that should be considered infectious.

1. Impact of the economic crisis on health in prison

The economic crisis in 2008 affected the Polish prison service to some degree. From 2008–2012, the prison population decreased from 85,920 inmates to 84,399,[4] while the general prison capacity increased. Combating overcrowding in prisons should be considered one of the main reasons for this trend. This trend led to an increase in the general number of prison officers.

The impact of the economic crisis is reflected in the budgetary allocation to the prison service. In the years 2008–2012, expenditure on prisons fell by €175 million. This primarily affected investments in the improvement of living conditions of prisoners. Some of these improvements were delayed, or even cancelled. During prison visits conducted by the Helsinki Foundation for Human Rights' (hereinafter HFHR), prison authorities complained about the lack of resources, even lack of funding for urgent repairs.

Other expenses of the penitentiary system were also restricted. For example, a significant reduction in post-penitentiary assistance has occurred. In 2008, prison authorities spent over €3.8 million for this purpose while in 2012, only €1.95 million was spent.[5] Furthermore, despite the increase in the overall capacity of penal institutions, the prison authorities did not provide new workplaces for prison healthcare employees. This had a direct impact on the availability of medical care given to prisoners. Unfortunately, there is no data concerning the availability of cultural activities for prisoners. It is very likely that the economic crisis also had a negative influence in this area as well.

From 2008–2012 the number of employed prisoners decreased by more than half, from 20,083 in 2008, to 9,426 in 2012[6]. However, the reasons for this situation can only be indirectly linked to the economic crisis. The judgment of the Constitutional Tribunal from 23 February 2010[7] had a significant influence on this situation. As a result of that ruling, remuneration of working prisoners was equalised to the minimum wage level. This caused a significant increase in labour costs, which led to a huge reduction in the number of businesses interested in providing work for prisoners. The economic crisis exacerbated that trend.

2. Health context

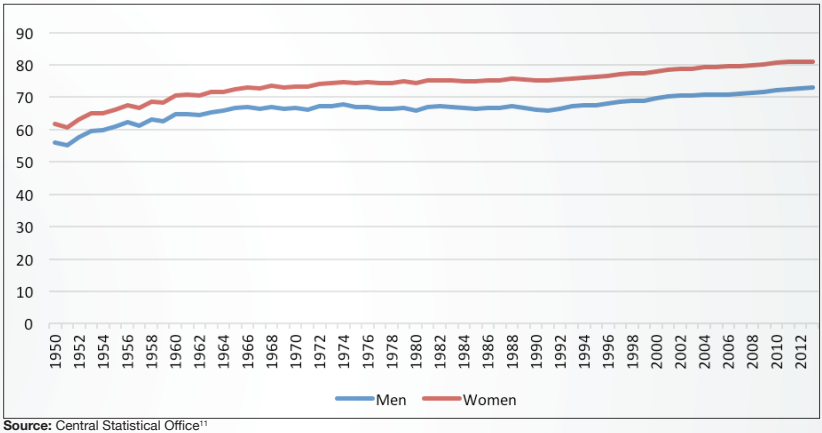
At the end of 2014, the population of Poland was about 38,484,000 people[8]. The improvement of the economic situation in Poland, which has been constantly observed since the beginning of the 1990s, has favourably influenced the life expectancy of Polish citizens.

In 2013, the average life expectancy of a Polish man was 73.1 years and 81.1 years for women. Compared to the life expectancy at the time of democratic transition in the early 1990s in which men were expected to live only 66 years and women 75. It

is evident that the life expectancy of Polish citizens since the democratic transition citizens has significantly increased. Since 2000, this increase was 3 years for both men and women.[9]

The demographics also show a very high rate of mortality among men when compared to the population in general, especially among boys. According to the Central Statistical Office of Poland (*Główny Urząd Statystyczny*), in the younger age groups the death rate among men is four times higher than among women. In older groups, these rates are two and three times higher, respectively.[10]

Life expectancy in Poland

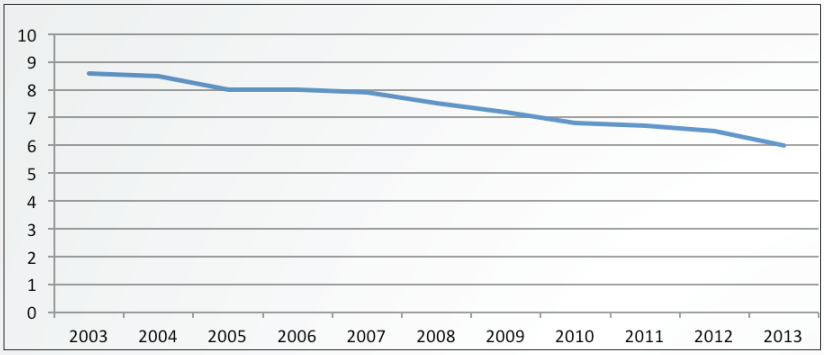


Source: Central Statistical Office[11]

Life expectancy of Polish citizens is markedly shorter than average in other member states of European Union – among men by 4.8 years and among women by 2.1 years. Eurostat estimates that men in Poland survive 81%, and women 77%, of their life expectancy in good health. 65-year-old Poles may expect that less than half of their future life will be spent in good health. According to Eurostat, a 65 year old man will survive an average 6.7 years in good health, while this figure for women is 7.5 years.[12] The data concerning infant mortality may illustrate the condition of healthcare in Poland. According to the National Institute of Hygiene (*Państwowy Zakład Higieny,* hereinafter NIH), the constant decrease in the mortality of children and young people is accompanied by a declining infant death rate.

In 2014, the deaths of 1.6 thousand children under the age of 1 year were registered, 100 less than in 2013. The death rate of infants was 4.2 per 1,000 live births, and was almost 4 percentage points lower than at the beginning of the century, about 15 percentage points lower than at the beginning of the 1990s.[13]

Perinatal mortality rate



Similar to the general infant mortality rate, the perinatal mortality rate (number of stillbirths and deaths of infants aged 0-6 days per 1,000 live births) also has a decreasing tendency. At the beginning of the 1990s it was almost 20%, at the beginning of this century it was 10%, and in 2013 it remained stable at 6.0%.[14]

The healthcare system

Stakeholders in healthcare in Poland can be divided into several categories.

The first are beneficiaries – the patients. They are insured against the risk of disease. The National Health Fund (NHF) is in charge of medical insurance. In the Polish healthcare system, the NHF serves as a payer, as it finances medical services given to insured people from the funds raised by obligatory insurance contributions from taxpayers. The NHF is also responsible for prescription drug reimbursement.

The NHF purchases medical services from different kinds of healthcare providers. These might be commercial entities, independent public healthcare centres, budgetary units, research institutes, associations or even churches.

It important to emphasise that the NHF is not responsible for providing medical services for people imprisoned in penal institutions. In these situations healthcare is provided by prison medical services, which are financed through the budget of the Central Board of the Prison Service. Prisoners use medical services outside of penal institutions only in extraordinary circumstances: when emergency medical help is needed or when the prison medical service is not sufficient for the provision of proper care. In such cases, these services are still financed by the prison system[15].

Healthcare expenditure

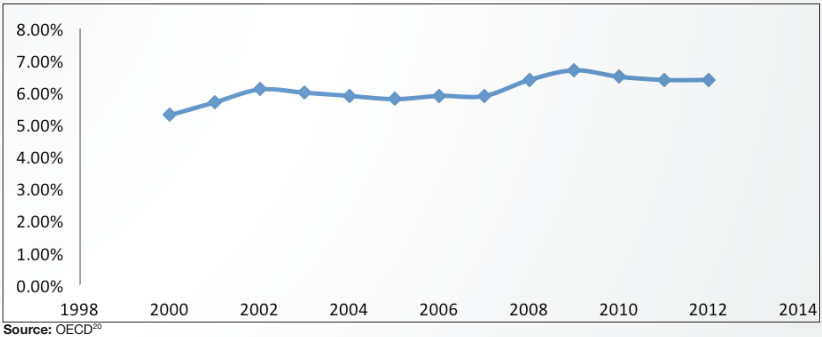
In Poland, just over 71% of healthcare costs are covered from public funds. This puts the country in one of the lowest positions in terms of health coverage in Europe. The greatest share in public expenditure is observed in the Netherlands and in Denmark (85%), and also in Luxembourg and in the Czech Republic (84%).[16]

Public expenditure for outpatient treatment varies greatly. For instance, Sweden and Finland spend over a third of public medical funds on outpatient treatment, whereas Poland is placed in one of the lowest positions, spending only 17% of public funds on outpatient treatment.[17]

In 2015, NHF revenue from insurance contributions will reach €16,512,438,333. In comparison to 2014, expenditure intended for healthcare has increased by about €500 million.[18] However, this is not the only expenditure incurred in healthcare – these figures do not include sums spent on private health insurance and healthcare services provided by private entities.

As a result, experts believe that the amount of money intended for healthcare in Poland exceeds €25 billion– 6.8% of Poland's GDP. Among the 34 countries monitored by the Organisation for Economic Cooperation and Development (OECD) – only Turkey, Estonia and Mexico had a smaller share of public expenditure for healthcare than Poland.[19]

Percent of GDP spent on healthcare



Source: OECD[20]

Other data gathered by the OECD may give a picture of healthcare in Poland. In 2012, the number of hospital beds per 1,000 residents was 6.5, ranking Poland in eighth place in Europe.[21] The full image is completed by the average length of hospitalisation; in 2012, this figure was 6.8 days, while in 2005 it was 7.9 days.[22]

The data concerning the number of doctors per 1,000 residents is troubling. In 2012, the rate was 2.2 doctors per 1,000 residents, which is one of the lowest rates in Europe. Furthermore, within the decade prior to this analysis, the number of doctors increased in every European country except for Poland and Estonia. Both countries noted a decrease of 0.1%.

At the same time, the data gathered by OECD shows that, statistically, Polish residents visited a doctor seven times a year in 2012. This is slightly higher than the examined average (6.3 visits per year), and is significantly higher than in 1960, when the number of medical consultations received by patients did not exceed 3.3 visits per resident.[23] There is also a growth in the number of vaccinations amongst children. In 1980, the amount of unvaccinated children constituted more than 95% of the general children population. Currently the number of vaccinated children exceeds 99%.

III. CRIMINAL JUSTICE AND PRISON CONTEXT

1. Drug control policy

The Act of 29 July 2005 on Counteracting Drug Dependence is the most important law related to drug possession in Poland. It sets out not only the general rules and procedures in the matter of preventing drug dependence, but also the competence and power of state administration in preventing violations of laws concerning production, trafficking and possession of drugs.

National Programme for Counteracting Drug Addiction (Krajowy Program Przeciwdziałania Narkomanii)

The Act on Counteracting Drug Addiction creates a duty to establish a National Programme for Counteracting Drug Addiction. The government adopted this programme on 22 March 2011. It will run through to 2016.

The programme's main aim is to reduce general drug use. This objective should be achieved by 113 campaigns, led and supported by ministries, institutions and communal governments in the 5 main areas of prevention, treatment, rehabilitation, harm reduction and social reintegration; supply reduction; international cooperation; research and monitoring.[24]

The implementation of the programme is coordinated by the National Bureau for Drug Prevention. The Bureau monitors the annual implementation of the Action Plan's measures that the relevant ministries, institutions and communes are required to comply with. Analysis of the programme's implementation is presented annually to the Minister of Health, the Council of Ministers and the parliament.[25]

The Act on Counteracting Drug Addiction also established the offices of the regional drug coordinators and regional experts. The former are responsible for the coordination of regional drug policy and the implementation of regional strategies. Regional drug experts' responsibilities include collecting data and exchanging information on drug problems. Every year these groups and individuals prepare reports on the drug situation in their regions.[26]

Criminal Law

The criminal law punishes the use, production, sale, export, import and possession of drugs. In general, the possession of drugs is punishable by 3 years imprisonment (possession of a large amount of drugs is an exception, and is punishable by 10 years imprisonment).[27]

This means that even possession of the smallest quantity of drugs is punished in the Polish system, which makes it one of the most restrictive models of drug policy in Europe.

Definition of a Drug

The Act on Counteracting Drug Addiction contains a list of substances which are defined as drugs. This is a problematic issue in the context of designer drugs, or "legal highs". Every time a new kind of drug appears on the market, it is necessary to put it on the list in order to make it prohibited.

Article 62a

In 2011, Article 62a was introduced to the Act. It allows for the discontinuation of criminal proceedings when the quantity of drugs possessed is insignificant and intended only for personal use.

The Helsinki Foundation for Human Rights undertook research on the effects of this regulation. According to this research, this amendment is not applied evenly across the country. In provinces where training has been conducted on the subject, Article 62a is used more often than in other provinces, where no training has taken place[28].

For example, in 2013 there were 12,812 cases concerning drug possession. Only 3,140 of these cases were discontinued due to Article 62a (3,132 by prosecutors and 208 by courts). Considering the fact that this article was created for prosecutors as a tool to shorten the procedure and reduce costs, it was used too infrequently.[29]

In addition, the research conducted by Prof. Krzysztof Krajewski from the Jagiellonian University claims that 53% of cases in the Krakow courts in 2008 dealt with persons who possessed only small quantities of drugs, with cannabis, hashish (50% of cases) and amphetamine (35% of cases) found to be the most frequently possessed. 79% of cases of possession of cannabis and 74% cases of possession of amphetamine concerned very small amounts – 3 grams or less.[30]

This means that the majority of these kinds of cases are of minor importance. Nevertheless, they have a significant impact on the state budget. According to research from the Institute of Public Affairs,[31] about €20 million is spent on enforcing the Act on Counteracting Drug Addiction – mainly because of Article 62.1, which states that a person can be imprisoned for the possession of any amount of drugs.

Other sources suggest that the costs connected with drug policy in 2011 represented close to 0.01% of Poland's gross domestic product (GDP); i.e., Poland spent an estimated €49 million on drug-reduction activities.[32]

Currently the government is not carrying out legislation work on the reform of the penal law in the context of drug policy. Discussion in that field is conducted only among non-governmental organisations and is mainly concerned with the legalisation of medical cannabis.[33]

Statistical data

According to research conducted by J. Sierosławski, more than 13% of Poles admit that they have used drugs. Nearly 5% declared that they had had contact with drugs in the past 12 months, while 2.5% of the respondents admitted to drug use during the last 30 days.[34]

Cannabis remains the most frequently used narcotic. More than 12% of the respondents declared that they had used it. Amphetamine (2.9%) and designer drugs (1.4%) rank second and third.[35] However, bearing in mind that designer drugs are quite easily accessible, their figure may have risen since the research was conducted.

J. Sierosławski's research indicates that young people are the group most likely to take drugs.[36] Details can be found in the table below.

Table 1. Drug use across age groups (male and female combined) in Poland.

	15 - 24	25 -34	35-44	45- 54	55-64
Marijuana / Hashish	21	20,3	10,5	4,8	3
LSD	0.8	1.3	1.5	0.2	0
Amphetamine	3.1	7.4	2.9	0.2	0.1
Psilocybin mushrooms	0.6	2.6	1.2	0.3	0
Ecstasy	1.4	3.2	0.5	0.2	0
Crack	0	0.1	0.5	0.3	0
Cocaine	1.1	1.1	1.2	0.2	0.3
Heroin	0.2	0	0	0.2	0.1
Polish Heroin	0.3	0.3	0	0.3	0.3
Anabolic steroid	0.9	0.8	0.5	0.2	0
Methadone	0.2	0	0	0	0
Intoxicative inhalants	0.3	0.6	0.2	0.8	0.3
Other	1.1	1	0.2	0.5	0.5

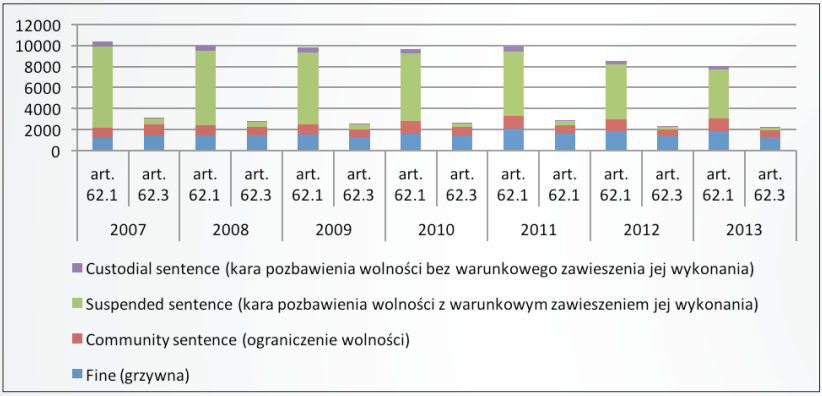
Source: Malczewski A and Misiurek A.[37]

The research suggests that drug use is mainly connected with citizens living in cities with populations of over 500,000 people. Every fourth respondent living in such a city admitted to drug use. With respect to education, nearly 20% of the respondents with university degrees declared that they had never taken drugs. The situation is similar in relation to persons with secondary education.

2. The criminal justice system

According to the data on drug-law offences obtained from the Police Headquarters in Warsaw and from Provincial Police Headquarters, the number of offences related to the illegal production of drugs has been stable since 1997. In connection with a change in the drug law in 2000, the number of drug-law offences has been steadily increasing. In the middle of the last decade (2006) the number of offences peaked at 70,202, and then fell in the two following years.[38] The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) points out that, "from 2009 the number increased again, and in 2012 the highest ever number of drug-law offences was registered (76,239 offences)".[39]

Drug possession crimes in years 2007 - 2011



Source: Ministry of Justice

The data obtained from the Ministry of Justice indicate that the number of people who are convicted due to drug possession is decreasing. This applies to both possession of small amounts of drugs (art. 62.1 of the Act on Counteracting Drug Addiction) and also significant amounts (art. 62.3). While in 2007 there were more than 13,000 people convicted of drug possession, in 2013 this number slightly exceeded 10,000. This might be caused by an ongoing demographic decline.

The suspended sentence was the most popular punishment used in such cases. While in 2007 it was used in nearly 60% of convictions for the possession of small amounts of drugs, currently this punishment is used in about 45% of cases.

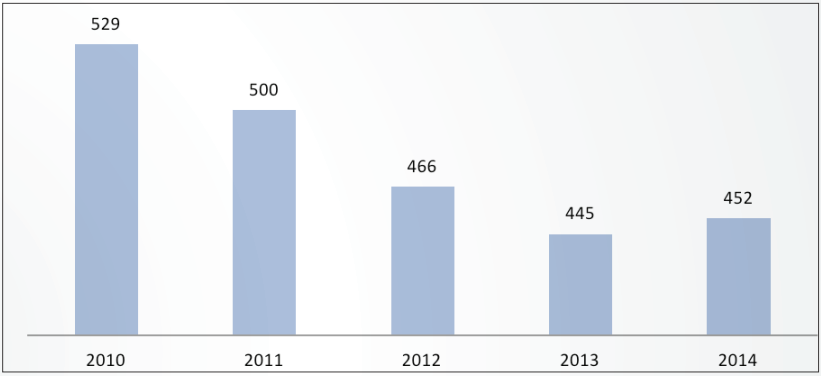
The penitentiary system

Currently more than 150 penitentiary units operate in Poland. 60% of them are prisons. As of 24 July 2015, there were 74,234 inmates, including more than 68,000 convicts. The population ratio was not higher than 86.8% (as of 24 July 2015). More than 11,000

places remained unoccupied. The monthly cost of maintaining one prisoner was about €690.[40]

There is no data about convicts who were imprisoned for committing a drug related offence. The Prison Service provides data only on inmates who are diagnosed as drug dependent. According to this data, the number of prisoners dependent on drugs has been slightly decreasing since 2011. Details can be found in the table below.

Average number of inmates serving sentences on therapeutic wards who were diagnosed as drug dependent



Source: Prison Service

3. Sex work

The issue of sex work remains taboo in Poland. This is a major issue when describing the subject.

According to the Polish Criminal Code (CC), sex work can be recognised as a legal vocation. However, certain behaviours connected with it are laid out and prohibited in the Criminal Code. The CC prohibits the pandering, procuration and facilitation of sex work.

In the early 1990s, the number of sex workers was estimated to be not more than 10,000 people. That part of the market was estimated to be worth between €1.25 to €2.5 billion. However, those estimates should be considered conservative. Current estimates point out that the sex work market is worth no less than €2.5 billion.[41]

Over the last 15 years, sex work has significantly transformed. It went underground and it is not as noticeable to the average Pole as it was a decade ago. New forms of sex work, especially among students, have appeared and have significantly increased the risk of spreading STDs.

IV. INFECTIOUS DISEASES IN THE COMMUNITY AND IN PRISON

1. Act on the Prevention and Control of Infections and Infectious Diseases

The Act of 5 December 2008 on the Prevention and Control of Infections and Infectious Diseases in Humans is the fundamental law governing the issue of infectious diseases. It lays down:

- rules and procedures for preventing and combating infections and infectious diseases, including monitoring and identification procedures on epidemiological situations and taking preventive actions against epidemics;
- tasks of public authorities for preventing and combatting human infections and infectious diseases;
- rights and obligations of persons residing on Polish territory in the field of the prevention of, and fight against, human infections and infectious diseases.

The Act is applied to all infections and infectious diseases listed in the Annex to the Act. In addition, if there is a serious risk that any other infectious diseases not listed in the annex may spread, the Ministry of Health may add a particular disease to the list. According to the Act, persons residing on Polish territory are obliged to undergo sanitary treatment, preventive vaccination, prophylactic use of medicines, quarantine, treatment and hospitalisation.

The Act also regulates the duties of medical facility authorities to prevent infectious diseases from spreading. These include, among other things, risk assessment, monitoring disturbing factors, and the development, implementation and oversight of the procedures for preventing infections.

Moreover, the Act outlines the bodies responsible for prevention, fighting infectious diseases and creating the early warning system in that field. They consist of sanitary inspection authorities (*Państwowa Inspekcja Sanitarna, Wojskowa Inspekcja Sanitarna, Inspekcja Sanitarna MSW*), veterinary inspection authorities (*Inspekcja Weterynaryjna, Wojskowa Inspekcja Weterynaryjna)* and an environmental protection authority (*Inspekcja Ochrony Środowiska).*

The Head of the public sanitary inspection authority (*Główny Inspektor Sanitarny*) is responsible for publishing reports on the number of infections, and the morbidity and mortality rates of infectious diseases which are reportable.

As mentioned above, the Act also enumerates the rights and duties of individuals. An individual may be subjected to hospitalisation, for example in cases of active tuberculosis. A case of lung tuberculosis is a premise for mandatory medical treatment. Furthermore, a person suffering from infectious diseases who refuses hospitalisation, quarantine or treatment might face legal consequences. In such cases the authorities have the right to apply coercive measures against him or her.

Some of the Act's provisions concern situations of people who have HIV and AIDS. According to article 41 of the Act, people with HIV/AIDS have the right to privacy with regards to their personal data. In such cases information about their identity is not transferred to the nationwide database. Only patients' initials, age, sex, diagnosis, route of infection and the district (*powiat)* in which he or she resides are recorded in public databases.

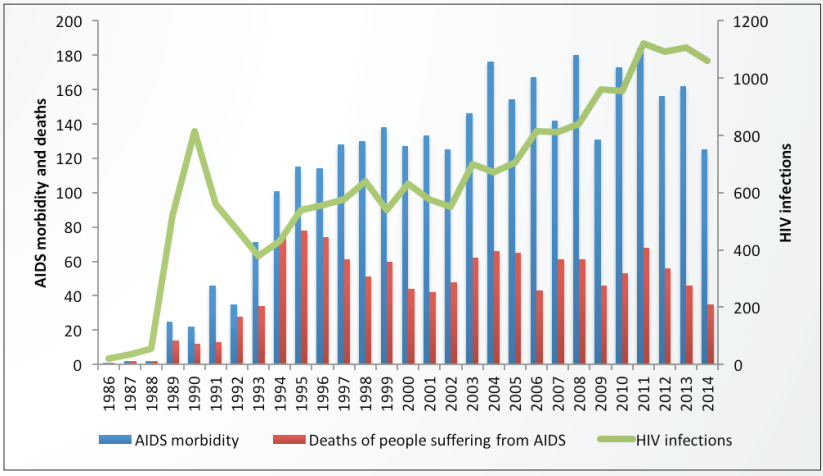
The Act guarantees that antiretroviral treatment is financed from public funds. This applies both to those who are infected with HIV and those who are exposed to the infection. When the risk of infection is connected with practicing a profession, the costs of treatment are incurred by the employer.

2. Human Immunodeficiency Virus

The first HIV tests in Poland were carried out in 1985. It was at that time that the first infection was recorded. A year later, the first person died of AIDS in Poland.

From when the first HIV test was administered, until 31 January 2015, 18,748 people were reported as being HIV positive.[42] The graph from the National Hygiene Institute (*Państwowy Zakład Higieny*) presents the development of diagnosed HIV infections, as well as AIDS morbidity and mortality rates.

HIV and AIDS in Poland



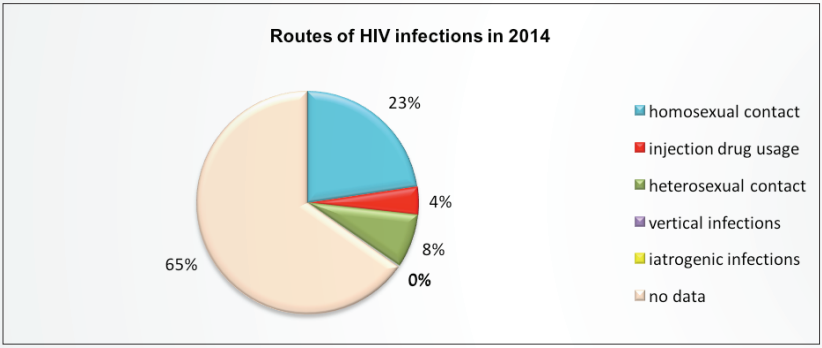
Source: NIH[43]

In 2014, 1,085 new HIV infections were reported; 138 people were diagnosed with AIDS, 32 of whom have since died of the disease.[44] Despite keeping records of the causes of infection, there is no confirmed information on HIV transmission.

This situation is very troubling, especially in regard to the prevention of the HIV epidemic. The lack of knowledge about HIV transmission methods limits the possibility of taking proper preventive measures. It also inhibits any investigation concerned with determining the cause of the rapid increase of HIV rates in Poland.

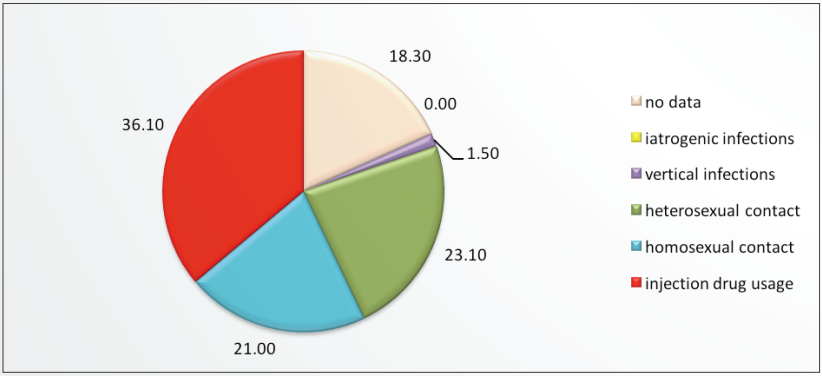
The graph below shows that in almost 25% of cases, HIV infections were transmitted among the groups of men who have sex with men (MSM) and women who have sex with women (WSW). Only 4% of the respondents indicated that their infection resulted from injecting drug use.

Routes of HIV infections in 2014



Source: NIH[45]

The routes of HIV infection in Poland in years 1986 - 2014



Source: NIH[46]

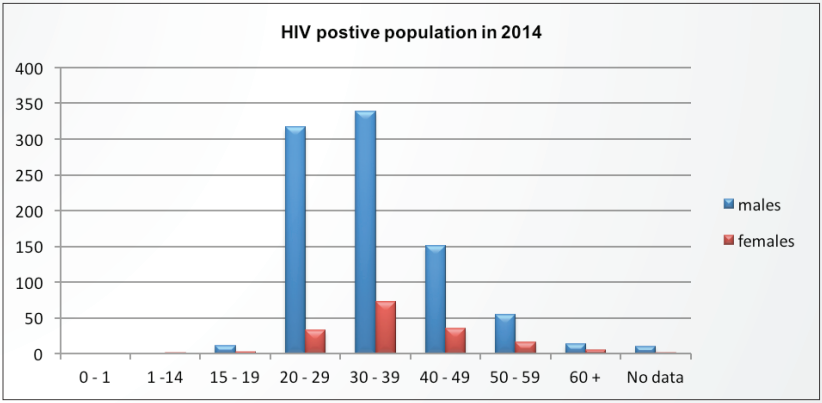
Data in the last graph significantly differs from the data collected by the National Hygiene Institute in 2014. What is of particular note is the significantly higher percentage of cases where the route of infection has not been established.

The percentage of people who declared sexual contact with members of the opposite sex as the potential route of HIV transmission in 2014 was nearly three times lower than in the overall statistics.

However, since 1986, 36% of interviewees have declared that their infection was transmitted through injecting drug use. This rate is nine times higher than in the data from 2014. According to the National Hygiene Institute, between the 2000 and 2010, the number of infections involving injecting drug use decreased by 90%.

A few reasons for such discrepancies may be identified. Unquestionably, the first is a change of habits among drug users. The second is the increased awareness of the potential methods of transmission. Moreover, changes in the national antidrug policy and punishments for the possession of even the smallest amounts of narcotic drugs could cause discrepancies in the survey results. The highly restrictive penal policy on drug possession may prevent HIV positive people from declaring their drug use, as this might generate negative attention from law enforcement agencies. Due to this, there is currently a huge gap in the data on HIV transmission routes.

HIV positive population in 2014



Source: NIH[47]

The data on the HIV positive population is worth analysing. According to surveys, in 2014, HIV infections were diagnosed several times more frequently among men. Both among women and men, most infections were diagnosed in the 30–39 age group.

Nevertheless, it is not clear whether the official data reflects the actual situation on HIV transmission. It should be emphasised that this data illustrates only the detected infections.

The National AIDS Centre estimates that nearly 70% of the HIV positive population in Poland has no knowledge about the cause of their infection. Experts estimate that 90 of Poles have never had an HIV test.[48] In most cases, HIV is detected during blood donation. The situation is worsened by the rising migration from Eastern European countries, where the HIV statistics are even more dramatic[49].

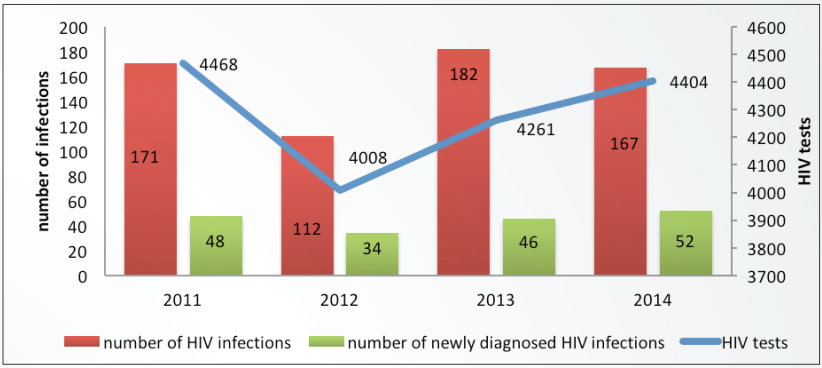
The National AIDS Centre (Krajowe Centrum ds. AIDS) and the National Programme for Combating AIDS and Preventing HIV Infections for the years 2012-2016 (Narodowy Program Zapobiegania Zakażeniom HIV i Zwalczania AIDS na lata 2012–2016)

In 1993, as a result of the structural changes within the system of social care and the reform of the administration in Poland, verification of the existing HIV/AIDS structures became necessary. Because of this fact, the Minister of Health and Social Care established, on 28 September 1993, the National AIDS Prevention Coordinating Office. Based on the Resolution of the Minister of Health of 30 December 1999, the National AIDS Prevention Coordinating Office has been transformed into the National AIDS Centre, managed by the Director of the Office. In addition to the co-ordination of prevention and education tasks, the Centre monitors and collaborates with the healthcare services in the area of fighting, preventing, diagnosing and treating HIV/AIDS.

The National AIDS Centre is also responsible for coordination of the implementation of the National Programme for Combating AIDS and Preventing HIV Infections. The Programme describes government policy in the area of HIV/AIDS. Its main goals are to limit the spread of HIV infections, to provide medical aid and to improve the quality of life and access to medical treatment for persons with HIV and their relatives. The tasks defined in the documents are carried out in cooperation with non-governmental organisations, Offices of Province Marshalls, Provincial Departments and Provincial Sanitary-and-Epidemiological Centres.

HIV in penitentiary units

HIV tests in penitentiary units



Source: Prison Service[60]

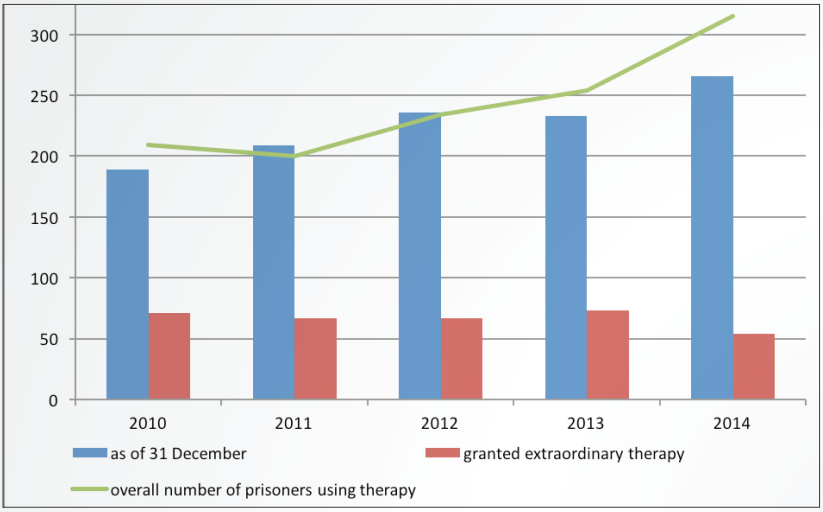
The data presented above illustrates the amount of voluntary HIV tests carried out among inmates. The prison services annually examine about 4,000 inmates to check the presence of HIV antibodies. According to this data, about 4% of the test results are positive. Every year about 30 to 50 new HIV infections are detected in prisons.

However it must be stressed that prisoners may hide information about positive results. Therefore the abovementioned data might be considered incomplete.

The data also presents the relationship between the number of tests that have been carried out and the amount of detected infections. It appears that it would be worthwhile increasing the number of HIV tests carried out among inmates, as this would ensure that new inmates receive appropriate treatment and care.

The administration of penitentiary units should also show concern for the protection of the right to privacy of HIV positive inmates. The Helsinki Foundation for Human Rights received several complaints from seropositive inmates about the fact that the penitentiary unit's administration disclosed their HIV status to prison officers. Shortly after that, other inmates became aware of their infection.

Antiretroviral Therapy



Source: Prison Service[51]

The above data indicates that the number of prisoners using antiretroviral therapy is increasing. Currently every HIV positive prisoner has access to antiretroviral treatment.[52]

Inmates awareness of HIV – M. Ksel's study

The study in 2005 by M. Ksel concerning infectious diseases in penitentiary units is of greater interest. It consisted of interviews carried out among prisoners (involving 2,000 inmates) and prison staff members (around 800 prison officers). During the study, laboratory tests of 1,600 inmates' blood samples were also carried out voluntarily.

The majority of the examined inmates were men. The biggest group among them were between the ages of 26 and 39. More than 33% of the examined prisoners were detained for more than 3 years. The sentences they were serving were predominantly for over 3 years of imprisonment (44% of the interviewees). Almost 40% of all interviewees declared that in the past 10 years they had spent more than 3 years in a penitentiary unit.

Table 2. Prisoners' knowledge about HIV transmission routes

Is it possible to become infected with HIV by:	Yes %	No %	I don't know %	No answer %
using the same toilet seat	19.7	63.7	15.3	1.3
using the same glass	23.6	65.4	9.8	1.2
contact with the saliva of an infected person	42.3	45.5	11	1.2
mosquito bite	39	44.8	14.7	1.5
injection	91.2	6.5	1.7	0.6
using the same razor	84.3	10.6	4.4	0.7
tattooing	92.8	4.1	2.4	0.7
shaking hands with infected person	4.3	92.5	2.1	1.1

Source: Kesel M et al.[53]

The majority of the study's questions concerned inmates' knowledge about HIV. 9% of the interviewees were not aware of the fact that HIV infection can be the result of unprotected sexual intercourse. Every twentieth prisoner was not able to answer this question.

Almost 20% of the questioned inmates believed that it was possible to be infected with HIV by using the same toilet seat, while almost 24% stated that infection may be caused by drinking from the same glass. This reveals the low level of awareness about infectious disease transmission among inmates.

These results might be connected with the risk of stigmatisation of HIV positive inmates by other prisoners. This opinion is confirmed by numerous prisoners' complaints lodged to HFHR regarding the fact that they were placed in the same cell as HIV positive persons.

Further relevant results of the survey highlighted the attitude of inmates toward infected persons in their different behaviours in different situations.

Table 3. Prisoners' opinion on relationships with HIV – infected persons

What's your opinion on:	I agree %	I disagree %	no answer %
working together with an infected person	80	19.9	0.5
having a meal together with an infected person	73.2	26.2	0.6
continuing a relationship with an infected person	42.9	54.6	1.9
sharing the same cell with an infected person	53	45.5	0.6

Source: Ksel M et al.[54]

Other questions applied to risky sexual behaviour. Almost 40% of the interviewees declared that during 12 months before their detention they had had only one sexual partner. Almost 30% had had at least three sexual partners.

In addition, nearly 41% of interviewed prisoners declared that they had never used condoms, while 30% declared that they used them occasionally.[55]

Other questions concerned inmates' sexual contact during detention. 0.1% of the interviewed men and 3.2% of women admitted that in the penitentiary unit they had had sexual contact with men. The vast majority of them declared that they did not have more than one sexual partner. 0.1% of men and 1.8% of women admitted to using condoms during sexual contact in prison. 9.6% of women and 0.1% of men declared they had had sexual intercourse without consent in penitentiary unit.

The answers concerning prisoners' hygiene habits were also very interesting. 5.1% of the interviewed inmates declared they had borrowed razors from other inmates. 1% of the respondents answered said that they had also shared a toothbrush. Nearly half of the inmates (40%) declared that they were tattooed during detention, while 2.8% confirmed that they had been pierced during detention.[56]

A separate group of questions concerned the use of drugs by prisoners. 36.9% of them said that in their opinion inmates in penitentiary units do not inject drugs at all. Slightly more than 10% believed that every fourth prisoner injected drugs.

Far more interesting were the answers about inmates' experiences with injecting drug use. 6.3% of interviewed inmates admitted they had injected drugs during detention. On the other hand, 95% stated that the question about the frequency of injecting drug use did not apply to them. 0.4% admitted that they had injected drugs at least once.[57] Furthermore, slightly more than 0.5% of prisoners admitted that they had borrowed their injection equipment in a penitentiary unit, while 0.1% stated that they had done that every time.

The last few research questions were about the inmates' awareness of infection with HIV, HCV or TB. 0.6% of the interviewees were aware of their HIV infection, 1.2% of their tuberculosis infection, and 2.7% of their HCV infection. However, of the 54 inmates who declared HIV infection, blood tests confirmed that only 35 were actually HIV positive. On the other hand, only 36 out of the 123 prisoners with HCV were aware of their HCV status.[58]

Prison Service officers' knowledge about infectious diseases

Part of the Ksel's study by was dedicated to examining the knowledge of Prison Service officers about infectious diseases. More than 50% of the officers interviewed claimed that during their work they had to face a high risk of HIV/HCV/TB transmission. 90% of the respondents considered their knowledge about these infections good or very good.[59]

However, more than 10% believed it was possible to become infected with HIV by drinking from the same glass as someone who is HIV positive. Furthermore, 43% indicated that they believed it was possible to become infected with HIV by coming into contact with the saliva of an HIV positive person, while 15% believed that a mosquito bite might transmit the virus.[60]

Fortunately, in recent years, prison authorities have conducted several training sessions on HIV and HCV transmission in prison. The aim of the training was to increase knowledge regarding those diseases, especially their routes of transmission, and also safe working practices.

Similar training was also organised for prisoners. Their aim was to promote healthier lifestyles and raise awareness about HIV and HCV transmission, prevention, diagnosis and treatment.

3. Hepatitis C Virus

Some sources point out that 730,000 Poles have HCV. Even the European Union indicates such numbers.[61] However, according to the National Institute of Hygiene, these figures are overestimated and, according to NIH, the number of Poles suffering from HCV is actually closer to 188,000.[62]

According to the experts from NIH, the difference between their estimation and the figures estimated by the WHO comes as a result of different definitions of HCV infection. The World Health Organization considers an individual to be an HCV carrier whenever anti-HCV antibodies are detected in the blood. While those antibodies might be found in the majority of infected persons, they can be also found in the blood of other people, for example, in the blood of those who were successfully cured, those who spontaneously eliminated the infection and those whose blood serum can yield false positive results.[63]

According to the NIH there is only one way to prove HCV infection – the detection of HCV RNA, the genetic material of the virus, in the patient's blood. In the opinion of the NIH, "inaccuracy between cited figures and the actual number of HCV carriers may be the result of the fact that the previous estimation was published between 2000–2010 and has become outdated".[64]

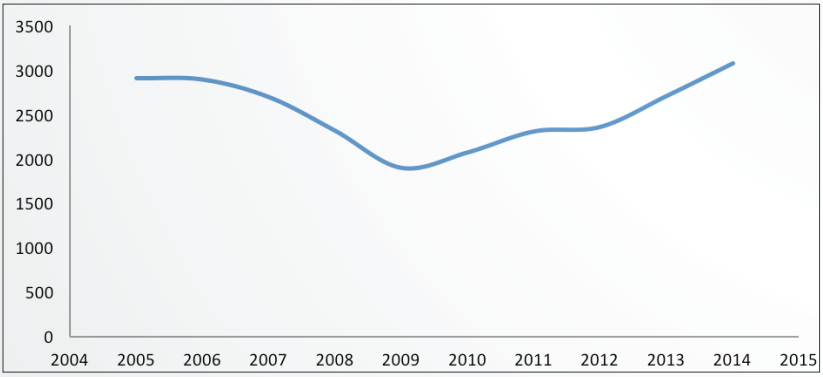
A recent epidemiological study was carried out in the years 2010–2012, whereby 4,822 patients were examined for the presence of HCV. According to the study results, anti–HCV markers were diagnosed in 0.86% of examined people. This factor, when extended to the entire Polish population, provides an estimation of about 270,000 HCV infections nationally. However, HCV RNA was found in only in 0.6% of the examined patients, which means that it is likely that around 188,000 people are HCV carriers, a figure that is nearly four times lower than WHO estimates.[65]

However, at the same time, the Polish Group of HCV Experts carried out more research on the HCV positive population. During that study more than 26,000 people were examined. According to the research results, anti-HCV was found in 1.9% of the people examined, which means that about 730,000 Poles might be carriers of such antibodies. HCV RNA was found in 31% of people who had positive anti–HCV results. This result, when extended to the overall population of Poland, reveals the number to be 226,000 HCV carriers.[66]

In the opinion of the NIH, these studies prove that the notion of the small detectability of HCV in the Polish population is inadequate. The NIH points out that until 2013, 54,700 people were diagnosed as HCV carriers. This means that the incidence of HCV in the Polish population does not differ from that of other European countries. Currently, it is about 20% of the estimated number of infected people, while with earlier assumptions this figure was only 7.5%.[67]

The numbers on newly detected infections appear quite alarming. Since 2008, the number of new HCV infections has been rising. This may indicate the lack of social awareness regarding HCV infections and the gradual threat for public health.

The number of newly detected HCV infections

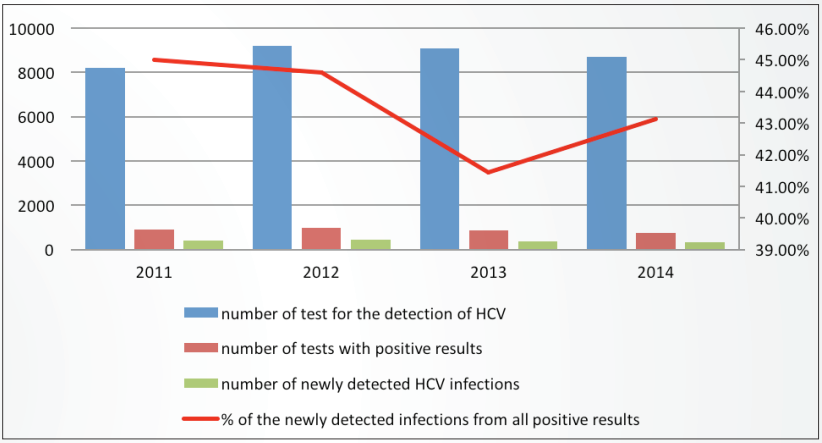


Source: NIH[68]

This trend is also confirmed by the ratio of the number of infections per 100,000 people. In 2006, the HCV morbidity rate was 7.62 people per 100,000 citizens. In 2009, the ratio decreased to 4.98. In 2014 it increased again to 7.98 infections per 100,000 citizens.

The data on HCV infections in penitentiary units looks equally alarming, as demonstrated in the graph below.

HCV in penitentiary units



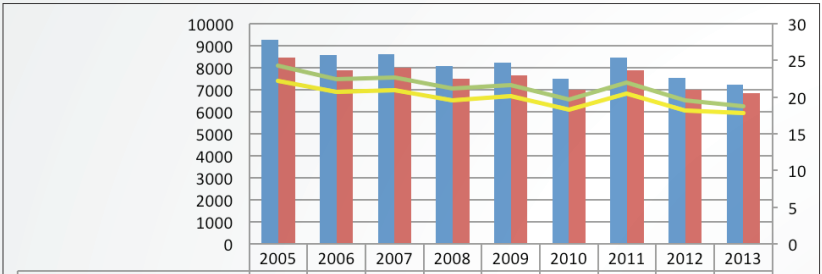
Source: Prison Service[69]

According to the graph, every year the Prison Service tests about 8,500 to 9,000 blood samples from prisoners for the presence of HCV. Of these, about 900 test results are positive, 43% of which are considered new infections.

4. Tuberculosis

Tuberculosis is recognised as another serious problem in Polish penitentiary units. This disease is also quite common in Polish society.

Tuberculosis in Poland

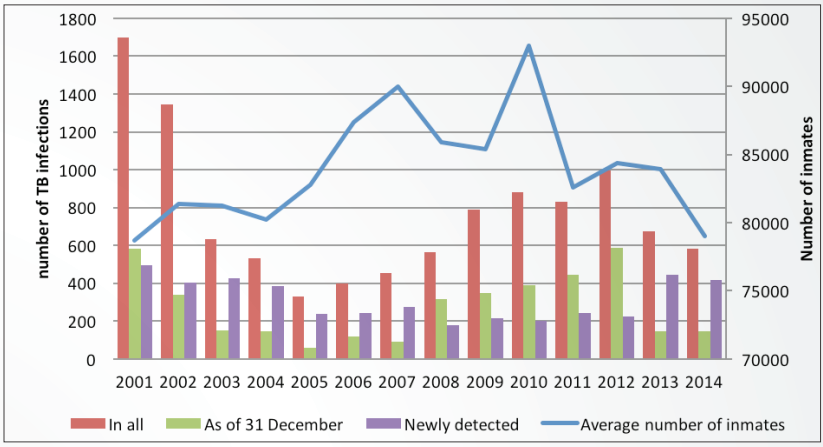


	2005	2006	2007	2008	2009	2010	2011	2012	2013
All forms of TB	9280	8593	8616	8081	8236	7509	8478	7542	7250
Pulmonary TB	8459	7884	8014	7484	7654	6992	7879	7018	6835
TB morbidity per 100.000 residents	24.3	22.5	22.7	21.2	21.6	19.7	22	19.6	18.8
Pulmonary TB morbidity per 100.000 residents	22.2	20.7	21	19.6	20.1	18.3	20.5	18.2	17.8

Source: NIH[70]

More than 7,000 cases of tuberculosis were detected in Poland in 2013. The vast majority of them were pulmonary TB. However, it is noteworthy that the TB morbidity rate has been gradually decreasing over nearly the last ten years. In 2005, there were 2,000 more cases of tuberculosis than in 2013. Unfortunately the situation is different in penitentiary units.

TB in Polish penitentiary units



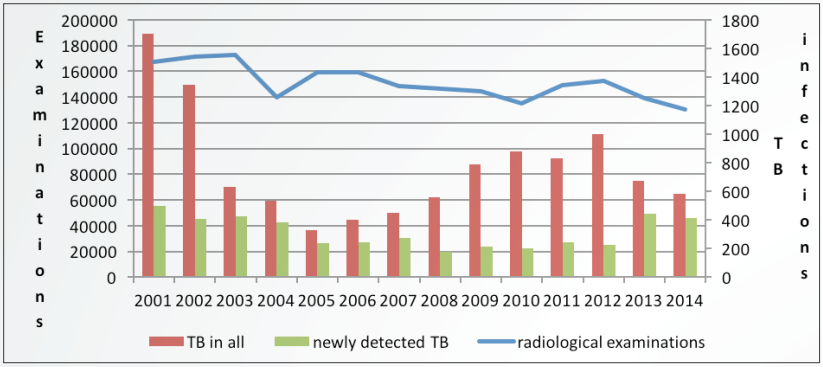
Source: Prison Service[71]

Data about overall number of inmates suffering from TB and cases of newly diagnosed TB is displayed on the above graph. The blue line describes the average number of inmates who were detained in a particular year. It is worth mentioning that in the years 2006–2007 the average population of some penitentiary units exceeded 150% of their capacity.

The graph proves that there is a connection between the overall number of inmates suffering from TB and the average number of inmates detained in penitentiary units. The more inmates held, the higher the TB morbidity rates were in the following years. Since 2012, the number of inmates with TB has been decreasing. However, it still has not dropped below the level observed in 2003.

The graph below presents the overall number of inmates with TB, the newly detected cases and the data on the number of radiological examinations conducted in penitentiary units. However, the number reflects all types of radiological examinations, not only those for the lungs. As a result, no correlation between this data can be found in the graph.

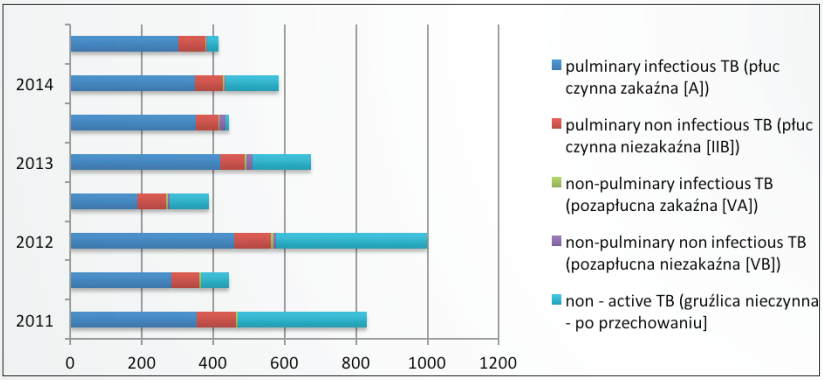
TB and radiological examinations in the penitentiary system



Source: Prison Service[72]

Pulmonary TB is the main form of TB that is present among prisoners. Every year about 400 cases of this type of TB are detected. The majority of these cases are infectious. For several years the number of inmates with active tuberculosis has been decreasing. Non-pulmonary TB only makes up a small percentage of morbidity rates.

TB forms in penitentiary system



Source: Prison Service[73]

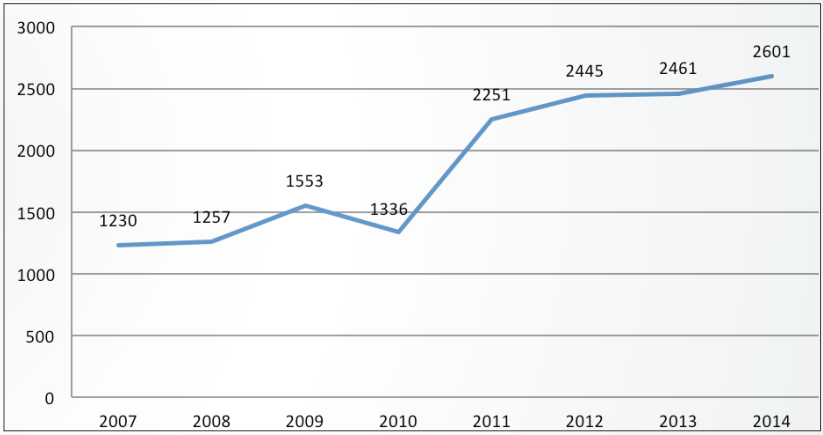
V. HARM REDUCTION IN PRISON

According to research conducted in 2009, the number of people using opioid drugs varies from 10,400 to 19,800 people. This is half as much as was estimated in a study conducted in 1994.[74]

Opioid drug users can benefit from 31 substitution programmes that currently operate in Poland. Public and non-public healthcare facilities are responsible for delivering this service.

According to the data obtained from the National Heath Fund, currently 2,601 people benefit from those programmes. This means that between 13% and 26% of opioid drug users have access to them. However, this data does not include people who are drug dependent and are deprived of their liberty.

Number of people using substitution therapy



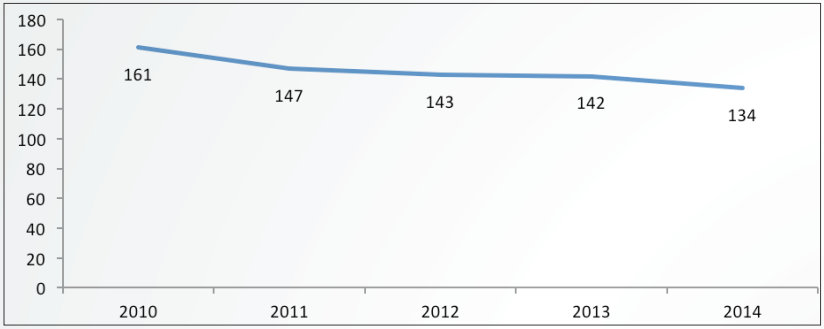
Source: National Health Fund

Records from the National Health Fund differ from those which were obtained from the National Bureau for Drug Prevention. According to these, 3,827 people have taken part in the substitution programmes since they began operating in 1992 (including patients held in penitentiary units). This number seems to be an underestimate, especially since, in 2014 alone the number of persons who benefited from substitution therapy amounted to 2601 persons[75].

Seven of these programmes have been established in 27 penitentiary units. According to the data obtained from the Prison Service, the number of prisoners using opioid substitution therapy is decreasing. In 2010, 161 prisoners took part in prison substitution therapy programmes, while in 2014, that number decreased to 134.[76]

Since the beginning of the penitentiary programmes, in 2003, 468 inmates have benefited from the therapy.

Number of prisoners using substitution therapy (as of 31 December)



According to data obtained from National Bureau for Drug Prevention (*Krajowe Biuro do Spraw Przeciwdziałania Narkomanii, NBDP*), methadone is the most commonly used method of substitution therapy.[77]

Type of substance	All patients	Patients during therapy
Methadone	3750	2052
Buprenorphine	25	17
Subuxon	213	72
Other	8	7

Source: NBDP

The majority of patients benefiting from treatment are men (currently 68% of people in the programmes). Generally patients receive treatment in infirmaries.

type of facility	All patients	Patients during therapy
infirmaries	2651	1250
stationary facilities	33	1
penitentiary units	468	175
stationary facilities with infirmaries	1374	722

According to an interviewed expert – Magdalena Bartnik – substitution therapy is carried out in Poland in a worrying manner. It is entirely based on an approach of abstinence. While Opioid Substitution Therapy (OST) is made available for drug users throughout the country, including in prisons, there are no needle and syringe

programmes offered – as this would constitute a tolerance for further use of opioids. At the same time, substitution programmes are established around an idea of stopping the use of drugs altogether.

Bartnik points out that "the programmes focus on abstinence. Tests for the presence of drugs other than the substitute are made not to promote health but to check whether a patient is cheating".[78]

Participation in the programme in the first months involves a daily visit to an infirmary. As a result, some of the programme's participants are unable to take up work. Programme participants are able to take supplies of a substitute home only when none of their drug tests come out positive. What is more, some of the programmes require that participants take part in group or individual therapy.

Lastly, according to Bartnik, there is no real support in the process of re-adaptation and re-integration to society. The treatment is only medical. There is a particular lack of social support, HCV and HIV prevention, and, last but not least, appropriate infectious disease treatment and care.

In Bartnik's opinion, this model of harm reduction does more harm than good. "As a consequence, an illegal methadone market is growing – it is the only source of income for patients in substitution programmes. Programme participants are stigmatised. They are starting to experiment with other undetectable drugs".

Simultaneously, there is no data that would prove the effectiveness of the current system. No one has verified how many people still participate in the project, or how many have been excluded from the therapy. According to Bartnik, this makes it difficult to assess the tools used during the programmes. She uses the example of Warsaw, where there is a huge rotation among participants of substitution programmes, which is known by some as "programme tourism".

VI. PRISON HEALTHCARE

1. Organisation

The Head of the Health Service Office (HSO), which operates in the framework of the Central Board of the Prison Service, is responsible for the organisation of the prison health system. Every District Inspectorate of the Prison Service appoints a Chief Medical Officer who is responsible for the supervision and coordination of the prison health service in that district.

Prison healthcare is provided in healthcare facilities that operate in each prison unit. Every healthcare facility consists of a sick bay with infirmary and dental practice. Some penitentiary units also include prison hospitals.

The prison healthcare system consists of 13 hospitals, including 37 specialised wards with various profiles and 3 anti-tuberculosis wards. According to the Supreme Audit Office (*Najwyższa Izba Kontroli,* SAO), the average number of hospital beds per 1,000 prisoners is 13, which is two times higher than in the public healthcare system.

Pursuant to article 115 of the Penal Execution Code, an inmate should be provided with free medical services, medicines and sanitary articles. He or she has the right to appropriate clothing, food, living conditions and healthcare services. However, not all medical services are available in the prison healthcare system. Highly specialised medical procedures in the fields of neurosurgery, oncology, etc. are performed only in public healthcare facilities. However, prisoners can access them free of charge.
The prison healthcare system is supervised by the Minister of Justice.

2. Healthcare services for inmates

According to the Ministry of Justice Regulation on providing healthcare service to persons deprived of their liberty[79], inmates should be subjected to mandatory initial and periodic medical examinations.

The initial medical examination consists of a medical interview and a physical examination. It should be conducted immediately, or not later than 3 days after the inmate's admission to the penitentiary unit. It should also be conducted after an inmate is transported to another unit. A physician should inform the inmate about his or her health condition and of the further need of treatment and rehabilitation. No mandatory HIV or HCV screening is conducted.

Within 14 days it should be ensured that the prisoner has access to a prophylactic dental and radiological examination. Radiological chest examinations should be conducted once every 2 years.

Decisions about placing a prisoner in an infirmary or in a prison hospital should be issued by a prison physician. Where a physician is not present, a nurse may decide about such a placement, but a doctor should be informed immediately. Only prison physicians may decide about placing prisoners in public hospitals.

In the case of an emergency, whenever there is a threat to a prisoner's life or health, the placement of a prisoner in prison or public hospital may be decided by any physician, nurse or medical professional.

3. Statistical data

Each year the Prison Service provides data on the number of medical professionals available to prisoners in public and prison healthcare systems. Details can be found in the table below.

	2013		2014	
	Prison Healthcare Service	Public Healthcare Service	Prison Healthcare Service	Public Healthcare Service
In all	1,638,835	26,228	1,554,440	29,227
primary care giver	1,098,601	248	1,051,930	1,369
dentists	248,343	1,518	227,320	966
emergency services	7,761		8,232	
occupational physicians	28,946	5,473	30,305	5,343
surgeons	25,284	2,335	23,572	2,447
infectious disease specialists	1,544	839	1,569	795
GPs	35,384	590	31,236	444
dermatologists	30,174	1,238	28,727	1,791
pulmonologists	5,295	644	4,869	695
gynaecologists	8,114	81	7,165	115
cardiologists	2,217	624	2,467	729
laryngologists	17,364	1,947	15,263	2,103
ophthalmologists	19,748	3,148	17,089	3,670
orthopaedists	12,216	1,820	12,744	2,252
neurologists	16,694	682	16,034	933
psychiatrists	70,015	722	66,695	1,229
urologists	2,317	971	2,079	1,017
others	8,448	3,448	7,144	3,329

Source: Prison Service[80]

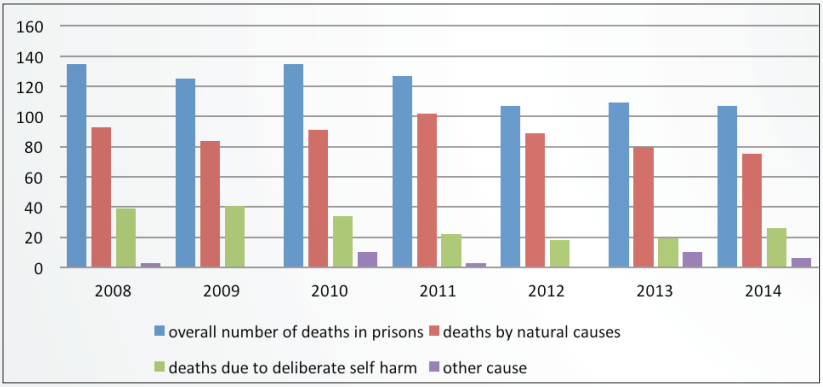
In 2014, prison healthcare staff carried out over 1,500,000 medical consultations. The average number of prisoners in that year was 78,987, which means that on average every prisoner received 20 medical consultations.

The Supreme Audit Office points out that prisoners were given the possibility to visit a primary care physician on the same day as declaring such a need, or at the latest on the following day. The waiting time for a visit to a prison specialist doctor was on average no longer than 14 days. On the other hand, prisoners who had to visit a specialist doctors in the public healthcare system had to wait 90 days.

Errors in the field of initial and periodic examinations of prisoners were found in five of the seventeen analysed penitentiary units. For example, in the Detention Centre in Łódź, radiological chest examinations of prisoners were conducted 80 days after their admission to the unit.[81]

A picture of the efficiency of prison healthcare can be given by analysing the data on deaths in penitentiary units. According to the graph below, in the last seven years there has been a decrease in the number of deaths in prisons. However, this might have been influenced by certain legal changes, especially in the field of internal regulation on the prevention of suicidal behaviours within prison facilities.[82]

Inmate deaths



In 2015, €620 mln of euro has been made available for the penitentiary system[1]. However, it is impossible to describe the overall expenditure on the prison healthcare system. Its budget is not separate from the rest of the prison system budget. Even the Supreme Audit Office was unable to indicate the overall amount of money spent on healthcare. One can assume that healthcare costs absorb a significant percent of the prison system budget. According to the Supreme Audit Office report, in 2010 and 2011 alone the expenses on medical care provided to prisoners by public healthcare institutions increased by 25 %.[83]

1 Ministry of Justice budget for 2015 available at: https://bip.ms.gov.pl/pl/dzialalnosc/budzet/download,2875,0.html

4. A Need for reform

Despite the optimistic data on the average number of medical consultations carried out in prisons, some experts advocate the reform of the prison healthcare system.[84] They indicate that the system should be part of the public healthcare system. Unfortunately, this issue is not on the agenda of the Ministry of Justice.

The lack of specialised medical personnel is one of the most common issues raised by experts. In their opinion, long waiting times for specialist medical consultations are a result of the lack of skilled physicians.[85]

Another serious problem is the fact that some prison physicians are simultaneously part of the Prison Service. Because of this, the basic relationship between prisoner and physician, which should be based on trust, is significantly compromised. This impacts on the whole treatment process.

The number of complaints raised against the prison healthcare system may also indicate a need for systemic change. In 2013, a total of 38,244 complaints to prison authorities were lodged by prisoners. Only 422 were found to be justified.

Furthermore, of the 6,675 complaints made regarding the prison healthcare system (17% of the overall number of complaints), the Minister of Justice found only 55 complaints (1%) to be justified.[86]

Some other major problems include the fact that prison medical staff are often overworked, and do not fulfil their duty to undertake additional education, regardless of whether or not this is offered by their employers. These issues are aggravated by all sorts of infrastructural problems, including the incompatibility of infirmaries with modern medical standards and the lack of coordination between those who are responsible for the functioning of the prison healthcare system. The last problem was brought to light in one the rulings of European Court of Human Rights (ECtHR) – *Dzieciak v. Poland*.[87]

In that case the ECtHR ruled that a failure to provide the applicant with appropriate medical care in due course during his 4 years of pre-trial detention jeopardised his life and health. The violation of the state's duty to protect the life of people who are detained involved a lack of coordination between different state bodies, failing to provide the applicant with two possibilities for cardiac surgery and not informing the court about his health condition. The ECtHR also indicated that Poland did not provide the applicant with proper medical treatment in the last days of his life. According to the ECtHR, the state also neglected the applicant's health condition when deciding on his detention.

VII. HUMAN RIGHTS MONITORING BODIES IN PRISON AND INFECTIOUS DISEASES

1. National monitoring mechanisms

National Preventive Mechanism (Krajowy Mechanizm Prewencji)

The functions of the National Preventive Mechanism (NPM) are performed by the Ombudsman (*Rzecznik Praw Obywatelskich,* RPO). The NPM team is made up of 13 individuals. The team has no separate budget from the budget of Ombudsman's Bureau, although in 2014, €748,980 was allocated for the work of the NPM team. Since the beginning of NPM activity, there have been suggestions that the number of staff employed in the Mechanism is too small. Such a sentiment can also be found in the last NPM report.[88]

The NPM is allowed to monitor all places of detention, including prisons, detention centres, police remand centres and also youth facilities.

One main focus of NPM monitoring is medical care in Polish penitentiary institutions. In its yearly reports, the National Preventive Mechanism indicates many problems in the Polish Prison Service; including harsh treatment by medical staff, ignoring reported complaints, long waiting times before receiving medicine and even to see a doctor, and the fact that prison medical staff belonged to the Prison Service. In some prisons the amount of highly qualified doctors and staff with mid-level qualifications is too low. Thus, the rest of the medical personnel are overworked. In many institutions there are no Patients' Rights Charters. Some prisons, because of overcrowding, place healthy prisoners in the infirmary.

The topic on infectious diseases has been rarely touched in statements by the National Preventive Mechanism. In 2011, the NPM identified one penitentiary institution which took payments for HIV tests when they were requested by prisoners. When the prison administration suspected an infection, the test was free of charge. [89]

Additionally, in a statement from 2011, the NPM emphasised the lack of preventive medical health examinations in penitentiary institutions.[90]

The Supreme Audit Office

The Supreme Audit Office (SAO) is the top independent state audit body whose mission is to safeguard public spending. The basic task of the SAO is to audit the activity of governmental administration bodies, state legal persons and other state organisational entities. The SAO undertakes audits ordered by the Sejm (lower chamber of the Polish Parliament) or its bodies, at the request of the President, the Prime Minister or on its own initiative.

In 2011, the Supreme Audit Office carried out an inspection of medical care for imprisoned persons. Within this framework, 17 penitentiary units were inspected. As a result of the inspection, the Supreme Audit Office positively assessed the availability of healthcare for people serving a prison sentence. In this assessment, prisons generally provided full access to healthcare and health services, which were applied instantly when needed. However, the SAO pointed out that the adopted system of recording expenses did not allow for an objective opinion about the effectiveness of the implied solutions.

The identified irregularities were related to the technical condition of buildings and facilities and the lack of due care for the maintaining of the proper condition of medical equipment, which was, in fact, considered outdated.

The Supreme Audit Office indicated several cases of abandonment or mass delay in the performance of prophylactic RTG testing on the chests of inmates, and also of periodic inspection checks. Moreover 65% of the monitored units had no guaranteed safety measures for the use of RTG devices.

The SAO also pointed out irregularities in substitution treatment. It emphasised the improper allocation of substitute medicine, lack of control in the recording of this medicine, and the fact that the National Bureau of Counteracting Drug Addiction was not informed about the beginning and use of substitute treatment, as well as the lack of staff training in that type of treatment.

The Supreme Audit Office also indicated that no Hospital-Acquired Infection Team was appointed in the Remand Centre in Poznań. In this unit the procedures for the proper handling of patients suspected of infection with tuberculosis were not observed.[91]
In 2015, the Supreme Audit Office delivered a report on the prevention of HIV infections and the combating of AIDS.[92] The SAO positively assessed the realisation of the National Programme for the Prevention of HIV Infections and the Combating of AIDS in 2012–2013. However, it indicated several issues worth mentioning.

The Supreme Audit Office pointed out that since 2007 the amount of funds allocated for the realisation of the programme has increased by 250%, from €23.5 million in 2007 to €66 million in 2014. Despite this increase in funding, the spread of HIV in Poland is still worrisome. The SAO emphasised that the number of Poles infected with HIV has doubled since 2006.[93]

According to the Supreme Audit Office, during the implementation of the programme, the issue of HIV prevention was neglected. The Supreme Audit Office pointed out that in 2014 only 0.9% of the programme's budget was allocated for prevention, while in 2007 this figure was more than 3,5%. This is reflected in a significant decrease in the number of activities aimed at raising public awareness about HIV.[94]

The SAO audit also indicated that in 2012 and 2013, 2 units (out of the 5 in Poland) involved in HIV diagnosis did not report 320 cases of new HIV infections to the relevant health services.[95]

2. International monitoring mechanisms

European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment (CPT)

Since Poland's ratification of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment in 1994, the European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment (CPT) has conducted 5 periodic visits to Poland. The last one took place in 2013. After that visit the CPT issued several recommendations on prison healthcare.[96]

In the opinion of the CPT, the level of skill of the healthcare staff in most of the visited establishments appeared adequate. However, it recommended that some of the facilities be reinforced by the recruitment of full-time practitioners and nurses. The CPT also received prisoners' complaints about delays in accessing to healthcare. The delegation was told that the waiting time for a consultation with, for example, a psychiatrist, could last several months.

In other units, the CPT delegation received complaints about the quality of prison healthcare. Prisoners complained about the lack of any basic medicines and of the superficial nature of medical examinations.

According to the CPT report, the medical examination upon arrival was superficial and usually consisted merely of an interview. The CPT pointed out that none of the establishments offered a systematic screening for transmissible viral diseases such as HIV and HCV.

The CPT was also concerned by the fact that medical examinations took place in the presence of custodial officers. Therefore, it recommended that the Polish authorities take steps to ensure that medical examinations are always conducted out of the earshot of non-medical staff and – unless the doctor requests otherwise in specific cases – out of the sight of such staff.

In regard to drug related programmes, the CPT was pleased with the fact that the methadone programme was available in all the facilities visited. However, none of the Prison Authorities had put in place any other harm reduction measures, such as the provision of bleach kits, condoms, needle-exchange programmes and information on how to sterilise needles. Furthermore, the CPT indicated that "it transpired from the discussion with doctors that they remained highly sceptical about implementing methadone programmes".[97]

Therefore, the CPT had to emphasise the recommendation issued during previous visits that the Polish authorities should develop and implement a comprehensive policy for the provision of care to prisoners with drug-related problems.

The results of the CPT visit in 2013 were similar to the conclusions of previous reports. However, in the report published in 2000, the CPT was pleased to note that an end had been put to the segregation of HIV-positive prisoners in Poland. At that time, the Committee expressed the hope that the Polish authorities would pursue their efforts to provide education and information to both prison staff and inmates about transmissible diseases (in particular HCV, AIDS, tuberculosis and skin diseases), including methods of transmission and means of protection, as well as the application of adequate preventive measures.[98]

The report published by the CPT following their visit in 1996 emphasised that information regarding HIV-positivity should be protected by medical confidentiality. The Committee was concerned that in one of the visited prisons the names of HIV-positive prisoners were displayed on a notice board in the nurses' room to which non-medical staff had access. The CPT recommended taking steps to ensure that appropriate counselling would be provided before any screening tests on infectious diseases were made and that, in the case of a positive result, psychological support should be guaranteed.[99]

Committee against Torture (CAT)

Poland signed the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in 1986. Since then the Committee against Torture (CAT) has issued several concluding observations on the periodic reports of Poland.

Unfortunately, those documents examined issues relating to the penitentiary system to only a marginal degree. In the last concluding observations on Poland's combined fifth and sixth periodic reports, the Committee welcomed the information that Polish prisons were occupied at 96.4% of their total capacity. However, the Committee shared the concern of the CPT that this assessment was based on the legal standard of 3 square metres per person, which in some cases can be reduced to 2 square meters per person.[100]

The Committee against Torture did not make any recommendation in the field of prison healthcare or infectious diseases.

VIII. CONCLUSIONS AND RECOMMENDATIONS

- Prison authorities should take measures to reform the prison healthcare system and transfer it to the sphere of public healthcare.
- Drug policy reform is needed. Instead of punishing people who use drugs, the authorities should focus on protecting their health and human rights.
- Undoubtedly, prison overcrowding, inadequate hygiene and poor living conditions contribute to the spread of infectious diseases. Therefore, the legal standard of cell size (3 square metres per person) should be changed to the level required by the Council of Europe. Similar actions should be taken in the field of prisoners' living conditions.
- The Prison Service should promote awareness – promoting activities, information and education on HIV, HCV, and TB among prisoners and prison staff members.
- Counselling and voluntary HIV and HCV testing should be easily accessible for all prisoners.
- The Prison Service should take measures to ensure that the results of HIV and HCV tests remain private. Any exceptions to that should depend on the consent of the prisoner.
- Support and therapy for people who are HIV or HCV positive should be at least equivalent to that available for persons living in the community.
- Every prisoner should be given, without delay, a radiological lung examination upon arrival.
- Periodic radiological examination should be carried out without delay.
- The Prison Service should prevent the transmission of infectious diseases by ensuring safer tattooing, piercing and other forms of skin penetration.
- Prisoners should have access to condoms free of charge. They should be easily and discreetly accessible at various locations.
- Prisoners should have access to sterile drug-injecting equipment, such as syringes and needles.
- The monitoring bodies, such as the NPM, should pay more attention to the monitoring of the phenomenon of infectious diseases in places of detention.

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