UNITED NATIONS
HUMAN RIGHTS
SPECIAL PROCEDURES
SPECIAL RAPPORTEURS, INDEPENDENT EXPERTS & WORKING GROUPS

PALAIS DES NATIONS • 1211 GENEVA 10, SWITZERLAND
www.ohchr.org • TEL: +41 22 917 9000 • FAX: +41 22 917 9008 • E-MAIL: registry@ohchr.org

QUESTIONNAIRE

Contact Details

Please provide your contact details in case we need to contact you in connection with this questionnaire. Note that this is optional.

	☐ Member State ☐ Observer State x Other – non-governmental organisation
Name of State Name of Survey Respondent	Helsinki Foundation for Human Rights Magdalena Dąbkowska – Drug Policy Program Coordinator
Email	magdalena.dabkowska@hfhr.pl

Background

Within the framework of Human Rights Council resolution 51/21, the Special Rapporteur on the highest attainable standard of physical and mental health has identified health equity as a strategic priority, ranging from the underlying determinants of health to the need to eliminate structural and systemic barriers in accessing health care services, goods, and facilities, particularly among persons living under vulnerable or marginalised circumstances. In compliance with her mandate and in line with these priorities, the Special Rapporteur on the right to health has decided to devote her next thematic report to the Human Rights Council, to be held in June 2024 to the theme of "Drug policies and responses: a right to health framework on harm reduction".

Objectives of the report

All persons are entitled to the enjoyment of the highest attainable standard of physical and mental health, which includes the underlying determinants of health and timely and appropriate health care. In the present report, the Special Rapporteur intends to explore the ways in which harm reduction intersects with the enjoyment of right to health and related human rights. Relying on the frameworks of the social and commercial,[1] determinants of health, the Special Rapporteur will examine the laws, policies, and practices that give rise to the need for harm reduction, as well as the laws, policies, and practices that take a harm reduction approach, aiming to address the negative health, social, and legal outcomes in various contexts.

Harm reduction has been primarily developed in the context of drug use, including needle and syringe programs, supervised injection and drug use facilities, opioid substitution therapy, overdose prevention, and community outreach programs, as well as access to legal assistance, social services, housing, and adequate food. However, in this

[1] See: www.who.int/news-room/fact-sheets/detail/commercial-determinants-of-health

report, the Special Rapporteur will take a broadened view of harm reduction to examine how this approach can intersect with the right to health and related human rights in other realms, including but not limited to sex work, abortion, and safe sex.

The Special Rapporteur also intends consider harm reduction as key public health interventions for populations that are often stigmatised and discriminated against. She will explore how the laws, policies, and practices that give rise to the need for harm reduction can disproportionately impact certain people, such as those in situations of homelessness or poverty, persons who use drugs, sex workers, women, children, LGBTIQ+ persons, persons with disabilities, persons who are incarcerated or detained, migrants, Indigenous Peoples, Black persons, persons living with HIV or hepatitis, and persons living in rural areas. Taking an anti-coloniality and anti-racism approach, the Special Rapporteur will explore how in some contexts criminalisation and stigmatisation can serve as a legacy of colonialism and slavery.

Definitions

Most commonly, harm reduction refers to policies, programmes and practices that aim to minimise the negative health, social and legal impacts associated with drug use, drug policies and drug laws.[2] For the purposes of this report, the Special Rapporteur defines harm reduction in a broader sense, including the policies, programmes, and practices that aim to minimise the negative health, social, and legal impacts associated with various behaviours and related policies and laws, as exemplified above.

Questionnaire

The questionnaire can be downloaded below in English (original language), French and Spanish (unofficial translations). Responses can address some of the questions or all of them, as feasible or preferred.

- Download the questionnaire (WORD): English | Français | Español

How and where to submit inputs

Inputs may be sent by e-mail by 15 November 2023.

E-mail address	ohchr-srhealth@un.org
E-mail subject line	Contribution to HRC report - SR right to health
Word limit	500 words per question
File formats	Word and PDF
Accepted languages	English, French, Spanish

Treatment of inputs/comments received

Please note that all responses will be published on the official webpage of the mandate of the Special Rapporteur by default.

Key Questions

[2] See also: https://undocs.org/Home/Mobile?FinalSymbol=A%2F65%2F255&Language=E&DeviceType=Desktop&LangRequested=False, para. 50.

You can choose to answer all or some of the questions below. (500 words limit per question).

Inputs may be sent by e-mail **by 15 November 2023**.

1. While the concept of harm reduction has traditionally been applied to drug use, the Special Rapporteur is taking a broadened approach to harm reduction. What types of harm reduction policies, programmes, and practices are in place in your community, and what is their purpose or aim? How successful have they been at achieving that aim? Please provide data, as possible.

   Despite the indisputable scientific evidence supporting harm reduction policies and the numerous international statement and documents (for example those issued by OHCHR, UNODC, UNAIDS, and WHO or the Political Declaration on HIV and AIDS adopted by the UN General Assembly in 2021) which recognize harm reduction interventions as a cost-effective method of HIV prevention and protection against other blood-borne disease, in Poland, the scope of harm reduction work have for years remained very scarce. Although national drug policy and HIV prevention strategies include harm reduction measures, in practice access to services remains poor, and outside urban areas – non-existent.

   The limited coverage has been justified by an insignificant number of people who inject drugs that appears in national reports on drug-related matters, as well as by the very low percentage of HIV incidence attributed to drug injection (which may result from an unreliable way of collecting data described in point 2 of this submission).

   According to estimates by the National Bureau for Drug Prevention (in 2022 replaced by the National Centre for Counteracting Addictions), about 15,000 people in Poland qualify as problem opioid users[3]. This presumably includes mainly people who inject opioids. But the total number of people who inject different psychoactive substances is undoubtedly significantly higher (since only 28% of clients of the needle and syringe exchange programs report using heroin[4]).

   According to UNAIDS, the risk of acquiring HIV is 29 times higher among people who inject drugs[5]. However, what can be seen in Poland is a decline in the number of needle and syringe programs between 2002 and 2020 - from 21 NSP operating in 23 towns to 13 in 12 towns[6]. They provide services to about 2,500 clients (latest data from 2019[7]).

   Opioid substitution treatment is available outside and inside prison settings (other harm reduction services are not available for people who are arrested or imprisoned). However, even though the number of OST patients increased between 2005 and 2020 from 750 to 3170 clients[8], it still ensures that OST is available to only one-fifth of those in need.

   The country lacks gender-sensitive harm reduction or health services at scale.

[3] National Bureau for Drug Prevention „Raport o stanie narkomanii w Polsce 2020" (Annual National Report 2020), p. 22; or European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Statistical Bulletin 2021, https://www.emcdda.europa.eu/data/stats2021/pdu_en.

[4] Annual National Report 2020, op. cit., p. 23.

[5] Global AIDS Strategy 2021-2026. Executive Summary, p. 10, https://www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026-summary_en.pdf.

[6] Annual National Report 2020, op. cit., p. 21.

[7] Ibid., p. 38; or EMCDDA, Statistical Bulletin 2021, https://www.emcdda.europa.eu/data/stats2021/hsr_en.

[8] Ibid., p. 34.

There are no drug consumption rooms in Poland (with the obligation to comply with the UN drug control treaties used in the past by the decision makers as an argument against opening and operating such facilities) and naloxone is not available for distribution within communities.

In general, harm reduction services are provided by civil society organizations and constantly underfunded.

2. How do legal frameworks affect the harm reduction policies, programmes, and practices (whether related to drug use or otherwise) that are available in your community, country, or region? Are there laws or policies that either facilitate or serve as a barrier to adopting or implementing certain harm reduction policies, programmes, and practices? Aside from legal and regulatory barriers, are there other obstacles in place? Please provide specific examples.

Despite the fact that worldwide criminalisation has proven ineffective and having numerus negative consequences, Poland's drug law remains restrictive. It is defined by the Act on Counteracting Drug Dependence, under which possession of drugs (even small quantities for personal use) is a criminal offence punishable by up to 3 years of imprisonment. Each year, law enforcement arrests around 30,000 persons on suspicion of drug possession alone.

While few of those arrested are immediately sentences to prison, those who develop drug use disorders and are repeatedly stopped by the police, are at greater risk of being sent to prison, where harm reduction services such as needle and syringe exchange programs do not exist.

But even if unlikely to face jail time - research shows - people who are stigmatized, marginalized, and perceived as criminals are less likely to seek professional help and medical treatment. They tend to avoid harm reduction services or medical facilities for fear of police harassment, arrest, and punishment. In Poland, 77,4% of respondents in a pilot study that aimed to estimate the prevalence of HIV and HCV infections among people who inject psychoactive substances in and around the capital city of Warsaw, reported having experienced sharing injecting equipment with another user(s)[9]. These percentages vary from one report to another, depending on the geographical area they cover and the profile of survey respondents, but there is nevertheless a justified reason to argue that criminalisation of drug possession in Poland, combined with insufficient harm reduction coverage, results in people who inject drugs being exposed, at least occasionally, to greater risk of contracting blood-borne diseases and overdosing.

Also, there is a disturbing lack of reliable data on new HIV cases. According to the National Institute of Public Health – National Institute of Hygiene, injecting psychoactive substances was a route of transmission in only 1.6% of newly diagnosed HIV cases in Poland in the year 2020[10], in 1.26% of newly diagnosed HIV cases in the year 2022, and in 15.7% of AIDS diagnoses between 1996 and 2020[11] (what can easily – and wrongfully – serve as a justification for the authorities to provide only limited funding for harm

[9] „Iniekcyjni użytkownicy substancji psychoaktywnych. Identyfikacja problemów i potrzeb na przykładzie pięciu polskich miast: Warszawa, Kraków, Gdańsk, Poznań i Lublin. Raport końcowy" (People who inject psychoactive substances. Identification of problems and needs on the example of five Polish cities: Warsaw, Cracow, Gdansk, Poznań and Lublin. Final Report), Warsaw 2015, p. 7.

[10] See: http://wwwold.pzh.gov.pl/oldpage/epimeld/hiv_aids/index.htm (National Institute of Public Health – National Institute of Hygiene).

[11] See: http://wwwold.pzh.gov.pl/oldpage/epimeld/hiv_aids/main.htm#Ryc_2 (National Institute of Public Health – National Institute of Hygiene).

reduction programs). However, in the vast majority of HIV cases diagnosed since the research was initiated in 1985, the mode of transmission has not been examined. Despite long-standing calls from civil society to collect data on how people get infected, in 2022, the mode of transmission remained unknown in 77.7% of new HIV infections and in 50.1% of HIV cases diagnosed between 1985 and 2020[12].

3. How does the jurisdiction in place in your region/country/state approach the criminalisation (or decriminalisation) of drug use? Please provide disaggregated data, including but not limited to gender, age, race/ethnicity, status of poverty, sexual orientation and the number of persons deprived of liberty for drug possession or consumption.

As mentioned above, the Act on Counteracting Drug Dependence, which defines the legal framework for drug policy in Poland, criminalizes possession of any amount of drugs (consumption as such is not a crime under the Polish criminal law). In 2011 though, the bill was amended by a new article (no. 62a), which allows to drop the legal proceedings against the person stopped by the police solely for drugs possession IF the substance possessed is for personal use and of a small quantity, therefore the social harm of the did is limited. The vast majority of ~30,000 cases of arrests for drugs possession annually could be dismissed on the basis of this article as these are usually the cases of possession of very small amounts of cannabis. If enforced by prosecutors and judges in all these cases as it was envisioned by the legislator, art. 62a could create a situation of de-facto decriminalization in the country. But as research shows, only in 30% of cases prosecutors decide to use the above mentioned legal possibility (and only a bit more than 1% of cases is processed this way by judges).[13]

The available data clearly shows that young men constitute the vast majority of persons stopped in Poland on suspicion of drugs possession (91% of the group studied by the Polish Drug Policy Network as presented in the outcome report published in 2022 by PDPN, the Ministry of Health and the National Center for Prevention of Addictions)[14] and of those mistreated by the police when the usage of psychoactive substances and/or severe mental health conditions are reported.

The lack of understanding of the importance of harm reduction policies translates to the lack of political will to effectively contribute to the development of such interventions and to the limited financial support offered to harm reduction programs.

4. Beyond reducing the adverse health, social, and legal consequences of drug use, what other areas can benefit from harm reduction policies, programmes, and practices in furtherance of the right to health and related human rights? Examples may include, but are not limited to, the decriminalisation of sex work, the decriminalization of abortion, and safe sex programmes.

[12] See: http://wwwold.pzh.gov.pl/oldpage/epimeld/hiv_aids/index.htm (National Institute of Public Health – National Institute of Hygiene) – data from 2020.

[13] Piotr Kładoczny, Krzysztof Krajewski, Agnieszka Sieniawska, Barbara Wilamowska „Karanie za posiadanie narkotyków. Ewaluacja stosowania art. 62a ustawy o przeciwdziałaniu narkomanii. Raport z projektu badawczego 2022" ('Punishment for possession of drugs. Evaluation of the application of Art. 62a of the Act on counteracting drug addiction. Research project report 2022), p 63: https://politykanarkotykowa.pl/wp-content/uploads/2022/09/ebook_karanie-za-posiadanie-2.pdf;

[14] Ibid, p. 18.

5. What type of harm reduction policies, programmes, and practices, as well as mental health and other support (e.g., housing, legal, social, educational, and economic), are available for people who use drugs in the community, institutions, or detention facilities? Please share examples of the impact of criminalisation, discrimination, stereotypes and stigma on the different groups of the population e.g., persons in situation of homelessness, migration, or poverty, sex workers, women, children, LGBTIQ+ persons, persons who are detained or incarcerated, persons with disabilities, Indigenous Peoples, Black persons, persons affected by HIV or hepatitis, and persons living in rural areas, etc.).

6. Are there alternative measures to institutionalisation or detention? For example, are there outpatient or inpatient facilities available in your country for people using drugs? Please provide additional details (are they compulsory, voluntary; number available in urban and rural areas; entity in charge; type of support provided and type of staff working in these facilities/centres)?

7. Please provide examples of harm reduction policies, programmes, and practices adopted or implemented with international cooperation or through foreign assistance in your country, as well as their impact on different groups within the population. What types of challenges can arise from reliance on foreign assistance? Please also provide examples focusing on the need for, and impact of, harm reduction policies, programmes, and practices on different groups of the population (e.g., persons in situation of homelessness, migration, or poverty, sex workers, women, children, LGBTIQ+ persons, persons who are detained or incarcerated, persons with disabilities, Indigenous Peoples, Black persons, persons affected by HIV or hepatitis, and persons living in rural areas, etc.).

8. Are there programmes of research and innovation related to harm reduction from a right to health perspective (e.g., needle and syringe programmes, supervised injection and drug use facilities, opioid substitution therapy, and others beyond the area of drug use), including outreach and education programmes, in your community, country, or region? Please provide good practices and examples.

In light of the above, we urge the Special Rapporteur to recommend in the upcoming report that Member States and stakeholders:

- decriminalise and remove all sanctions for drug use and possession and seek alternatives to punitive drug polices;
- ground their drug policies in human rights, scientific evidence and reliable data;
- invest in increasing coverage and diversifying the range of harm reduction measures to ensure equal access for all;
- and actively combat stigma and discrimination against people who use psychoactive substances.