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人权理事会

第十四届会议

议程项目 3

增进和保护所有人权——公民权利、政治权利、  
经济、社会和文化权利，包括发展权

## 人人有权享有可达到的最高水准身心健康问题特 别报告员阿南德·格罗弗的报告\*

增编

对波兰的访问\*\*

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\* 逾期提交。

\*\* 本报告的内容提要以所有正式语文分发。报告本身附于内容提要后，只以提交的文本分发。

## 内容提要

应波兰政府的邀请，人人有权享有可达到的最高水准身心健康问题特别报告员于 2009 年 5 月 5 日至 11 日访问了波兰。这次访问的主要目的，是了解波兰是如何努力落实健康权的，特别是在关于性和生育的权利以及减少伤害的政策方面。访问期间，特别报告员走访了华沙和格但斯克，与卫生部和外交部的政府高级官员，卫生专业组织、国际组织、非政府组织和民间团体的代表举行了会晤。

特别报告员在报告中赞扬迄今为止波兰政府为确保人人享有可达到的最高水准健康权而作出的努力。波兰作出了重要承诺，以在不歧视和平等的基础上，实现人人能获得服务和必要的目标；由于国家保健基金的发展，人民的医疗服务有了很大范围的资金来源。此外，过去二十年里，政府努力改善整个保健制度，全面保证获得保健权。

尽管波兰在确保获得服务和保健信息方面取得了一些成就，但在性和生育健康权方面的某些问题依然令人关注，特别是在获得合法流产、爱滋病毒感染的伤害减少措施以及阿片替代治疗毒品依赖等方面。1993 年《计划生育法》限制依法终止怀孕的可能性，撤消了以社会经济为由的流产，因此而增加了不安全的地下流产。《防毒赢法》对少量拥有毒品实行惩罚，使人难以得到必要的替代治疗。就爱滋病毒而言，爱滋病毒预防方面的供资与实际工作之间有差距，这反过来又影响了预防服务，包括减轻伤害措施的提供。

## Annexe

### Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover

#### Mission to Poland (5-11 May 2009)

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## I. Introduction

1. At the invitation of the Government, the Special Rapporteur visited Poland from 5 to 11 May 2009. The purpose of the mission was to assess, in a spirit of cooperation and dialogue, how Poland implements the measures taken for the successful realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (“right to health”) and the obstacles encountered both at the national and international levels.

2. The objective of the mission was to assess the enjoyment of the right to health in Poland, including access to health care and the underlying determinants of health. The key themes of the mission were issues regarding sexual and reproductive health rights and harm reduction policies in respect to drug use and HIV/AIDS. The Special Rapporteur considered the implementation of the right to health with a view to assist the Government - and other relevant actors - in their efforts to address the challenges and obstacles to its realization.

3. The agenda for the Special Rapporteur’s visit was arranged in close cooperation with the Ministry of Health and the Ministry for Foreign Affairs of Poland. Throughout the mission, all levels of Government - central, regional and local - were constructive and open. The Special Rapporteur is grateful for the valuable cooperation and assistance he received before, during and after the mission.

4. During his mission, the Special Rapporteur visited Warsaw and Gdansk. In Warsaw he met with senior government officials from the Ministry of Health including Marek Twardowski, Undersecretary of State, Marek Haber, Undersecretary of State, Adam Fronczak, Undersecretary of State, Ineza Królik, Director of the Department of International Cooperation, and Mr Wojciech Klosinski, Deputy Director of the Public Health Department who was present at the majority of meetings held with Government officials. He also met Ms Grażyna Bernatowicz, Undersecretary of State, Marcin Nawrot, Director of the Department of United Nations and Human Rights, and Jakub Wołásiewicz - Plenipotentiary of the Minister of Foreign Affairs for cases and procedures before the European Court of Human Rights Agent for the Government of Poland, from the Ministry of Foreign Affairs. He also had discussions with Ms Elżbieta Radziszewska, Government Plenipotentiary for Equal Treatment, Secretary of State, Ms Barbara Kozłowska, Director of Patients' Rights in the Ombudsman’s Office, as well as with Bolesław Grzegorz Piecha, Chairperson of the Parliamentary Committee on Health and Ryszard Kalisz, Chairperson of the Parliamentary Committee on Justice and Human Rights. In Gdansk, he met with representatives of local authorities, including the Deputy Mayor of Gdansk, Wiesław Bielawski. In Warsaw, the Special Rapporteur visited the national AIDS Centre, the National Bureau for Drug Prevention and the Institute of Psychiatry and Neurology.

5. The Special Rapporteur also had the opportunity to meet with representatives of numerous non-governmental and civil society organizations working on issues related to access to healthcare services, people living with HIV, persons with disabilities and national health professional associations.

6. The Special Rapporteur expresses his sincere thanks to all those whom he met for their excellent cooperation.

## II. International and national legal framework

7. Poland has ratified a number of international human rights treaties on the enjoyment of the right to health and other health-related rights, including the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention of the Elimination of All Forms of Discrimination against Women (CEDAW), the International Convention on the Elimination of All Forms of Racial Discrimination (CERD) and the Convention on the Rights of the Child (CRC) and its Optional Protocols. Poland has also signed the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families and the Convention on the Rights of Persons with Disabilities and its Optional Protocol.

8. Furthermore, Poland is a party to the major regional human rights treaties such as the European Convention for the Protection of Human Rights and Fundamental Freedoms, the European Social Charter, the European Convention for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment and the Framework Convention for the Protection of National Minorities.

9. The ratification of these international legal instruments gives rise to obligations that are binding under international law. The Special Rapporteur notes that some of the provisions of these international human rights instruments are reflected in the Polish Constitution of 2 April 1997, laws and other legal instruments currently in force in Poland. He welcomes the commitment of the Government to respect the rights recognized therein, but is nevertheless concerned that the ability to realize the right to health on a basis of non-discrimination and equality can be hampered without the implementation and establishment of equality and non-discrimination legislation. He calls upon the Government to take the necessary measures in order to ensure full compliance with international human rights standards for all.

10. The right to health is recognized in Articles 68 and 69 of the Constitution of Poland, which stipulates the principle of equal access to healthcare services which are financed from public funds and guarantee access to special healthcare for children, pregnant women, the elderly and persons with disabilities. Furthermore, Article 32 of the Constitution provides for the equality of everyone before the law. The 1993 Act on Family Planning, Protection of the Human Foetus and Conditions of Permissible Termination of Pregnancy (“the 1993 Act on Family Planning”), the Statute on Occupational and social rehabilitation of the disabled, and the Statute on social assistance, further develop the provision of health care and the need for equality.

11. A functioning health system is the basis for the exercise of the right to health. The Special Rapporteur welcomes Poland’s commendable work in the last two decades to improve the health system as a whole and its commitment to ensuring access to healthcare for all.

12. The lives, health and human rights of Polish and foreign nationals under the jurisdiction of Poland depend upon its Government, which must make the maximum use of its available resources to implement the right to health. The process of health reform, initiated in 1999, was followed by the adoption of the new law on Health Care Services Financed from Public Sources in 2004. This new law amended the existing laws by defining the roles and responsibilities, leadership, management and financing of the health system, of the Ministry of Health, the National Health Fund and territorial self-government administrations.

13. Public authorities are in charge of the protection of equal access to healthcare services, and of developing national health policies. The Ministry of Finance and the

Ministry of Health jointly monitor the activities of the National Health Fund (NHF), which is the main funder of the health services. Territorial or regional self-governments are responsible for the strategy and planning, health promotion and management of public health institutions. Their activities are based on identified health needs in a given region; local public health centres fall within the province, county hospitals come under the county authorities, while primary health care services are provided by local authorities.

14. Healthcare in Poland is financed both from public and private sources. Public finance is provided through universal health insurance, deducted at a rate of nine per cent of the salary or the relevant income, contribution from the State budget (approximately four per cent) together with contributions from province, county and local budgets. Private financing is regulated by the Act on Healthcare Services Financed out of Public Funds adopted in July 2004.<sup>1</sup> Social insurance benefits are provided by the State and are distributed on an equal basis, regardless of gender, marital or family status.<sup>2</sup>

15. The Special Rapporteur notes however that the budgetary allocations for health are insufficient to meet the growing needs of the population. The long waiting lists, sometimes resulting in complications and avoidable deaths, are, at least in part, indicative of the insufficiency of funding available to the public health system.

16. The Special Rapporteur welcomes the entry into force of the Act on the Patient's Rights and the Patient's Rights Ombudsman in June 2009 which establishes a complaint mechanism that allows any patient to file an objection against a physician's "opinion or ruling [which] affects the patient's rights or obligations under the law". He also commends the impressive work and the resolve of the office of the Patient's Ombudsman to overcome existing obstacles and provide the urgently needed healthcare services in difficult and dire circumstances.

17. Despite these achievements, the Government of Poland still needs to address a number of issues, particularly regarding rights to sexual and reproductive health, HIV and harm reduction, and drug dependence treatment. The Special Rapporteur appreciates that Poland is a country with long and deeply rooted traditions, and understands that the question of sexual and reproductive health, including access to contraceptives and abortion, raises complex issues for the Government. However, the Government should make concerted efforts to overcome these obstacles and ensure the full protection of human rights.

### **III. Rights to sexual and reproductive health**

18. Rights to sexual and reproductive health are integral elements of the right to health<sup>3</sup>. From the 1994 International Conference on Population and Development (ICPD) in Cairo and the Fourth World Conference on Women held in Beijing in 1995, States have moved from focusing only on family planning programmes to recognizing the importance of an integrated approach to sexuality and reproduction that puts women's experiences, rights and needs at the forefront. They have also confirmed the crucial role that human rights play in the context of rights to sexual and reproductive health<sup>4</sup>. The objectives of the ICPD Programme of Action focused on the needs and rights of individuals and 179 countries pledged to reduce maternal mortality, combat HIV/AIDS and improve rights to sexual and reproductive health. These objectives were further reaffirmed in the Millennium

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<sup>1</sup> Journal of Laws 2004, no.210, item 2135.

<sup>2</sup> Social Insurance System Act, 13 Oct. 1998, art. 2a.

<sup>3</sup> Commission on Human Rights resolution 2003/28.

<sup>4</sup> A/CONF/171.13, Ch. 2, principle 1.

Development Goals, three of which, maternal health, child health and HIV/AIDS – have a direct bearing upon rights to sexual and reproductive health.

19. Rights to sexual and reproductive health encompass both freedoms, such as freedom from discrimination and the freedom to control one's health and body, and entitlements, such as the right to a functioning health system or access to information on sexual and reproductive health issues. Consequently, States have obligations to ensure appropriate services in relation to rights to sexual and reproductive health, including services related to pregnancy and childcare, family planning, pre- and post-natal care, emergency obstetric care and access to legal abortion, and to address the effects of unsafe abortion and sexuality education, among other issues.

20. However, there are many obstacles to the full realization of rights to sexual and reproductive health which are interrelated and encompass not only biological factors but also cultural, social and economic ones.<sup>5</sup> In particular, some deeply rooted traditions or beliefs can be a major impediment to the timely and adequate provision of sexual and reproductive health services.

21. Rights to sexual and reproductive health also raise extremely important issues, quite often sensitive and controversial. In order to address these adequately, there is clearly a need to identify effective, equitable and evidence-based policies which are respectful towards individual autonomy, privacy, dignity and well-being and that are non-discriminatory. The right to health approach, including active and informed participation of all stakeholders and the establishment of effective and accessible mechanisms of monitoring and accountability, would ensure the success of sexual and reproductive health-related policies and therefore provide for the full protection of women's rights to sexual and reproductive health.<sup>6</sup>

22. In Poland, SRHR are regulated by a number of legislative acts, including family planning legislation, legislation dealing with pre-natal care, termination of pregnancy, and motherhood in general.

23. Article 18 of the 1997 Polish Constitution stipulates that "motherhood and parenthood shall be placed under the protection and care of the Republic of Poland". In the same context, article 47 guarantees everyone the right to legal protection of their private and family life. The 1993 Act on Family Planning further sets out issues directly related to sexual and reproductive health rights obliging government and territorial or regional governments to provide women with medical, social and legal care, specifying which form this care should take.<sup>7</sup> However, the law concerning consent of parents for advice on contraception in the case of minors, and the concepts of "assisted reproduction" and "conscientious objection" are open to different interpretations, and thus the legal uncertainty may limit or prevent access to redress.

24. The Special Rapporteur notes with concern that, despite the ratification by the Government of Poland of human rights treaties and declared commitment to honour them, access to certain reproductive health services, such as contraception, pre-natal testing and legal abortion, is seriously impeded. In this context, reports and personal testimonies indicate that women, even in the limited circumstances in which abortion is legal, encounter serious difficulties in having it performed.<sup>8</sup> The Special Rapporteur also received

<sup>5</sup> E/CN.4/2004/49, para 40.

<sup>6</sup> Cairo Programme of Action, Chapter VII, E/CN.4/2004/49, para 54-56.

<sup>7</sup> 1993 Act on Family planning, Art. 2, para 1.

<sup>8</sup> See e.g. *Tysic v. Poland*, App. No. 5410/03, ECHR (2007) at 116, where the court explained that where abortion is legal it should be accessible. See also, Contemporary

allegations that young people were not permitted to buy condoms over the counter, despite no legal prohibition denying access to these.

## A. Access to information and sexuality education

25. Access to comprehensive, non-discriminatory, unbiased and science-based sexuality information and education in Poland is one of the issues related to rights to sexual and reproductive health that raises concern for the Special Rapporteur, particularly with regard to adolescents facing unwanted pregnancies.<sup>9</sup> Despite the fact that the 1993 Act on Family Planning requires the Ministry of Education to introduce sexuality education into the school curriculum, sexuality education falls into the category “Family life education” as provided for by the Regulation of the Minister of National Education and Sport of 26 February 2002 on the core curricula for pre-school education and general education.<sup>10</sup> Family life courses focus narrowly on marriage and family and touch only to a very limited extent on issues of sexuality and procreation, merely promoting abstinence and traditional methods of family planning. The curriculum also lacks science and evidence-based information on contraception, abortion and non-discriminatory content on gender and sexual orientation. The Special Rapporteur was also informed that schools do not follow a consistent programme and often sexuality education courses are taught by school counsellors, physical education teachers or teachers of vocational subjects. Sometimes, these courses are given by priests or nuns, whose religious beliefs may affect their ability to provide unbiased, science-based and reliable information about sexual and reproductive health, irrespective of whether they are otherwise qualified to teach.

26. The Special Rapporteur welcomes the steps already taken by the Government to improve access to sexuality education and information, and calls the Government to further eliminate the possibility for parents to object to the provision of sexuality education in schools.<sup>11</sup> Furthermore, the Special Rapporteur calls on the State to review the content of the curricula to ensure the provision of comprehensive, unbiased and science-based sexuality education.

## B. Access to contraception

27. Impeded access to contraception is another important health issue that women in Poland currently face. Research confirms that Poland has one of the lowest rates of use of modern contraceptive methods in Europe - only 19 per cent compared with 81 per cent for Great Britain, 38.9 per cent for Italy and 29.5 per cent for Romania<sup>12</sup> - which is most likely due to multiple barriers faced by Polish women seeking to access contraceptives. According to the 1993 Act on Family Planning, citizens have the right to free access to “methods and means servicing conscious procreation”.<sup>13</sup> Few institutions promote family planning and

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Women's Hell: Polish Women's Stories Polish Federation for Women and Family Planning, Warsaw, 2005.

<sup>9</sup> CRC/C/15/Add. 194.

<sup>10</sup> Journal of Laws, No. 51, item 458.

<sup>11</sup> CRC/C/GC12, para 101; see also, Kjeldsen, Madsen & Pedersen v. Denmark, (ECHR), 1 E.H.R.R. 737 (Application no. 5095/71; 5920/72; 5926/72), 7 December 1976, where the court explained that a State has an interest in providing comprehensive sex education without parental consent, as it is in the interest of protecting the health and welfare of the child.

<sup>12</sup> Health of women in procreational age 15-49, report 2006 (2007), United Nations Development Programme, Warsaw.

<sup>13</sup> Art. 2(2) of the 1993 Act on Family Planning.

even though some methods of contraception are available over the counter, they are often too expensive and therefore inaccessible to many women. The Committee on Economic Social and Cultural Rights in its Concluding Observations to Poland reiterated that contraceptives need to be available at affordable prices.<sup>14</sup> In addition, the reduction in the number of State refundable oral contraceptives further limits their accessibility.<sup>15</sup> Moreover, the Special Rapporteur received allegations that some doctors provide misinformation (or no information at all), and often impose judgmental and personal views regarding family planning. In practice, doctors offer women contraceptives only upon request. Due to a lack of awareness of the effectiveness of contraceptives or the need for them, women often remain in fear of unwanted pregnancies and resort to finding alternative routes to terminate pregnancies, thereby risking their health and lives.

### C. Access to legal abortion

28. Poland remains one of the few European countries that significantly restrict women's access to abortion. While in the overwhelming majority of European countries the termination of pregnancies is safe and legal, in those with very restrictive laws women often resort to illegal and unsafe abortions or travel to other countries when they wish to terminate a pregnancy.

29. Various international human rights bodies have concluded that, in Poland, the grounds for legal termination of pregnancy are of a very restrictive nature.<sup>16</sup> In comparison with laws in other European Union countries, only Malta and Ireland set out similar significant restrictions. Poland's provisions are much more restrictive compared with the situation which prevailed in Poland before the adoption of the 1993 Act on Family Planning, when the conditions for termination of pregnancy were less formal and much more liberal. The termination of pregnancy on request was made legal in Poland in 1956 and was accessible, on both medical and socio-economic grounds, and free of charge in public hospitals until the early 1990s. At that time, abortions were also performed in private clinics upon payment. However, the 1993 Act revoked the right to termination of pregnancy on social or economic grounds, compelling women to resort to unsafe, clandestine abortions.

30. The 1993 Act on Family Planning obliges Government bodies, including regional authorities, to provide pregnant women with medical, social and legal care, explaining also the forms<sup>17</sup> of this care. These bodies are also required to provide free access to "methods and means serving conscious procreation",<sup>18</sup> which was not further elaborated in the law or its implementing decrees.

31. The Act stipulates that the woman should give her consent in writing, including where she is a minor or living with a mental disability; an exception exists for cases where obtaining consent could endanger a patient's life or pose a serious risk of bodily harm, or to

<sup>14</sup> E/C.12/POL/CO/5, para 27.

<sup>15</sup> Human Rights Committee, Concluding observations to Poland, 2004.

<sup>16</sup> Concluding Observations of the Human Rights Committee on Poland, CCPR/CO/82/POL; Concluding observations of the Committee on the Elimination of Discrimination against Women, CEDAW/C/POL/CO/6, Memorandum to the Government of Poland-Assessment of the progress made in implementing the 2002 recommendations of the Council of Europe Commissioner for Human Rights (CommDH(2007)13, para 98, ECHR, *Tysiąc v. Poland*.

<sup>17</sup> 1993 Act on Family Planning (art 2, para 1).

<sup>18</sup> *Ibid.* (art. 2, para 2).

health.<sup>19</sup> If the woman is a minor or a person incapable of giving informed consent, consent is provided by the statutory representative (usually the parent or the Custody Court). In light of the Convention on the Rights of Persons with Disabilities, the Special Rapporteur notes that people with disabilities have full legal capacity, and that any support they may require to provide informed consent should be assessed on a case-by-case basis.<sup>20</sup> If the woman is over 16, her consent is also required (“parallel consent”). However, the Special Rapporteur is concerned that, although provision is made to seek the opinion of patients under 16 years of age regarding their treatment, there appears to be no obligation to consider this opinion. The Special Rapporteur believes that ability to consent to a procedure should be determined on a case-by-case basis, taking into account the maturity of the minor in question, and her understanding of the procedure and its risks.

32. The Act also obliges the Government, including local authorities, to “provide free access” to information and pre-natal tests in particular when there is an increased risk or suspicion of the occurrence of a genetic or developmental defect of the foetus or incurable illness which threatens the life of the foetus.<sup>21</sup>

33. More importantly, the Act stipulates the conditions which permit the termination of pregnancy.<sup>22</sup> The consent of the pregnant women is always required and a doctor, who must be a specialist in obstetrics and gynaecology, can perform abortion only in the following circumstances:

1. when pregnancy constitutes a risk to the life or health of the pregnant woman (medical reasons);
2. when pre-natal tests or other medical evidence available indicate a high probability of severe and irreversible disability to the foetus or an incurable illness threatening its life (embryopathological reasons);
3. when there is a justified suspicion that the pregnancy arose as a result of a criminal act, such as rape (legal reasons).

34. In the first case, there is no time limit for terminating the pregnancy, in the second, the termination may be performed until the moment of foetal viability, and in the third case, the termination may take place up to 12 weeks from the beginning of the pregnancy.

35. The law concerning abortion necessarily requires an exercise of discretion by a medical practitioner. Performing an illegal abortion is punishable under the Criminal Code of 6 June 1997, which punishes the doctor performing it.<sup>23</sup> These sanctions have a chilling effect on decisions made by doctors, deterring them from performing abortions which may, in fact, be legal.

36. In 2007, the Committee on the Elimination of Discrimination against Women voiced concern in relation to Poland’s obligations under article 12 of the Convention (on women’s equal right to access health care services) and specifically called for “concrete measures to enhance women’s access to health care, in particular to sexual and reproductive health services, including: research on the scope, causes and consequences of illegal abortion and its impact on women’s health and life; measures to ensure women’s access to legal abortion services and against limitation of such access “by the use of the conscientious objection

<sup>19</sup> Act of the Physician’s profession, Art. 33 and 34; In such cases, consent is not required, and legal representatives are subsequently informed of the treatment given.

<sup>20</sup> Art. 12, Convention on the Rights of Persons with Disabilities.

<sup>21</sup> Ibid, Art. 2, para 2.

<sup>22</sup> Ibid, art 41, para 1.

<sup>23</sup> (Art. 1.5.3).

clause.” In 2009, the Committee on Economic, Social and Cultural Rights in its Concluding Observations, noted that Poland does not guarantee basic services in the area of sexual and reproductive health and called upon the State to “take all effective measures to ensure that women enjoy their right .....by enforcing the legislation on abortion and implementing a mechanism of timely and systematic referral in cases of conscientious objection.<sup>24</sup> Unfortunately, the situation remains unchanged and recommendations have not yet been implemented.

37. The respect of physical integrity and the freedom to control one’s own body are fundamental rights of all human beings, including women. The ultimate decision on whether or not to give birth should be made by the woman concerned. However, abortion should not be regarded as a method of family planning under any circumstances, and the need for abortion must be reduced. In that context, methods compatible with women’s rights to plan their families must be available in order to reduce the number of unwanted pregnancies and abortions.

38. The Special Rapporteur notes with regret that women in Poland face numerous obstacles in accessing abortion services, even when they are legally entitled to an abortion. He is concerned that non-State actors, such as priests, interfere with access to legal and safe abortions. The Special Rapporteur was informed of the case of a priest who pressured a girl of 14, who became pregnant as a result of a rape, not to seek legal abortion. In another case, a priest interfered with a doctor’s decision on abortion of a pregnant woman suffering from cancer. In the latter case, clearly intimidated doctors changed the decision, and as a result no abortion took place. Such interference also raises serious concerns about medical confidentiality which is may be compromised. It was also reported that religious ministers often work with midwives who report doctors who would be prepared to provide abortion services. The Special Rapporteur reiterates that the State has the obligation to ensure that no one interferes with or prevents the woman’s right to access legal and safe termination of pregnancy. This applies with equal force to religious ministers of any belief/denomination. The Special Rapporteur is concerned that interference by non-State actors, such as priests, into the rights of women to access legal abortions is defended on the grounds of patients’ rights to refuse pastoral care, apparently without consideration of social or other pressures upon patients to accept such pastoral care services. The Special Rapporteur calls upon the Government of Poland to fulfill its obligation to proactively prevent interference by non-State actors.<sup>25</sup>

#### **D. *Tysic v. Poland* case**

39. Not only does Poland have a restrictive abortion law, but the existing law is applied very narrowly, which prevents women from obtaining abortions, even when they are legal.

40. The European Court of Human Rights in *Tysic v. Poland*, held in March 2007 that Poland had violated Article 8 (right to respect for private and family life) of the European Convention on Human Rights as it failed to establish an effective procedure through which Ms. Tysic could have appealed her doctors’ refusal to grant her request for abortion.<sup>26</sup>

41. The *Tysic* case involved a Polish woman who suffered from a severe eye condition and sought to terminate her pregnancy after doctors confirmed that the pregnancy and pending delivery threatened her eyesight. Despite the fact that the Polish law permits

<sup>24</sup> E/C.12/POL/CO/5, para 27 and 28.

<sup>25</sup> E/C.12/2000/4.

<sup>26</sup> See *Tysic v. Poland*, App. No. 5410/03, ECHR (2007).

abortion on health grounds, Ms. Tysi c's doctors refused to give her the required health certificate allowing her for termination of the pregnancy. Ms. Tysi c then sought additional medical advice and eventually obtained a medical certificate confirming the dangers posed to her health, but was again denied permission to terminate the pregnancy. As predicted, Ms. Tysi c's eyesight considerably deteriorated after delivery.<sup>27</sup>

42. In finding Poland in violation of the European Convention on Human Rights, based on Ms. Tysi c's inability to access legal abortion services, the Court's judgment required the Government of Poland to provide an effective remedy, including compensation to Ms. Tysi c for her injury, and to implement of concrete procedural measures to ensure a woman's access to a legal abortion and to prevent the future occurrence of similar violations of Article 8.

43. In that regard, the European Court specifically called upon Poland to establish an appeals mechanism to review cases where there is a disagreement, either between a woman and her doctors or between two doctors, as to whether or not the conditions for legal abortion have been met. The European Court directed that such procedural safeguards would require:

- (a) an independent body of review;
- (b) a guarantee that the woman's views would be considered in the review process;
- (c) a written decision by the review body; and
- (d) decisions rendered in a timely matter, considering the circumstances of the case.

44. While the Government of Poland has paid compensation to Ms. Tysi c, it has not yet fully implemented the Court's decision by instituting effective mechanisms and procedures to ensure a woman's access to a legal abortion. During the mission, the Special Rapporteur had the opportunity to meet with the Agent representing the Government of Poland before the European Court for Human Rights. The Special Rapporteur expressed concern regarding the then draft law on patients' rights that, according to the government, implements the *Tysi c* decision. Some of the concerns expressed by the Special Rapporteur regarding the procedure established by this law are:

- (a) The composition of the board – the law provides that the review board will be composed exclusively of three physicians, which raises serious concerns of impartiality, since quite often, physicians are reluctant to question another colleague's decision regarding the termination of pregnancy;
- (b) Women's considerations – the law does not reflect that women's consideration should be taken into account, even though the judgment clearly requires this;<sup>28</sup>
- (c) Timely decisions – this is critical in the context of termination of pregnancy and the gestational limits the law places on terminating pregnancies,
- (d) Written decisions – there is no obligation to provide a written decision, or an appeal. Without such procedures in place, the effectiveness of this mechanism, and due process, cannot be ensured.

45. The Government of Poland provided extensive information to the Special Rapporteur concerning measures it has taken in this regard. The Special Rapporteur believes that a panel composed exclusively of medical professionals has an inbuilt structural bias, affecting its impartiality. This cannot be cured by the right of the patient to

<sup>27</sup> *Idem*.

<sup>28</sup> *Ibid*, at 19, para 88.

challenge the partiality of an individual physician. The Special Rapporteur calls upon the Government of Poland to enact legislation in compliance with the decision in the *Tysiąc* case.

## E. Unsafe abortions

46. The Special Rapporteur underlines that a woman's need to have an abortion is not dependent on the legality of abortion. However, her access to safe abortion is severely impacted by criminalization of abortion. The Special Rapporteur emphasized that when abortions are legal, as well as being safe, they must be made accessible. The implementation of restrictive abortion laws do not necessarily reduce the number of abortions performed, but result in women seeking clandestine abortions which are predominantly unsafe, traumatic and often result in serious health and life-threatening conditions.<sup>29</sup>

47. Regrettably, the Polish authorities could not provide information on the extent of illegal abortions and their effects on women. Available official statistics show only that legal abortions are less accessible in public medical centres. However, the unofficial estimates that the Special Rapporteur has received of illegal abortions performed in Poland are very worrying as the number of terminations of pregnancies per year is reported to be between 80,000 and 180,000. The Special Rapporteur has also received reports that women go abroad in order to access abortion services.

48. It is evident that there are many obstacles to women's access to abortion - legal, social, cultural and religious. In order to improve women's health and save women's lives these obstacles must be eliminated. It is of the utmost importance for Poland to improve public policies and ensure unhindered access to abortion when legal.

## F. Health professionals

49. Health professionals play an important role in ensuring women's access to sexual and reproductive health services. The Special Rapporteur had the opportunity to meet with representatives of health professionals' associations and discuss various issues affecting their role in ensuring the enjoyment by everyone of the right to health. He regrets that Polish health professionals do not have the opportunity to receive education and training in human rights.

50. Healthcare providers' conscientious objection to involvement in certain health-related procedures is grounded in the right to freedom of religion, conscience and thought. However, the exercise of conscientious objection should not entail interference with sexual and reproductive health rights, which are fundamental. Health systems should have procedures, such as administrative procedures to provide immediate alternatives to healthcare users when conscientious objection would otherwise lead to a denial of services, and effective remedies, in place to ensure that in practice, legitimate conscientious objection does not obstruct the enjoyment by women and men of their sexual and reproductive health rights. States should also monitor the exercise of conscientious objection with a view to ensuring that all services are available and accessible in practice. In short, health service providers who conscientiously object to a procedure have the

<sup>29</sup> I Shah & E Ahman, "Unsafe abortion: global and regional incidence, trends, consequences and challenges" (2009) 31(12) *Journal of Obstetrics and Gynaecology Canada* 1149, 1153-1154.

responsibility to treat an individual whose life or health is immediately affected, and otherwise to refer the patient to another provider who will perform the required procedure.

51. However, the Special Rapporteur notes with concern that these conditions for invoking conscientious objection are not being met in Poland. Numerous reports indicate that some doctors, hospital directors, anaesthesiologists and auxiliary medical personnel such as midwives and nurses invoke the conscientious objection clause in refusing to perform abortions, and do not comply with their legal obligations under the Act of 5 December 1996 on the profession of physician and dentist, to refer women to other providers who will perform the termination of pregnancy.<sup>30</sup>

52. Under Article 39 of the Act of 5 December 1996 on the medical profession, “the doctor may abstain from accomplishing medical services discordant with his/her conscience, (...) nevertheless s/he is obliged to indicate real possibilities of obtaining the service from another doctor, or in another medical institution and justify his/her decision and mention about the refusal in the medical documentation”. There are also reports of doctors refusing to provide prenatal examinations out of concern that these could lead to a lawful abortion if severe foetal impairment were diagnosed. Furthermore, as conscientious objection is not recorded or registered, there are no records of the number of health providers who invoke the conscientious objection clause in cases when they are asked to perform a termination of pregnancy. There are no records either of health providers who would perform abortions. Without regularly updated information, women’s access to legal health services is seriously compromised. Despite enquiries by the Special Rapporteur regarding arrangements made by hospitals to ensure that services are provided only by those doctors who will not conscientiously object, no answers were provided.

53. The case of a 14-year-old (outlined in paragraph 38) illustrates the situation aptly. Although the case met all the necessary legal requirements for legal abortion on criminal grounds, several hospitals and health care workers refused to perform an abortion, ostensibly on the grounds of conscientious objection. It was apparently only due to intervention by the Minister of Health that the abortion was finally performed secretly in a remote town, without formal records of the procedure. This raises questions about the options available to women who do not enjoy this kind of high-level support.

54. The Special Rapporteur was also informed that the regulation aimed at improving implementation of the conscientious objection clause has been repealed. This regulation established a procedure which obliged a hospital to subcontract services in the instance of a medical professional invoking the conscientious objection clause. The Special Rapporteur is concerned by this, and wanted to be informed as to whether the Government is planning to enact a similar instrument. However, at the time of completion of the present report, no information was forthcoming.

55. The issues concerning the conscientious objection clause have been raised within other human rights mechanisms, such the Human Rights Committee.<sup>31</sup> The Special Rapporteur considers that there is a need for decisive action in this regard: such action should reconcile the legitimate concerns of health providers exercising their right to conscientious objection with the legitimate and pressing interests of patients.

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<sup>30</sup> See also CESCR Concluding Observations, E/C.12/POL/CO/5, para 28.

<sup>31</sup> Concluding Observations, Human Rights Committee, 2004.

## G. Access to reproductive technologies

56. During the visit, the Special Rapporteur was informed about limitations regarding access to reproductive health technologies, such as in vitro fertilization, under the Protection of the Human Genome and Embryo Act. The draft law limits the number of eggs that can be fertilized through in-vitro fertilization to a maximum of two and prohibits the freezing of sperm or eggs. This reduces a woman's ability to become pregnant and also requires women to repeat hormone therapy to produce more eggs and undergo multiple in vitro processes, conditions which impose grave financial, physical and emotional risks for women and their partners. The draft law also prohibits pre-implantation testing and diagnosis, thus denying a woman's right to learn whether or not her embryo fertilized in vitro has defects. Consequently this contravenes existing Polish law which allows for pre-natal testing post-implantation. The Special Rapporteur calls upon the Government to review the draft law, with a view to ensuring that its provisions do not limit access to reproductive technologies, and facilitate women's access to infertility treatments.

## IV. Harm reduction policies and practices

57. Just as States parties to the Covenant on Economic, Social and Cultural Rights are obligated to respect, protect, and fulfill the right to health, they are required to find measures to prevent the spread of epidemics. In this regard, the right to health requires that all States, as a matter of priority, provide national, comprehensive harm reduction services to reach people who use drugs and other groups most in need. Moreover, general comment No. 14 of the Committee calls upon States to establish policy, budgeting, monitoring and accountability measures to support such services and to implement mechanisms to promote the informed participation of those most in need.<sup>32</sup>

58. The prevention and treatment of HIV depend significantly upon harm reduction measures adopted by States. Harm reduction can be broadly understood as the reduction of health and social harm associated with drug use.

59. Harm reduction strategies involve clean needle and syringe distribution, outreach and peer education, and condom promotion amongst people who use drugs and amongst their partners. It is now well established that harm reduction interventions include opioid substitution therapy, which is an extremely effective way to prevent HIV transmission and improve the lives of people who inject drugs.<sup>33</sup> Studies have indicated that patients under methadone maintenance treatment and buprenorphine substitution therapy are more likely to discontinue or considerably decrease their use of illegal psychoactive substances. Furthermore, harm reduction interventions are well supported and promoted by UNAIDS, WHO and UNODC in their best practice guidelines.<sup>34</sup>

60. The Special Rapporteur wishes to underline that national criminal laws and regulations have a significant impact on the success of harm reduction measures implemented in countries. National criminal laws need to complement harm reduction strategies and programmes. In this regard, criminal laws should not impede, but facilitate measures taken by States to reduce the transmission of HIV and to provide HIV-related care and treatment for people using drugs. Research has shown that criminal laws

<sup>32</sup> International Harm Reduction Association Conference, May 2008, address by Prof. Paul Hunt.

<sup>33</sup> Available at: <http://www.unaids.org/en/PolicyAndPractice/KeyPopulations/InjectDrugUsers/default.asp>.

<sup>34</sup> WHO, UNODC, UNAIDS Technical Guide for countries to set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users, *WHO 2009*.

proscribing syringe possession and promoting police practices targeting people using drugs increase the risk of HIV transmission and other health-related consequences, both directly and indirectly.<sup>35</sup> Furthermore, such laws are likely to create a fear amongst people using drugs of seeking treatment and other health-related services, further fostering unsafe practices and risky behaviour.

## A. National legal framework

61. In Poland the Act of Law of 2005 on Counteracting Drug Addiction provides the legal framework for monitoring drug possession and providing substitution treatment in Poland. It specifically lists as offences:<sup>36</sup>

- (a) manufactures, processes or converts narcotic drugs or psychotropic drugs or processes poppy straw (article 57)
- (b) imports or exports narcotic drugs, psychotropic substances or poppy straw (art. 55)
- (c) possesses narcotic drugs or psychotropic substances (art. 62)
- (d) cultivates poppy or cannabis (art. 63)
- (e) advertises or promotes a psychotropic substance or narcotic drug for purposes other than medical (article 68)

62. As it stands, the Act is especially restrictive in relation to possession of drugs. Drug possession, even in minute amounts, constitutes a crime and a punishable act. This is of particular concern, as, even though the purpose of the Act is to treat rather than punish, people undergoing treatment have occasionally been punished simply for possession of methadone.

63. Moreover, case studies regarding drug possession reveal that more than 55 per cent of cases in Krakow courts concern the possession of one gram of cannabis, and 70 per cent of the cases concerned possession of up to three grams, whereas only 17 per cent of cases pertained to amounts considered commercial, i.e. more than 3 grams.<sup>37</sup> This is in contrast to most European countries, where drug possession of up to three grams<sup>38</sup> is regarded as possession for private purposes.

64. The 2005 Act also lays down the basis and conditions by which people using drugs may be treated in accordance with the substitution treatment programme. A programme of this type may be provided by a health care centre licensed by the provincial governor upon the recommendation of the Head of the National Bureau for Drug Prevention. It establishes the following criteria for admission:

- Substitution treatment may be provided where a patient has been addicted to opioids for at least three years,
- Is 18 years of age or over,
- Conventional treatment attempts have failed,
- He/she promises to abstain from narcotic and psychotropic substances, and

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<sup>35</sup> Idem.

<sup>36</sup> Act of Law of 29 July 2005 on counteracting drug addiction (*Journal of Laws* 2005. 179. 1485).

<sup>37</sup> European Monitoring Centre for Drugs and Drug Addiction, 2008 National Report to EMCDDA, *Poland: New Development, Trends and In-depth information on selected issues*. p. 7-8.

<sup>38</sup> Ibid, p. 8.

- He/she expresses written consent to enter into such treatment.

Methadone is the basic substitute drug used and patients in the programme must receive psychotherapy and rehabilitation for at least two hours per week.<sup>39</sup>

## B. Drug use and harm reduction

65. There is a need for improved harm reduction measures to treat drug dependence in Poland. Studies indicate that drug use is most prevalent amongst men, as approximately 68 per cent of men and 32 per cent of women report drug use.<sup>40</sup> There are approximately 100,000-120,000 people using drugs and around 25,000-27,000 people using opiates. Marijuana and amphetamines are the most popular illicit substances. The age of persons using drugs ranges from 15-40.<sup>41</sup>

66. While the history of drug use in Poland dates back to the 1970s, it was not until the 1980s and 1990s that drug prevalence became of particular concern in Poland as the first case of HIV amongst injecting drug users (IDUs) came to light. Injecting drug use correlates significantly with infectious diseases such as HIV, Hepatitis C (HCV), and Hepatitis B (HBV). The spread of these infections is often facilitated by increased exposure to blood from sharing needles and syringes. Studies on infectious diseases and people using drugs indicate that HCV is far more prevalent amongst IDUs than HIV, as nearly 56 per cent of IDUs test positive for HCV and 32.5 per cent test positive for HIV. Only 70 per cent of people using drugs are tested for infectious diseases. Thirteen per cent of those testing positive for HIV are treated as compared with 10 per cent of those testing positive for HCV.<sup>42</sup>

67. In response to the need to address drug use, the Polish Ministry of Health established the National Bureau for Drug Prevention in 1993. The Special Rapporteur met with the Bureau's representatives and commends its efforts to provide programmes and measures to counter drug addiction and abuse. The Bureau has been committed to raising the quality of prevention programmes by establishing and supporting public education on drugs and treatment as well as working to improve treatment and rehabilitation of people using drugs, including harm reduction and social reintegration programmes. It cooperates closely with international institutions and organizations and supports the implementation of national programmes by adhering to international policies.

68. In cooperation with a number of non-governmental organizations (NGOs) the Bureau had successfully established a number of facilities for the treatment of drug use by 2007.<sup>43</sup> Eighty-five inpatient centres have been established, thirty-three of which admit underage patients. Furthermore, 295 outpatient centres (nine being day care centres) have been created including public and private outpatient facilities, hospital outpatient clinics, crisis intervention centres, mental health centres, consulting centres, nine day centres and 30 detoxification centres and wards.<sup>44</sup> Moreover, the Bureau intended to increase and

<sup>39</sup> Regulation of Minister of Health of 19 Oct. 2007 on Specific conduct procedure in substitution treatment and detailed conditions to be met by a health care unit which provides substitution treatment.

<sup>40</sup> Data submitted to Special Rapporteur on Health, 08-05-2009, Problem Drug Use in Poland Epidemiology, presented by the National Bureau For Drug Prevention.

<sup>41</sup> Ibid.

<sup>42</sup> Ibid.

<sup>43</sup> Data submitted to the Special Rapporteur on Health 08-05-2009, Drug Counteracting in Poland, by the National Bureau for Drug Prevention. pp. 5-6.

<sup>44</sup> Ibid, pp. 5-6.

further develop the availability of prevention and treatment for drug-related infectious diseases. In this regard, there has been an increase in safe-sex awareness through educational programmes advocating safe-sex practices and through the distribution of condoms. In addition, 2009 saw the development of the Drug and Narcotic Substances Addiction Prevention Programme – “Say STOP to Drugs” Early Intervention in Non-Adaptation Behavior, constituting an element of the Programme of the Ministry of the Interior and Administration on the Prevention and the Combating of Drug-related Crime within the framework of the National Drug Addiction Prevention Programme.

69. Drug addiction programmes have been relatively successful, as current trends show that there has been an overall decrease in the number of drug-related deaths and a trend towards stabilization in the number of new HIV infections amongst IDUs. Furthermore, there has been an overall decrease over the past few years in the number of admissions for inpatient drug treatment. However, while there has been an increase in the number of people receiving substitution treatment (1,531 as of May 2009), studies still indicate that only 14 per cent of people using drugs under medical supervision are receiving methadone treatment, while nearly 82 per cent under medical supervision receive no substitution treatment. Furthermore, it has been indicated that there has been a decline in the number of available needle and syringe programmes over recent years. For example, while there were 21 needle and syringe programmes available throughout the country in 2002, only 13 such programmes existed in 2008. The total number of people being treated by these programmes has significantly decreased and as of 2008, only 432,720 needles and 318,054 syringes were distributed in the country.<sup>45</sup>

70. Moreover, trends indicate that, while substitution treatment is available, a drug-free treatment regime is still prevalent within the country. This is of particular concern, as studies demonstrate that substitution therapy is a more efficient and less costly way to treat drug dependence.<sup>46</sup>

71. The Special Rapporteur however notes a significant improvement in this regard, as methadone is available in a number of cities throughout the country. In 2007, there were 15 substitute treatment programmes available in both public and private health care units and three new methadone programmes were launched (two of which are in Warsaw). Furthermore, the National Health Fund financed health services at 15 substitution treatment programmes in 10 provinces. In 2009, this Fund provided 17,747,307 PLN (approximately 6.3 million US\$) for financing substitution treatment programmes.<sup>47</sup> However, even though the National Drug Bureau aims at increasing accessibility of methadone to reach 20 per cent of those in need by 2010, sustained efforts must continue to ensure that methadone becomes more widely available and accessible. It is the right of everyone who is opiate-dependent to receive evidence-based treatment.

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<sup>45</sup> Available at <http://www.narkomania.org.pl/czytelnia/96,Pierwsze-ogolnopolskie-badanie-klientow-oraz-programow-niskoprogowych>.

<sup>46</sup> Evaluation of an opioid substitution therapy programme in the Kyrgyz Republic showed that treatment with methadone substitution therapy changes risk behaviour of patients, decreases crime, and increases the quality of life and self-assessed level of health. WHO (2009) Evaluation of opioid substitution therapy in the Kyrgyz Republic, p. 7.

<sup>47</sup> Data submitted to the Special Rapporteur on Health 08-05-2009, Drug Counteracting in Poland, by the National Bureau for Drug Prevention, p. 9.

### **C. Drug-free treatment centres**

72. During the mission, the Special Rapporteur visited Gdansk, where he met with representatives of the local Government and had discussions with representatives of civil society.

73. Despite the fact that the 2005 Act on Counteracting Drug Addiction provides for the establishment of substitution programmes, drug-free treatment - the therapeutic community model based on total abstinence theory - is the norm in the Tri-City region of Gdansk, Sopot, and Gdynia. There are nearly 310 places in the region for those in need, including both inpatient and outpatient treatment centres, and the regional government has allocated up to 7 million PLN (approximately 2.5 million US\$) to such drug free centres. As the therapeutic community model remains the standard in Gdansk, it is difficult for people requiring methadone treatment to receive the care they need in the area, and they must travel to Warsaw or Krakow to receive it.

74. The Special Rapporteur commends the decision of the local Government to start a methadone maintenance programme in Gdansk by September 2009, but regrets that, as of March 2010, the programme has not yet been established.

### **D. HIV/AIDS and harm reduction policies**

75. Although HIV was not a focus of the mission, certain observations that were made need to be noted. In this context, the need for improved harm reduction measures still remains of significant importance in Poland. Statistics provided in the Report of the National AIDS Centre reveal that since 1985, approximately 12,068 people have been tested positive for HIV, 5,476 being infected primarily due to injecting drug use. 962 people have died of HIV and AIDS-related illnesses and there are about 800 new HIV infections per year, 809 in 2008. Currently 3,603 people living with HIV (PLHIV) are being treated with antiretrovirals (ARVs) and the average age of PLHIV is 20-39, with 70 per cent men and 20 per cent women.

76. Moreover, there is significant concern that people do not take the risk of being infected with HIV seriously, that HIV infections are often diagnosed too late, that there is a permanent necessity to enhance availability of ARVs and that there are few and limited financial resources allocated to HIV prevention. As a result, there are few voluntary counselling and testing (VCT) centres and severe limits on the ability to finance programmes implemented by NGOs.

77. Due to the growth in the number of new HIV infections over the years, there is a real need to make treatment available and ensure that education regarding the epidemic is provided to the general population. In response to this need, the National AIDS Centre was established in 1993. The Centre has been responsible for the implementation of the National AIDS programme, which aims to reduce the spread of HIV around the country, improve the quality of life for people living with HIV and their families and ensure wide access to diagnostic and ARV treatment. In its implementation, the Centre targets those communities most at risk of HIV, such as sex workers, men who have sex with men, and women and children. Furthermore, it supports the work of NGOs and funds 22 out of 27 VCT centres around the country. The Special Rapporteur welcomes the work undertaken so far and encourages the Government to further strengthen its engagement by providing additional support for the implementation of such programmes and activities.

78. The Centre also seeks to raise awareness at the community level regarding HIV and AIDS. It hosts workshops for doctors, nurses, teachers, VCT counsellors and mounts campaigns, to promote safe sex, use of condoms and other harm reduction

techniques. Education and awareness programmes target people within the 18-35 age group, those who travel, are sexually active, and specifically targets groups most vulnerable to HIV, such as women and children, members of lesbian, gay, bisexual and transgender communities, people using drugs, street workers etc.<sup>48</sup> This includes the dissemination of appropriate information relating to health, availability of services, and supporting people in making informed choices regarding their health.

79. The Special Rapporteur commends the Government's commitment to ensure access to the necessary ARVs for people living with HIV. Through the support of the Ministry of Health, the Government has made sustained efforts to comply with its obligation to make the necessary ARVs available to the population. However, while most funds are spent on treatment of HIV, there is still concern that there remains a gap in available funds and work on HIV prevention. This impacts prevention services including harm reduction measures. In this regard, there is a need to scale up prevention services, including harm reduction services.

80. Furthermore, the Special Rapporteur notes with satisfaction that the Government recognizes that there is a stigma associated with HIV and that people living with HIV (and those perceived to be HIV positive or at risk) face discrimination and continue to be marginalized in society at large. Moreover, the Special Rapporteur commends the development of the educational and campaign programmes and the efforts of the National AIDS Centre to collaborate with different NGOs to raise awareness about HIV and AIDS and address issues relating to stigma and discrimination. However, it is important to realize that the fundamental basis for human rights and the right to health is embedded in the principle of non-discrimination and equality. With this in mind, there is a need for such educational programmes to be aimed at the inclusion of at-risk groups in society. It is therefore necessary to reiterate that medical services and goods are available and accessible to all on the basis of equality and non-discrimination, regardless of one's health or other status. This can be achieved by ensuring the participation of people living with HIV and those most at risk in campaigns.

## V. Conclusions and recommendations

81. **In accordance with its obligations under international, regional and national law, Poland is committed to the realization of the right to health. General comment No. 14 of the Committee of the International Covenant on Economic, Social and Cultural Rights provides that Governments make health facilities, goods and services available and accessible on the basis of non-discrimination and equality. It further requires that health services be acceptable and of good quality. In this regard, Poland has made a significant commitment towards the availability of services and medicines for all on the basis of non-discrimination, and, with the development of the National Health Fund, medical services for the population have been widely funded.**

82. **The enjoyment of the right to health, however, still requires the full participation of all groups at the national, regional, and local level of programme and policy making. Moreover, States are required to ensure that health-related information and education be provided and that harm reduction measures be incorporated into national policies and legislation. Despite Poland's achievements to ensure the availability of health-related educational information and advancement of harm reduction policies, it is clear that issues regarding sexual and reproductive**

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<sup>48</sup> Report of the national AIDS Centre 2009.

health rights, especially those in respect of access to legal abortions, and regarding HIV and harm reduction still raise concerns.

83. The Special Rapporteur notes with concern that the 1993 Act on Family Planning revoked the grounds for termination of pregnancies for economic and social reasons, resulting in an increase in unsafe, clandestine abortions. Furthermore, doctors invoking, both formally and informally, the conscientious objection clause, refuse to perform abortions and legal and appeals procedures for women seeking abortions still remain elusive and complicated. Sexuality and reproductive health education in schools often neglects the importance of safe sex and the need for contraception and hence need to be revised.

84. In the context of harm reduction policies the Special Rapporteur notes with concern that the Law on Counteracting Drug Addiction penalizes even the possession of very small amount of drugs, making it difficult for people to receive necessary substitution treatment.

## Recommendations

85. The Special Rapporteur urges Poland to consider the following recommendations in the area of sexual and reproductive health rights:

- (a) Adopt a comprehensive strategy for the promotion of rights to sexual and reproductive health, promote dialogue on rights to sexual and reproductive health in public health policies, and increase investments from the national budget to improve sexual and reproductive health services and information.
- (b) Adopt mandatory, age-appropriate, comprehensive, science and evidence-based, non-discriminatory and gender-sensitive sexuality education taught by appropriately trained personnel, including non-judgmental information and education on healthy relationships and family life, sex and relationships, and comprehensive sexual and reproductive health.
- (c) Enact legislation enabling minors to consent to certain procedures on a case-by-case basis, depending on their maturity and understanding of the procedure and its risks.
- (d) Guarantee women's effective exercise of their right to the highest attainable standard of health, including access to safe, acceptable and affordable abortion services by ensuring that health care facilities have an established protocol for the provision of abortion and abortion-related services.
- (e) Establish effective and transparent monitoring and accountability mechanisms in the context of access to sexual and reproductive health-care services, including abortion; particularly, establishment of an appeals mechanism in accordance with the ruling in the case of *Tysic*.
- (f) Through appropriate regulation, establish a mechanism whereby a medical professional invoking the conscientious objection clause is required to refer patients to a practitioner who will perform the required procedure.
- (g) Ensure rights to sexual and reproductive health counselling services to support women;
- (h) Improve accessibility and affordability of all forms of contraception by subsidizing contraceptives to underserved groups such as youth and the unemployed, and by allocating sufficient public health funds for sterilization

procedures and other modern methods of contraception, through incorporating such allocations into the country's annual appropriations act.

- (i) Improve information and counselling on contraception within the public health-care system including promotion of all forms of family planning and modern methods of contraception.
- (j) Investigate and conduct research on the scope, causes and consequences of illegal abortion and its impact on women's health and lives; and on the basis of such research take appropriate legislative and other measures to improve the realization of women's right to health.
- (k) Effectively regulate the practice of conscientious objection to ensure that access to safe and legal abortion, contraception and other sexual and reproductive health services is not restricted. Such regulation should include the obligation of the State to have providers available who do not invoke the conscientious objection clause, to ensure adequate referral systems, and the provision of termination of pregnancy in emergency situations.
- (l) Review the law concerning assisted reproductive technologies, and in doing so, ensure that any regulation of such technologies does not impose limitations on women's access.
- (m) Introduce regulations that require physicians to provide timely prenatal examinations and termination of pregnancies as permitted by law, and which provide a thorough, fair, transparent and effective investigation process in circumstances where physicians fail to provide adequate and timely medical care.
- (n) Fulfil the obligation to protect the right to health, through prevention of interference by non-State actors in the decisions of individuals concerning their own health care.

86. The Special Rapporteur urges Poland to consider the following recommendations in the area of harm reduction policies and practices:

- (a) Ensure that needle and syringe programmes, opioid substitution therapy and other harm reduction strategies become widely available throughout the country.
- (b) To establish, without further delay, an opioid substitution programme in the Tri-City region of Gdansk, Sopot and Gdynia.
- (c) Amend the National Law on Counteracting Drug Addiction to avoid penalization of the possession of minute quantities of drugs, in order to foster access to substitution therapy for people using drugs.
- (d) Ensure the informed and active participation of people using drugs and other marginalized groups at the national, regional, and local level in the establishment of policies and programmes.
- (e) Include the participation of people living with HIV and those groups most at risk of HIV in HIV/AIDS-related educational projects and campaigns.
- (f) Ensure the enactment and implementation of a comprehensive anti-discrimination and equality law to help ensure the full enjoyment of the right to health, based on equality and non-discrimination within the State.