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Defining HIV Risk and Determining Responsibility in Postsocialist Poland:

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Abstract

Drawing on 15 months of ethnographic research on HIV prevention programs in Poland, I explore the consequences of the shift from models of HIV prevention that emphasize "risk groups" and AIDS blame, to models that focus on "risky behaviors" and universal risk. The centrality of choice making and individual risk management in these models suggests objective risk assessment free from moralizing arguments. The Polish national prevention strategy shifted to focus on choice making, address all risk groups, and include concrete prevention strategies. This shift created a backlash that resulted in the reassertion of moral arguments about risk and risk groups that positioned those most vulnerable to HIV outside the purview of prevention efforts. AIDS organizations working with marginalized, "morally problematic" populations used the label "at risk" to legitimize claims to resources. They enacted a model of risk reduction in which the relevant actor is the individual buffeted by social forces, and behavior change, and therefore HIV risk reduction, is a long process because of myriad forms of vulnerability clients face. Despite efforts to reconceptualize risk, organizations positioned the individual as the locus of HIV prevention interventions, rather than attempting to address the social context that shapes risk.

Keywords

HIV prevention; Eastern Europe; definitions of risk

A group of 15 medical students, physicians, biologists, and educators sat in a wide semicircle at an HIV/AIDS education workshop, held outside Warsaw in 2004. Facilitators handed out strips of colored construction paper on which they had written various sexual acts. On the floor, they placed five pieces of construction paper with the labels, "No Risk,' "Theoretical Risk/None Documented," "Low Risk," "High Risk," and "Don't Know/Need More Information." They asked participants to place each sexual act in the category corresponding to the risk of HIV infection each act posed. At the end of the exercise, the group determined that "necking" and "dry kissing" presented no risk for HIV infection; "fingering" and "penis touching" presented a theoretical risk; oral sex presented a low risk; and vaginal sex and sex after using alcohol or drugs presented a high risk. Participants placed "sex within marriage" and "sex with girlfriend" in the "Don't Know" category. At workshops conducted by different organizations, facilitators listed other potential modes of infection, including masturbation, "jerking off parties," sex between a husband and wife, sex between two women, using erotic toys, and sharing someone's shower shoes or eating utensils.

Facilitators' lists reflected what they thought were the participants' gaps in knowledge, misinformation about HIV transmission, and target populations with which participants would presumably work. At the end of the exercise, participants had a clearly organized, visual picture that represented risk of HIV infection as objectively linked to specific behaviors. At the beginning and end of the exercise, facilitators reminded participants that there are no "risk groups," only "risky behaviors." This exercise, however, lacked any discussion of specific strategies of risk reduction, such as how to negotiate condom use, strategies for incorporating low-risk behaviors into sexual relationships, or how to avoid risky situations altogether. For participants, presumably, simply possessing knowledge about risk was sufficient to make the right decisions to avoid HIV risk themselves and educate others about how they could avoid risk infection.

This particular workshop took place as part of cooperative HIV prevention and education efforts of governmental and nongovernmental organizations in Poland. As with other similar workshops, it was sponsored by the Polish National AIDS Center (NAC), and facilitated by representatives from an NGO.[1] Despite a diversity in organizers and participants, all the workshops used a similar exercise to discretely and hierarchically organize risk of HIV infection. This model of risk and prevention links HIV risk to specific behaviors and supports the idea that knowing about these risks constitutes sufficient prevention. It also obscures the contested nature of risk, specifically how various organizations and institutions both define HIV risk and mobilize these definitions in prevention efforts outside the context of these workshops.

This article contrasts how two organizations—the NAC and the gay rights and support organization Lambda-Warsaw—define their target populations and notions of risk. Since 1999, the NAC has represented the foremost Polish institutional authority and funding source regarding HIV prevention and care for people living with HIV/AIDS. Since the mid-1990s, Lambda-Warsaw has worked to "build a positive identity among lesbians, gay men, bisexuals, and transgender individuals, and create social acceptance of them." In pursuit of this goal, Lambda offers support groups, discussion groups, counseling services, social clubs, and HIV prevention programs. I approach the question of HIV risk and the concept of risk more generally from the perspective of who is determined to be "at risk" for HIV in an era when there are no risk groups, only risky behaviors. Tensions between AIDS-blame models of risk and risk reduction that focuses on individual risk management raise questions about how organizations can argue that their constituents are at risk—as a means of gaining access to scarce prevention resources—while negotiating complex discourses of blame, stigma, morality, and responsibility.

Risk, HIV, and Postsocialist States

The first case of AIDS in Poland was registered in 1985, and by 1989, on the eve of socialism's collapse, the number of HIV cases had grown to 721. Today, just over 12,000 cumulative cases have been documented, and about 700 new cases of HIV are diagnosed each year. Consistent with trends under socialism, the majority occurs among intravenous drug users, but new infections through both heterosexual and homosexual contact have risen slowly throughout the 1990s and 2000s (Państwowy Zakład Higieny 2007). The HIV

epidemic in Poland is more stable than in other postsocialist contexts, such as Russia, where HIV rates skyrocketed after the collapse of socialism and have remained high.

Understanding HIV risk is a central concern in developing effective prevention strategies. Proliferation of risk discourses, techniques of risk management, and theoretical engagement with the concept of risk raise questions regarding the "meanings and strategies constructed around risk" (Lupton 1999:13). Who is and is not seen to be at risk has implications for what types of prevention messages are offered and to whom they are targeted. Public health institutions label groups as "at risk" to determine the direction of epidemics, allocate resources for vulnerable populations, and conscript members of these groups into action against a health threat (e.g., Briggs 2003). Prevention and surveillance based on "risk groups" reify boundaries between populations and reinforce the idea that those positioned outside these risk groups are not vulnerable to infection (Kane 1998:5). In the 1980s and 1990s, institutions such as the Centers for Disease Control in the United States and gay-rights organizations saw the impact of HIV on women in general and women of color in particular as minimal. As a result, funding privileged gay (white) male bodies and prevention efforts targeted them, to the exclusion of others (Giffin and Lowndes 1999; Susser 2001; Treichler 1987, 1999). In addition to becoming a recipient of public health resources, being labeled "at risk" for HIV, particularly by others, also invites accusations of blame and threat to the well-being of others, as well as stigmatization (e.g., Farmer 1992; Glick Schiller et al. 1994). Prevention efforts targeted at populations already marginalized as deviant, such as gay men and injection drug users, link HIV risk and clearly demarcated risk groups, based on stereotyped behavior within "risk groups." "Risk groups" exclude the general public from HIV risk, and the stigma attached to the label "at risk" can be deployed for political or moral purposes (Briggs 2003; Kane 1993:226). This model of HIV risk, which dominated HIV prevention and education efforts throughout the first decade of the epidemic, utilizes "AIDS-blame" in exclusionary and moralizing rhetoric (Brown 2000:1280).

Discovery of HIV as the causative agent of AIDS precipitated the presentation of risk as universal, based on biological agents and individual decision making. This focus strengthened the notion that AIDS is everyone's problem (Lane et al. 2004), functioned to break the association between homosexuality and AIDS, and challenged moral arguments and discourses of blame against gays (Terto 2000:69). Universal risk translates into prevention programs with general messages that appear to neutrally provide information equally useful to everyone, regardless of gender, sexuality, ethnicity, or class. These messages often employ scientific language and avoid moralizing arguments (Pigg and Adams 2005).[2] More specifically, these apparently neutral messages come in the guise of the objective "risk" associated with particular sexual acts (Fee and Krieger 1993), as in the exercise at the Polish workshops

The focus on universal risk and objective risk calculation reflects a shift away from AIDS blame to a model of risk reduction based on behavior, personal responsibility, and individual risk management (Brown 2000:1280). Together, the label "at risk" and focus on individual decision making lend themselves to a narrow, biomedical interpretation of what creates risk. Prevention resources are allocated for programs that target a narrow range of factors that

contribute to risk, such as behaviors, to the exclusion of other aspects of risk, such as socioeconomic status, discrimination, social vulnerability, and gender inequality. Rational risk management as a prevention strategy suggests that if a person receives complete information regarding HIV risk, he or she can and will take the appropriate action—through rational decision making and self-reflection—to reduce, eliminate, or mitigate these risks (Adkins 2001; Brown 2000; Lupton 1999; Wallack and Winkleby 1987). In this model, individuals are responsible for social risks, including illness, poverty, and unemployment (Beck 1992; Lemke 2001:201; Lupton 1995; Rose 1993). At the same time, objective risk calculation works to destigmatize "risk" and offers new possibilities for strategically mobilizing the label "at risk." In contexts of social, political, and economic upheaval, groups may draw attention to themselves as vulnerable to ill health or poverty, or "at risk," as a means of advocating their need for resources (e.g., Paley 2001; Petryna 2002; Verdery 1996).

On the one hand, economically or socially marginalized groups or individuals can use risk assessment and management as strategic resources to navigate the multiple threats to their welfare that they face on a daily basis. One's ability to assess, manage, and avoid risk can denote a person's agency (although confined to choice making within a limited set of options; see Roche et al. 2005). For example, harm reduction, developed in the context of injection drug use, purports to avoid moralizing about drugs and drug users, support drug users as "active" decision makers in their own lives, prefer pragmatic solutions over abstract ideals, and to be value free (Keane 2003; Miller 2001). This paradigm originated in the 1960s and 1970s as activists, physicians, and policymakers sought to end the oppressive treatment of drug users and addicts (Roe 2005:243). Suggesting that injection drug users possess the same valued qualities as other citizens offers a powerful tool in countering the stigmatizing depictions of them as diseased and irresponsible to themselves and others (Moore and Fraser 2006). Proponents of harm reduction see this approach as a counter to the highly moralizing rhetoric at the center of most debates on drug use and sexuality. Promoting a subject who exercises agency by acknowledging, confronting, and taking steps to reduce the risks she faces can also serve as a method of empowerment that deliberately draws on notions of individual risk management (Paiva 2000).

On the other hand, in this charged landscape, a commitment to neutrality itself becomes a moral position (Keane 2003). In fact, harm reduction is often couched in narratives of individual autonomy and agency, rationality, and self-regulation, all attributes of the "good citizen" at the core of neoliberal governance (Fraser 2004). Models of risk and prevention that focus on individual behavior change and risk management, including harm reduction, have increasingly come under criticism for their failure to document sustained, long-term changes in risk behavior (e.g., Campbell 2003); address structural factors that produce HIV risk (e.g., Farmer 1999; Parker et al. 2000); or create social environments that enable prevention strategies to be enacted (e.g., Campbell et al. 2007; Kelly et al. 2006; Susser 2001). Bourgois (2000:173), for example, argues that methadone substitution programs are a "technocratic magic bullet" applied to resolve myriad social, economical, and human problems. Furthermore, the "responsible individual" often becomes the target of blame, in addition to the target of services and aid (Fraser 2004:216).

In short, although anthropologists have long recognized "risk" as a social construct (e.g., Douglas and Wildavsky 1982), the label "at risk" is also a resource. When applied to others, it reinforces moral social orders that excluded groups deemed to be deviant. It can also be used as a self label, as a means of procuring health resources. These definitions of who is at risk raise questions, then, of how different interpretations of risk are mobilized and incorporated into public health programs. When risk is constructed as being eliminated or reduced through individual risk management, prevention programs often focus on behavior change and knowledge procurement, to the exclusion of addressing structural factors that shape risk. It also raises questions about how so-called "deviant" groups, who apply the label "at risk" to themselves, define risk and mobilize these definitions in their prevention programs.

Methods

The ethnographic research on which this article is based focused on HIV prevention programs in postsocialist Poland as conduits for cultural and political discourses of risk, responsibility, and morality. Conducted between September 2004 and November 2005 in Warsaw, Poland, it drew on participant-observation, qualitative interviews, archival research, and institutional histories. Participant-observation was conducted at a number of venues, including the weekly HIV prevention programs of two NGOs, the gay rights and support organization Lambda-Warsaw, TADA, which targets commercial sex workers. Time was also spent at MONAR, which works with injection drug users.[3] Participant-observation was also conducted at four overnight HIV education workshops held by different organizations. Qualitative interviews, including key informant, informal, and semistructured interviews, were conducted with 40 people working on HIV and its prevention in Poland. Interviewees included staff and volunteers at NGOs with HIV prevention programs, physicians working with people living with HIV/AIDS, and representatives from the NAC. Others with histories of engagement with HIV were also interviewed, including several playwrights who wrote and produced theatrical productions dealing with HIV/AIDS, an independent consultant who assisted NAC staff, staff at an advertising agency that created several HIV/AIDS awareness campaigns in collaboration with the NAC, and people who had independently conducted HIV prevention education during the late 1980s and early 1990s. Interviewees were recruited directly through participant-observation at NGOs and workshops, and indirectly through these interviewees and others familiar with the research project.

The interviews consisted of open-ended questions about individuals' own histories of involvement with HIV prevention; perceptions of success and failures of HIV prevention in Poland; and the role of various institutions in HIV prevention. Sample questions included, "Please tell me about how you came to this organization and why you decided to dedicate your time to this particular health issue," and "What do you see as the most challenging aspects of work in this organization?" Interviews were conducted by the author in English or Polish, depending on the preference of the interviewee; they were recorded when permission was given. Polish interviews were transcribed into Polish by a native Polish speaker, and English interviews were transcribed by the author. IRB approval was obtained for the project and informed oral consent was obtained for interviews and participant-observation.

Archival research at several libraries, including the National Library, the Warsaw University library, and the libraries of NGOs focused on newspaper and other articles written about HIV, HIV prevention, sexuality (particularly homosexuality), and drug addiction from the early 1970s to the present. These news sources elicited the narratives that were constructed around HIV/AIDS, prevention, and risk–risk groups from Poland's socialist past through today. Field notes, interviews, and archival materials were coded and analyzed thematically using Microsoft Word, focusing on messages of risk, approaches to HIV prevention, perceptions of effectiveness, targets of outreach, and histories of involvement in HIV prevention.

The National AIDS Center and Prevention Messages

In Poland, HIV prevention messages, campaigns, and programs come from diverse sources, including the NAC, regional and city initiatives, and NGOs. The national program falls under the Ministry of Health, and coordinates the HIV prevention efforts of governmental and nongovernmental agencies. Its mandate includes overseeing HIV prevention, educating society about HIV, and ensuring integrated care for people living with HIV. The NAC is the sole institution through which the allocated budgetary resources from the Ministry of Health are distributed. Despite a series of reforms in the postsocialist era, the Polish health care system is chronically underfunded, and economic decline has led to a decreased availability of funds for all public health programs. HIV/AIDS prevention competes for funds with public blood service, capital expenditures in hospitals, pharmaceuticals, and other health policy programs and services. Unfortunately, HIV prevention and treatment fall low on the list of priorities when budget decisions are made. The biggest challenge for HIV prevention in Poland, however, stems from the decrease in funds for prevention as the cost of treatment and care rises. In 1999, 25 percent of NAC funds, or €2.5 million, was allocated for prevention. By 2002, the percent of total funds available for prevention had declined to 13, or €1.6 million (Daniluk-Kula 2002). Although this budgetary reallocation means that Poland boasts free access to the most current HIV medications, HIV prevention efforts see increasingly limited funds as the cost of care for HV infected people rises and the number of new infections increases.

With its decreasing budget for prevention, each year the National AIDS Center develops a new campaign with a different target audience, based on Polish and international epidemiological data. Beginning in 2001, these campaigns focused on persuading people to get tested, rather than promoting ways to prevent exposure, such as through condom use or engaging in alternative forms of sexual intimacy besides penetrative intercourse. These campaigns targeted heterosexuals (including youth, women, and couples), either in their imagery and language, or in official letters from the NAC describing their development. The 2001 campaign, for example, pictured the "modern" Polish woman in multiple roles—businesswoman, mother, wife—but possibly infected with HIV through the past and unknown (to her) relationships of her husband. It read, "I also may be infected without knowing it." The 2003 campaign, directed at heterosexual couples, depicted a young man and woman engaged in conversation as they sat on a couch. The campaign simply urged its audience to talk about their sexual histories, warning that "the past might be dangerous." The 2004 campaign targeted heterosexual women and featured a series of billboards with

true–false questions that sought to challenge people's beliefs about HIV infection, such as "I'm faithful to my partner and that's why I am certain that I don't have HIV" and "I choose my partners carefully so AIDS doesn't threaten me." The television and radio spots ended with, "An HIV test: the one way to be sure."

In 2005, the NAC launched a campaign based on the ABCs of prevention (**A**bstain, **B**e faithful–reduce partners, use **C**ondoms), arguing that data from Poland, consistent with global trends, indicate that sexually active youth and heterosexual women are increasingly at risk for HIV.[4] Worldwide, the ABC prevention strategy has garnered support based on the supposed success of this program in reducing the number of sexually transmitted infections in Uganda (Halperin et al. 2004). Globally, religious, political, health and scientific leaders have endorsed this prevention message because it purportedly presents diverse strategies for protecting oneself that can be useful to diverse segments of a population (Moran 2005).[5] As the Polish version of the ABC campaign got underway, billboards touting the ABC's of prevention in bold blues, greens, and reds sprouted throughout Warsaw; print ads appeared in popular newspapers and magazines throughout the country; and animated spots were shown in movie theaters and on television. The campaign's central message advocated that each person choose the appropriate strategy of risk reduction to render HIV no longer threatening. The 2005 ABC campaign marked a significant departure in the NAC's prevention messages because it included concrete strategies for reducing HIV risk, seemingly addressed everyone in its gender-neutral imagery and language, and integrated condom use into its message.

With the development of the ABC campaign, representatives of the National AIDS Center expressed reservations about how it would be received by the Catholic Church. It was an election year and one employee of the NAC worried that the campaign would bring the attention of Catholic, conservative politicians who determined the funding and status of this organization. People often expressed fear that if the NAC's HIV prevention messages became too explicit and morally controversial, conservative political actors might shut it down as part of a broader political agenda. The NAC's public promotion of the ABC campaign, therefore, minimized condom use as a key element of the "ABC" strategy. The director of the NAC emphasized at the press conference commencing the campaign that the ABC strategy presented an opportunity for "every group to choose something for itself." Other panelists echoed this call with statements such as, "We don't want to moralize. It's your choice." However, Father Nowak, an internationally recognized and nationally championed Catholic priest who has served as an advisor to the National AIDS Center since its formation, described the campaign as a compromise. He asserted that condoms do not guarantee protection from infection, but allow a person to choose between avoiding risky behavior (not having sex, protected or unprotected) or decreasing risk (by having sex protected with a condom). Instead, he promoted a "healthy lifestyle" to avoid infection through faithfulness. From his perspective, HIV infection results from particular types of behaviors and decisions. Condoms, he argued in an interview with a popular women's magazine, may reduce risk but do not guarantee complete protection from infection. Because one can never be sure if a potential sexual partner has HIV and because condoms do not guarantee protection, one should avoid sex before marriage, simultaneously adhering

to Christian values of fidelity, making the morally correct choice, and avoiding HIV (Domagalik 2005:64).

The ABC campaign was also criticized by conservative elements within the Catholic Church. An article that appeared in the conservative Catholic newspaper *Nasz Dziennik* criticized the ABC campaign for failing to address the moral foundations of all human behavior:

> Presenting abstinence and fidelity on the same level with condoms (even if they were an effective solution) as AIDS prevention methods is a complete error of ideas, a demoralization directed at people between 18 and 29 years of age, who are the campaign's target audience. No demands are made, and immoral solutions are proposed as equivalent to a life of celibacy, which should be a goal to achieve, always in place, not only a means to an end. [Lewandowicz 2005]

The author further accused the National AIDS Center of "deprecating marriage," promoting adultery, and threatening the Catholic values of abstinence and faithfulness. From this perspective, presenting condoms as a choice among several for preventing infection undermines the foundations of a Catholic and moral life.

Similarly, at a church-sponsored debate about HIV prevention held in 2005 and attended by the author, a Polish expert argued that in Uganda, the ABC message encouraged people to go to church and put up posters of people suffering from AIDS. He asserted that these acts alone, rather than increased condom use, had been enough to prevent the spread of HIV. He echoed the argument made in the Catholic newspaper that promoting condom use condones sexual promiscuity. The discussion that followed the expert's presentation, rather than focusing on HIV/AIDS more generally, deteriorated into a series of comments about the immorality of homosexuality and the importance of religion to protect society from its harmful effects. Some speakers pondered if gay men and lesbians could be the product of "good Catholic families." Within the antigay context of the debate, the three pillars of the "ABC" HIV prevention strategy were reduced to two, as any benefits of condoms were denied.

In response to these criticisms, the NAC changed its prevention campaign strategy yet again the following year. The campaign targeted heterosexual couples with children and focused on promoting "family values" through the campaign. The billboards depicted a mother, father, son, and daughter in color-coordinated shirts, leaning against one another as they sat on the lawn outside their home. The slogan, "Love. Faithfulness. Trust. The family together against AIDS," reflected the NAC's message that the campaign would promote a model of the family in which the relationship between two people is based on mutual love, faithfulness, and trust, and in which there is no place for "risky behavior." This new campaign signaled the morally problematic nature of discussions of sexuality and choice in the context of HIV risk reduction, and clearly defined who was not included to be either "at risk" or participating in the fight against HIV.

Redefining Risk and Responsibility

The backlash against the ABC campaign illustrated that HIV prevention messages that in some ways encompassed "everybody," including gay men, were unwelcome. It also suggested that HIV prevention campaigns can position certain segments of the population as outside the purview of prevention efforts. Such exclusion, however, creates room for the development of alternative interpretations of risk and responsibility, particularly within NGOs working with populations both historically excluded from public campaigns and stigmatized by HIV. Since the advent of HIV/AIDS in Poland, links were made between so-called sexual deviance, immorality, and HIV/AIDS. The socialist government determined gay men to be both at risk for HIV and a threat to the general Polish population. Depicting gay men as parasitic, criminal, hermetic, overly sexual, and a threat to "normal" Poles—and linking these pathologies to HIV—served as the basis for surveillance and state-sponsored repression of gay men. In the mid-1980s, functionaries of the Citizens' Militia entered into schools, universities, and workplaces, and took men suspected of being gay to police headquarters. The men were questioned about their sexual contact with others, forced to sign documents declaring their homosexual activity, and persuaded into cooperating with the secret police (Kopka 1986:13). Files were made that included fingerprints and photographs. Organizers of these now famous Hyacinth action used HIV/AIDS as a pretext for this action. They argued that it was necessary for the Citizens' Militia to maintain an interest in "particular sexual tendencies" as a means of protecting society from the danger of AIDS (Œwieczyński 1988). Those active in the gay community at the time, however, countered that the action was undertaken to destroy the birth of a gay-rights movement in socialist Poland.

Despite these negative associations between homosexuality and AIDS, in the late 1980s and early 1990s fledgling gay organizations deliberately drew attention to the links between homosexuality and AIDS in their efforts to advocate for increased rights and encourage public dialogue about the issues gays face in their daily lives.[6] One leader of the early gay-rights movement highlighted the lack of visibility of homosexuality prior to AIDS in Poland when he commented, "We had to get sick … in order to find ourselves in front of the television cameras" (Szczygiel 1989). Recognizing the power of AIDS as a tool to mobilize resources and incite people to action, gay-rights organizations made HIV prevention and awareness education central pillars of their newly formed organizations. Lambda-Warsaw emerged as a formal organization from its informal predecessor "Rainbow," when it began conducting HIV prevention activities among lesbian, gay, bisexual, and transgender (LGBT) people with the support of the United Nations Development Program in 1997. Two of Lambda-Warsaw's four main goals were dedicated to HIV: to promote behavioral guidelines to prevent HIV and to cooperate with social and governmental organizations in the field of HIV prevention and fighting AIDS in general (Adamska 1998:101). The other two goals were promoting social tolerance toward homosexuality and forming a positive self-identity among gay men and women. From its beginnings, therefore, Lambda-Warsaw linked HIV prevention and the promotion of tolerance toward LGBT people.

Safer Liaisons: Defining and Serving the Gay Community

Today, "Safer Liaisons" constitutes Lambda-Warsaw's most active and enduring HIV prevention program. The Safer Liaisons program combines a "drop-in center" with street-level outreach ("streetworking").[7] The drop-in center offers clients psychological counseling, doctor's consultation, and legal advice. It also provides food, drink, and conversation at designated times each week, and serves as the distribution point for lubricants and condoms, including some purchased with the funds from the municipality and others donated by the National AIDS Center and private businesses. Significantly, the NAC does not fund this organization's HIV prevention program (apart from its occasional workshops) because it only funds national prevention initiatives, and the Lambda program is only regional in scope.[8] According to one interviewee, relying on municipal funds is strategically more beneficial because the municipal government has a larger pool of money dedicated to prevention in the region than would be available from the NAC.

Each week at the drop-in center, a group of between 5 and 15 young men, mostly in their early twenties, some of them sex workers and others not, gathered in Lambda's small community room. For two hours, they ate, drank, listened to music, read magazines, browsed the internet, chatted about things such as television and what they did over the weekend, and received one-on-one counseling with a trained psychologist. At the end of each meeting, clients received "safer sex" materials, such as condoms and lubricants, but without, for example, discussions of how to negotiate their use with sex partners.[9] Staff recorded the numbers of each in a ledger that they later gave to funding agencies. The streetwork component consisted of teams of usually two (one male and one female) trained counselors who went out to gay clubs and the streets where prostitutes work to hand out information and talk with clients. Counselors discussed HIV/AIDS and sexually transmitted disease education, as well as education about workplace safety, and how to access other social services and forms of institutionalized social assistance.

The format of this program reflects that staff saw HIV risk as shaped by social factors such as social status, peer group influences, material situation, education, and age. Staff also saw other factors as contributing to HIV risk, such as individual psychology, including lack of self respect, lack of a sense of purpose, internalized homophobia, mentally dividing partners into "safe" and "dangerous," lack of knowledge about HIV/AIDS and degrees of risk associated with various behaviors, and belief in one's own resistance to infection. The suggestion that HIV risk results from a broad range of factors—independent from one's sexual identity—was a common way through which volunteers, employees, and directors of this program understood their work. Although staff recognized their clients' vulnerability to infection through their behaviors and the decisions they made regarding sexual encounters, they also addressed the myriad problems that clients face on a daily basis. Grzegorz, one of the founders of such a program, made the following assessment of risk and prevention when I asked him about the organization's clients and program format:

> Everything is very connected. For example, the problematics of employment. In case you don't have a job, you are marginalized—unemployment. The problematics of the unemployment market. So everything is connected. We can't only work for HIV prevention or unemployment or something like that. Everything

> here is connected. They [the clients—JO] are not well educated, they have no job, they practice risky sexual behaviors, they sometimes work as sex workers, they are homeless, they have no friends, very often they are mentally ill. We are sure about it. That is a problem. I think that we need to treat them holistically. [Interview 2]

In his view, vulnerability to HIV existed as one of many threats with which clients struggle, from unemployment to procuring shelter, and saw these myriad problems as potentially contributing to HIV vulnerability.

One woman in her early thirties who had been working in HIV prevention at a second NGOs —but with many of the same clients and a similar format—told me, "We do less prevention. Of course we remind them [the clients] about the principles of safety, etc. However, generally we look after our clients" (Interview 29). Beata, who worked for several years in two different HIV prevention programs based on harm reduction among sex workers, similarly assessed her work and effective prevention. She described one program as taking care of clients' material, social, and psychological needs:

> This is HIV/AIDS prevention conducted in the method of streetworking, based on stationary and external counseling. Here … HIV prevention directed at men having sex with men and other men has a very wide range. We don't only educate but also try to act on changing the attitudes of these people, support them in some difficult situations, shape their attitudes. And that's associated with that—that we have to do a lot, yes, because they frequently don't take care of themselves because they have different problems of a psychological, material, economic, and social nature. And it's necessary to be concerned with all of these things in order to lead them to being able to take care of themselves in the context of HIV/AIDS. Yes, it's a really widely comprehensive action. [Interview 11]

For Beata, the comprehensive nature of the prevention program constituted its defining feature.

Consistent with the notion that there are no "risk groups," only "risky behaviors," when asked why particular people are "at risk" for HIV infection, volunteers of these HIV prevention programs were quick to point out that everyone is "at risk" for HIV. As one informant responded when asked who is at risk for HIV:

> Everyone. Everyone who has sexual contact without protection; everyone who does not know how to use condoms or other protection; everyone who has sexual contact but with protection; everyone that injects drugs. Everyone and it is independent of whether it's a man or a woman. Some more, some less, of course, but it's independent of sexual orientation. [Interview 9]

Andrzej, one of the founders of Lambda's HIV prevention program noted, however, that the notion of universal risk is problematic:

> As you know, right now we are saying that there are risky behaviors and not risk groups. But at the same time we know very well that there are risk groups. Of course other people can be infected and it depends on their sexual behavior, for

> example, or other behaviors that are risky. *But* we know that those behaviors are very specific for particular groups of people. [Interview 5, emphasis in original]

Andrzej acknowledged that clients engage in more HIV risk behaviors than other groups. He also conflated risk groups and risky behaviors, reflecting the difficult task of separating the behavior, the person, and the group to which the person belongs. This complex picture of risk destabilizes the notion of "risk groups" and highlights the tensions inherent in notions of risk as they are mobilized in prevention efforts.

Safer Liaisons attempted to navigate this tension by counteracting the stigma and marginalization that many of its clients encountered in their daily lives as sexual minorities in Poland. The space of Lambda and the opportunities it afforded—listening to music, socializing, eating, receiving advice and counseling—offers the clients social space to "be normal," and a place to enact complex identities and to meet other people. Marek, a volunteer, drew attention to the links between other needs besides reducing HIV risk through sexual activity and methods of HIV prevention:

> It's strange because I cannot say that I'm doing something special, something defined. I'm coming, saying hello, and after this we are talking … I don't know if it's correct or if it's enough for those people [the clients—JO]. But every time when I'm starting to think about it, Beata, for example, said to me that your presence here in Lambda is valuable because these people, for example, they don't have homes and do not have work. They do not have money, do not have someone who they can speak with not only about sex. And [few if any opportunities to speak] with someone who is not saying that they are stupid and that they are "unnaturals" or something like this. And maybe it is enough, I don't know. I don't know if I can say that I am doing something special. [Interview 3]

Later in the interview, Marek questioned the ability of his presence to actually help the young men attending the program. He recognized that changes are often slow and difficult to notice, and wondered how merely talking with such a small group of men week after week could be considered "harm reduction." But he concluded, "I cannot imagine something different than the Lambda activities." Andrzej also justified this approach by saying, "We can also offer them something they need additionally. So when they need a place to meet for a moment, and sit down and drink a cup of coffee, then we are able to offer them this place. Then at the same time we are able to talk with them about HIV and HIV related problems" (Interview 5). To address clients' risk, rather than simply providing clients with HIV infection information, Lambda-Warsaw's program attempted to counter HIV risk by offering the men a safe social space, food and drink, and possible solutions to multiple problems they face.

Discussion

Both the National AIDS Center and Lambda-Warsaw engage in processes of defining what constitutes HIV risk, who is at risk for infection, and how to most effectively reduce or eliminate risk. By invoking choice making and neutrality, the NAC attempted to circumvent the political controversy that public promotion of condom use as a prevention strategy

incites. The supposedly objective ABC campaign avoided gendered and sexualized imagery and language, and presented HIV risk as the product of rational choices made by individuals. In this example, simply knowing about risk provides the basis for making this choice. Recipients are never told explicitly what the risks are, but urged to make the rational choice. Despite this purported neutrality, the campaign became mired in social and political debates because it attempted to remove moralizing messages from prevention strategies. In contrast, the prevention strategy of NGOs such as Lambda, based on broad interpretation of what causes risky behavior, asserted that changing particular sexual practices is often not the most important and appropriate way of helping a client. Staff of Safer Liaisons saw clients as already well-informed about HIV risk and means of avoiding or reducing these risks. They saw getting clients to use this knowledge, through changing both individual and social circumstances, as the path to reduced HIV vulnerability. Despite seemingly neutral language and emphasis on rational choice making, the sexual bodies implicit in the ABC campaign continued to be moral objects and invoke moral debate (Pigg and Adams 2005:22). Offering comprehensive services to stigmatized clients and refusing to accept that they are a cohesive group at risk for HIV based solely on their behaviors also becomes a moral and value-laden stance. Reintroducing a moral argument into HIV prevention strategies produces two effects. First, it underscores that to be labeled “at risk” is to be publicly acknowledged and that inclusive messages legitimize claims to resources. Second, it highlights that “choice” is never void of moral arguments, and that choices are not made outside social, political, or moral contexts.

These prevention efforts reveal three competing models of risk: the model at the workshops, in which it is sufficient to know the “objective” risk associated with various acts; the NAC model, in which HIV risk is the product of individual decisions and altered through instantaneous behavior change, if one self-reflexively makes the right choices; and the Safer Liaisons program, in which risk is a complex, socially determined quality and individuals may know about risks but lack the ability to act on or manage them. In the Safer Liaisons model, the relevant actor is the individual buffeted by social forces, including homophobia and social and economic marginalization. Behavior change, and therefore HIV risk reduction, is a long process because of myriad forms of vulnerability and disenfranchisement that clients face. Despite these differences, however, the ways of managing risk actually converge. The focus on choice making as risk management takes the individual as the locus of HIV prevention interventions. Prevention strategies may look at risk as requiring intervention in multiple aspects of a client’s life, such as helping a client procure housing or steady employment. However, as Beata noted, the ultimate goal of these interventions is to get clients to “take care of themselves in the context of HIV/AIDS.” In this way, harm reduction strategies demonstrate a concern with “fixing the individual,” rather than the social context that shapes risk.

The task of changing the social context, however, is formidable. In Poland and throughout postsocialist Eastern Europe, gay-rights movements did not exist before HIV/AIDS. In Poland, there are few venues for addressing the social, economic, political, and health needs and interests of sexual minorities in general, and even fewer opportunities for men who have sex with men for money. Gay-rights parades in Poland, often called “Marches of Tolerance,” are routinely banned by city governments, attacked by stone-throwing

oppositionists, or countered by a “March of Normalcy” (Gruszczynska 2009). Legislation protecting sexual minorities from discrimination or violence regularly fails in Polish parliament, even after European Union accession. Billboards portraying gay couples are vandalized and their creators forced to remove them. The perceived paradox of linking HIV to gay identity to legitimize the existence of their organizations and gain resources was obvious to leaders of the gay-rights movement in the early 1990s. Even though the early gay-rights leaders attempted to emphasize the multiple pillars of their programs, media interviews invariably turned to the issue of HIV prevention. Concerns with tolerance, discrimination, and informing about the “gay community” were largely ignored (e.g., Gadomski 1990). Safer Liaisons attempted to dissociate homophobia, stigma, and HIV risk for its clients, while still garnering resources for ensuring their well-being.

Discussions of risk and the allocation of resources based on risk reveal tensions between specific risk groups for resource allocation, and promotion of the idea that “everyone is at risk” as a strategy for reducing stigma. In the postsocialist context where state resources for public health are scarce and the concerns of stigmatized populations are marginalized, to fight for recognition that a social group is vulnerable to a disease can serve as a means through which material and symbolic resources can be accessed. Disagreements about who is at risk, how a person becomes “at risk” for HIV, and the steps needed to avoid it constitute the foundation of these contestations. Examining the HIV prevention programs of organizations coexisting within any given locale reveals competing and sometimes contradictory interpretations of risk and determinations of responsibility, whether it is “immoral” sexual behavior or economic and social marginalization. These debates suggest that we must acknowledge that prevention strategies are created in and adopted within politicized landscapes. These landscapes marginalize and exclude certain groups and values while promoting others (e.g., Kalipeni et al. 2004). Moreover, when HIV prevention organizations compete for legitimacy and resources, the differences between their interpretations of risk become key factors in determining what prevention targets and strategies are given priority, either by international researchers, national governments, or international donors. In a context in which behavioral interventions emphasizing individual risk management are the norm, HIV prevention experts must be cautious that the models of prevention they promote do not further marginalize those they aim to serve. Alternative HIV prevention strategies can mobilize a model of risk reduction that addresses the ways in which marginalization and homophobia possibly contribute to HIV vulnerability. The Polish example suggests that program developers need to more fully consider how notions of risk are translated into prevention strategies. If risk is understood as shaped by a social context rife with inequalities and discrimination, then programs need to be developed that aim to change this context, rather than defaulting to strategies of individual risk management.

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1. Organizations that sponsored overnight HIV education workshops included a medical students' organization whose members conducted and participated in the workshops. Two other organizations held separate workshops targeting health professionals, educators, and health department workers. Lambda-Warsaw directed its workshop to people who were working or potentially could work with men who have sex with men or commercial sex workers.

2. Dodds (2002:150) argues that materials targeting the "general population" signify a community of "normal individuals" that excludes gay men and intravenous drug users, creating a moral division between "us" and "them." "AIDS as everyone's problem" can also serve as the impetus for national action against AIDS by conveying a sense of shared responsibility that links the values and actions of the individual to the safety of the nation (Dodds 2002:161).

3. TADA was founded in 1995 in the Polish city of Szczecin to prevent HIV/AIDS among commercial sex workers. It has expanded to several other cities, including Warsaw, and broadened its outreach to include youth and men who have sex with men. MONAR is the acronym for Młodzieżowy Ruch na Rzecz Przeciwdiałania Narkomanii (Youth Movement Against Drug Addiction). Founded in the late 1970s, MONAR began as a series of centers for drug addiction recovery. In addition to caring for drug users, MONAR also conducts drug education and abuse prevention among youth, particularly based on the principle of peer education (Kotański 1984). It also conducts needle exchange programs in major cities throughout Poland.

4. The "ABC's" were imported without modification into Poland, despite that it only partially translated. "A" for "abstinence" and "B" for "be faithful" were easily transposed into the Polish ***a****bstynencja seksualna* and ***b****ycie wierym*, respectively. However, "C" for condoms does not align with the Polish word for condom, *prezerwatywa.* The campaign's creators capitalized the letter "C" in the phrase *zabezpie****C****zenie prezerwatywą*—"protection with a condom."

5. Critics of the ABC approach argue that it ignores structural determinants of risk; fails to interrogate the relationship between poverty, inequality, and vulnerability to infection (Farmer 2003); and does not fully address gender-based power inequalities and social meanings of fidelity (Parikh 2007). They also accuse those who promote it as too focused on abstinence and using HIV/AIDS as a mechanism to promote a conservative religious ideology on a global level (Feldman 2005:4). Others argue that political structures, rather than the specific content of the HIV prevention message, were responsible for its success (e.g., Parkhurst and Lush 2004). Still others argue that abstinence messages are not fully responsible for the decline and suggest that such campaigns may even distort life-saving prevention information and exclude certain people (such as victims of sexual violence) from prevention efforts (e.g., Cohen et al. 2005).

6. The use of AIDS vulnerability in the formation of the gay-rights movement, however, also had the effect of excluding lesbians from this process of defining gay identity in the public sphere. Only in 2004, with the formation of *Porozumienie Lesbijek* ("Lesbian Coalition"), has an organized effort developed to increase the visibility of lesbian social issues in Poland.

7. Going to clubs and local gay hangouts, as well as to the places where prostitutes work, is referred to with the English words *streetwork* or *streetworking.* A person who does these activities is a *streetworker* (plural, *streetworkerzy*).

8. Likewise, a social marketing organization developed an HIV prevention project that would focus on HIV awareness among truck drivers that frequently crossed the border between Poland, Belarus, and Ukraine. It later developed a project on HIV prevention among businessmen living in the Russian territory of Kalingrad who frequently traveled to the West, including Poland. Neither campaign, however, received support from the NAC because of their international scope. Lambda-Warsaw's workshops, however, are national in scope (in that anyone in Poland can attend); therefore, they receive financial and other support from the NAC.

9. Staff and volunteers at the programs almost exclusively used the term *client* (*klient* in Polish) when referring to program participants.

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