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Understanding the Determinants of Policy Performance in Collaborative Context: The Case of Drug Harm Reduction Services in Central-Eastern Europe

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Doctoral dissertation

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1. CHAPTER 1: INTRODUCTION

The scholarly attention towards policy implementation among political science researchers and policy analysts was a consequence of the disappointment in the effects of policies implemented in the United States in the 1960s and 1970s (O'Toole 2000:264). Earlier, being preoccupied with how policies are formulated, scholars saw the implementation as almost automatic (Howlett 2019), assuming that 'political mandates [are] clear and that administrators would do what their political bosses demanded of them' (Hill and Hupe 2002:42). It was not until the landmark work of Pressman and Wildavsky (1973) that the questions like '[h]ow great expectations in Washington are dashed in Oakland; Or, why it's amazing that federal programs work at all (…)' gained significance in the field of policy studies.

Policy implementation, understood as 'organizational activities directed toward the carrying out of an adopted policy by administrative bureaucracies at the national, state, and local levels' (Clemons and McBeth 2017:167), became one of the main foci of interest of political science research in the 1970s and 1980s. This resulted in the proliferation of studies addressing the phenomenon from different perspectives: from focusing on single cases to attempts to develop contingency models and theories of policy implementation to methodological developments, to works testing existing models empirically, to – finally – attempts to incorporate implementation into broader models of the policy process.

However, it is argued that 'periodic meta-reviews of the subject continually find this area of policy studies to be largely descriptive and poorly integrated into mainstream policy theorizing' (Howlett 2019:2). Already three decades before Howlett's assessment of the condition of implementation scholarship, Goggin and colleagues, proclaiming the advent of third-generation implementation studies, called for improved quality of the research, where the task would be 'to develop and test

explanatory and predictive implementation theories of the middle range' (Goggin et al. 1990:15). This call was answered by a number of scholars throughout the 1990s (Howlett 2019). Yet, it seems that no new, widely recognisable conceptual or theoretical works were published during the first two decades of the 21st century.

As a result, the scholarship is based mainly on the developments of three generations of implementation research (described in more detail in Section 1.2.) with only a few models of implementation and a plethora of variables (Matland 1995:146). One of the areas of disagreement is concerned with factors contributing to policy success or failure; in other words, factors affecting policy performance. In the top-down approach, the extent of cooperation between actors involved, the necessary amount of change and the degree of agreement, and structures of policy scenarios are mentioned as the major factors determining policy implementation results (Shamsuddin 2020). On the other hand, the bottom-up perspective puts emphasis on street-level bureaucrats' decisional discretion and pressure-induced routines resulting from the discrepancy between needs to be fulfilled and insufficient resources, and communication and consensus between actors (Shamsuddin 2020). Finally, the works synthesising top-down and bottom-up approaches or offering yet other views on implementation mention levels of ambiguity and conflict, relationships between actors involved in the implementation, public servants' commitment and their interpretation of messages, and availability of resources as some of the critical variables influencing policy effects (Shamsuddin 2020).

The latter view on the factors affecting policy performance reflects the recent shift in public administration theory and practice – a shift from government to governance or 'from a hierarchic or bureaucratic state to governance in and by networks' (Rhodes 2012:33). The shift to governance, including efforts of multiple actors engaged in new forms of horizontal and vertical coordination, was – among others – related to the increasing emergence of so-called wicked policy problems, i.e. cross-sectoral, complex public policy issues which are difficult or impossible to address successfully by a traditional approach involving only one organisation (Christensen and Lægreid 2007; Head and Alford 2015; McGuire 2006). Concerning policy implementation, it was already emphasised four decades ago that the coordination of multiple actors (both public and private) is essential for success (Scharpf 1978). Recently, more

participatory theories of public administration, like New Public Governance (Osborne 2006), highlight non-state actors' involvement as the core of public policymaking (Pestoff 2012). It is recognised that 'even if national governments juridically are superior, they (…) need to cooperate (…) with partners in the private and voluntary sectors to increase the system capacity' (Hanssen, Mydske, and Dahle 2013:872)

To enhance the understanding of how policymaking works in such non-hierarchical governance settings, in our dissertation, we set out to investigate the factors affecting policy effects. More specifically, we examine how policy formulation and policy implementation influence policy performance in an essentially collaborative field. To this end, we ask the following overarching research questions:

RQ1: What are the factors affecting policy performance in a collaborative context?

RQ2: How do these factors affect the policy performance?

We focus on drug policy (and within it, harm reduction policy) and countries of the Visegrád Group as a context that is especially suitable for investigating the problem (the detailed case selection logic follows in Section 1.1.).

This work's structure, consisting of three independent, albeit closely related papers published in peer-reviewed journals, is as follows. First, the following section includes a justification of case selection and outlines the broad conceptual framework. Subsequently, a brief overview of the policy implementation scholarship is provided. Section 1.3. of this chapter outlines the model of the policy implementation process used in this work. In Section 1.4., we describe the model's elements in the specific empirical context of this dissertation. Finally, the fifth section of Chapter 1 (1.5) shortly summarises the main parts of the dissertation, while Section 1.6 provides general methodological remarks.

Chapter 2, Chapter 3, and Chapter 4 include the three articles comprising this work. A detailed explanation of how these chapters fit together into the whole dissertation is provided in Section 1.5. The work ends with conclusions in Chapter 5.

1.1. Empirical context

In the previous section, we outlined the research problem this dissertation addresses. We argued that the drug policy field and geographical scope encompassing member states of the Visegrád Group are especially suitable for examining this problem. This section will justify this claim, additionally providing an outline of the conceptual framework used in this dissertation.

1.1.1. Drug policy

We believe that drug policy is an exciting policy field for the study of implementation. We understand drug policy as 'a variety of laws and programmes intended to influence whether or not individuals decide to use psychoactive substances and to affect the consequences of use for both the individual and the community' (Babor et al. 2010:4). It is, therefore, one of a few policy fields concerned with the regulation of the behaviour of individual citizens. Drug policy, however, is relatively peculiar even compared to other such policies.

First, from a global perspective, the extent of the use of criminal law as a policy tool against individuals engaging in prohibited activities (i.e., drug use, drug possession) is incomparable to other, similar policy problems, like sex work, gambling or use of legal psychoactive substances.

Second, it is a policy field firmly embedded in and regulated by international agreements. Namely, the international drug control regime is based on three International Drug Control Treaties (the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol, the Convention on Psychotropic Substances of 1971 and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988), which oblige their signatories (virtually all countries in the world) (Buxton 2008:2) to cooperate in the efforts to achieve a drug-free world through translating the Conventions into domestic laws. As a result, national policies around illicit drugs are, to a large extent, restricted by the Treaties. For example, the framework does not allow for regulated markets for recreational drug

use, and countries introducing or attempting to introduce such solutions have been widely criticised in the international arena (Bewley-Taylor and Jelsma 2012).

With respect to the international drug control system, its origins are also worth mentioning. Quite interestingly, the global consensus on prohibiting certain substances and introducing penalties for their use, possession, production, cultivation, and trafficking is not based on potential harms or other considerations related to these substances' intrinsic characteristics. In fact, in its beginnings, the international drug control system aimed for restricting the power of colonial empires (Carstairs 2005). Later, race-related considerations shaped the US drug policy, with gradually increasing severity of laws against more and more substances, first domestically, and later, pressured into the international system (Buxton 2008).

The third major peculiarity of drug policy is a policy field 'that typically requires the collaborative efforts of different ministries and agencies to implement it properly due to its intersectoral character (…)' (Knill and Tosun 2012:151). Indeed, drug policy combines fields of health, education, economy, national security, international relations, and criminal justice, among others.

Today, drug policies in developed countries are based on four pillars: law enforcement, prevention, therapy and harm/risk reduction (Savary, Hallam, and Bewley-Taylor 2009). Law enforcement is concerned with criminal justice and focuses on legal-type measures to reduce the supply of illicit substances, albeit usually including provisions aimed at the demand side (individuals using substances), such as the criminalisation of drug possession and/or use. Prevention, in the narrow sense, includes activities aiming to deter non-using individuals from using drugs or delay the onset of drug use. In the broader sense, it also includes the prevention of transition from occasional use to more high-risk use in individuals who already use drugs. The therapy pillar is focused on treatment, recovery and social integration of high-risk drug users or drug-dependent individuals. Finally, harm/risk reduction – the specific area of interest of this dissertation – aims to minimise the possible adverse consequences of drug use. It is the origins and specific features of harm reduction policy that we turn to in the next section.

1.1.2. Harm reduction policy

Harm reduction in the context of drug policy is defined as 'a policy or programme directed towards decreasing adverse health, social and economic adverse consequences of drug use even though the user continues to use psychoactive drugs at the present time' (Single 1995:289). Some broader definitions do not limit the scope of addressed harms to those resulting from drug use but extend it to adverse consequences of drug policies and drug laws (Harm Reduction International 2020), thereby recognising the possible negative social impact of the policy itself.

Harm reduction as a policy is quite distinctive from the 'traditional' approach to tackling substance use. First, it is based on public health considerations instead of the crime-morality or disease approaches, which have been dominant for many decades before the emergence of the harm reduction perspective. Second, while it respects non-use as a legitimate policy outcome, it recognises that abstinence is not a feasible goal for many individuals at a given time. Third, the emergence of harm reduction took place in a bottom-up manner because of the advocacy efforts of people who use drugs and only later became an actual public policy. Fourth, harm reduction includes low-threshold interventions, making them easily accessible, as opposed to high-threshold character of many health and social services (Marlatt 1996).

Harm reduction in response to the drug use phenomenon first emerged in Europe around the middle of the 1980s. In the face of the high prevalence of injecting heroin use and an outbreak of HIV epidemic among people injecting drugs, interventions aiming to limit the spread of the virus were launched – by state health authorities, civil society organisations and people who use drugs themselves – first in the United Kingdom, and the Netherlands (Marlatt 1996), and later in other European countries. Such interventions included, first and foremost, the distribution of sterile needles and syringes to people injecting drugs. The reasoning behind this activity is that if individuals have access to sterile injecting paraphernalia, the number of instances of needle sharing, multiple-use or use of needles found on the streets will decrease, in consequence reducing the risk of contracting blood-borne infections, including HIV.

Back in the 1980s, one could not yet talk about harm reduction policy as such. Needle exchange services were often non-institutionalised, grassroots-based, and ad-hoc (Marlatt 1996). The idea of reducing adverse consequences of drug use, however, gained popularity. Over time, new types of services emerged, and the existing ones were scaled-up.

Today, harm reduction interventions aim not only to tackle the HIV and viral hepatitis infections but aim to improve the health status and general well-being of people who use drugs and their communities. The range of interventions includes services for individuals using drugs in a high-risk manner and those using occasionally. The former category encompasses services aiming, besides prevention of blood-borne viruses, to prevent overdoses. Specific services include distribution of Naloxone, a medicine reversing the effects of opioids, drug consumption rooms (DCRs) where individuals can administer their drug under the supervision of a medical professional, and opioid substitution treatment (OST), where a person receives an individually adjusted dose of a medical drug preventing the occurrence of opioid withdrawal symptoms). The latter category involves primarily party-setting services (provision of information on substances and their interactions, distribution of water, earplugs, condoms, and other relevant equipment) and drug-checking services, where individuals can get a sample of their substance tested for its content, which is intended to warn individuals about especially dangerous substances prior to their consumption.

It is not only the development in terms of scope and number of interventions that allows us to think about harm reduction as policy. Contemporary drug policies often mention harm reduction explicitly in relevant strategies and programmes. Moreover, in developed countries, harm reduction interventions became an integral part of the care system. As low-threshold services available to and accessible by anyone (regardless of, for example, their employment or insurance status, citizenship, residency, etc.), they often serve as a bridge between people who use drugs and the broader system of health and social care. In many cases, it is the harm reduction programmes which identify people in need of support and make them visible for the broader care system. Ideally, harm reduction programmes provide also social work, psychological help, assistance in contacts with the state administration, support in

looking for accommodation, job, etc. and are a part of a broad network of actively cooperating institutions providing various types of care.

The choice of drug policy and – within it – harm reduction policy for investigating the problem of policy performance in collaborative settings is motivated primarily by its intersectoral character. This is understood both in terms of encompassing several policy areas and extensive involvement of non-state actors (in this particular case, non-governmental organisations) in policy implementation, especially in the context of service delivery. Indeed, contrary to other policy fields, like economic policy, defence policy, foreign policy, etc., the specificity of drug policy is that relatively broad collaboration is essential. It is relatively easy to imagine that collaboration between sectors has a significantly lower weight even in fields such as health or social policy. Meanwhile, in drug policy – and especially in harm reduction – being the (ideal)typical example of a 'wicked' policy problem, the substantial part of the policy implementation is non-state actors' task (Head 2008). As such, it is a policy field especially suitable for investigating policy performance and factors influencing it in a collaborative context.

1.1.3. Visegrád Group

The geographical scope of the work is Central-Eastern Europe. More specifically, we focus on countries forming the Visegrád Group (V4): Czechia, Hungary, Poland, and Slovakia. Although the Visegrád Group is not an analytical category but a political entity, researchers often choose these countries as their focus while researching the region. The V4 countries are highly suitable for comparative analyses of politics and policies (and, especially, their variance) due to significant similarities between them, on which we elaborate in the following paragraphs.

Historically, Central-Eastern European countries, being a 'transitional zone between the Western tradition of the division of power and the Eastern tradition of concentration of power' (Schöpflin 1990:61), shared the Western European experience of the transition from feudalism to the Enlightenment, albeit only partly. The state was stronger than in the Western countries, and its dominant position was additionally strengthened by the long-lasting foreign domination (Schöpflin 1990).

Until the end of World War I, all four countries were (at least partly) under the rule of the Habsburg Empire. Poland, in fact, has not existed as an independent country since 1795, with its territory being shared between the Habsburg, Russian and Prussian empires. This lack of sovereignty constituted a significant hindrance to the development of state institutions in the region for decades. It was only in 1918 that Czechoslovakia, Hungary, and Poland emerged as independent, modern nation-states.

After the interwar period of semi-autocratic regimes in the newly sovereign Central-Eastern European countries, World War II brought German occupation. Subsequently, the region was forcefully put under the Soviet dictatorship characterised by blurring borders between the politics and administration, and total dominance of state, politics and ideology over society, the rule of law and the economy (Kornai 1992).

After the 1989/1990 transition from an authoritarian state to democracy and from the centrally planned economy to free-market (and, in the case of some countries, like Czechia and Slovakia, to independent statehood), we can still see parallels among the examined countries (Randma-Liiv 2009). However, differences are also visible (we will come back to this issue later). The shared Socialist past is one of the leading causes of these similarities, next to the 'radical elimination of the old "Party-state" structures and the creation of new ones practically from scratch' (Hajnal, Jeziorska, and Kovács 2021:4).

Although during the 1990s, some Central-European countries were praised as success stories in the transition from autocracy to liberal democracy (Foa and Mounk 2017) and announced consolidated democracies after their accession to the European Union (Rupnik and Zielonka 2013:3), their development of democratic institutions was highly incomplete. With respect to public administration and policymaking in the period after the transition, Post-Soviet countries are characterised by lack of institutional stability, administrative practices differing from established sets of (anyway weak) formal rules, and politicisation of civil service with cabinets highly influencing policy coordination (Meyer-Sahling 2009), among others. Further, it is argued that public services are shaped by needs and interests of non-accountable informal groups rather than actual policy objectives (Rupnik and Zielonka, 2012), that provision of services is monopolised by the state, with centralism restricting the access

to policy implementation for non-state actors, including civil society (Fric and Bútora 2003; Rees and Paraskevopoulos 2006). The fragmentation of public administration results in deficiencies in policymaking coordination (Zybała 2017); policymaking processes are non-participatory, restricting the possibilities of dialogue and deliberation and expert involvement, with the central government having strong dominance (Rees and Paraskevopoulos 2006).

In this section, so far, we have argued that the chosen geographical context of the dissertation – the four countries belonging to the Visegrád Group – are characterised by profound historical and political similarities. Critical in this dissertation's context are the features related to the policymaking process – centralism, monopoly of government in service provision, lack of or limited options for participation of non-state actors in the policy process.

Importantly, there is one significant difference between the examined countries, namely, the extent of departure from the liberal democratic principles in policymaking, described as – among others – de-democratisation (Ágh 2015), a U-turn (Kornai 2015) or democratic recession (Diamond 2015), which has been a global trend over the last several years. In Central-Eastern Europe, it is Hungary and Poland, which are in advanced stages of this process, started by FIDESZ-MPP in 2010 and Law and Justice in 2015, respectively. This new type of governance is characterised by seizing democratic procedures. For example, decision-making processes in Poland and Hungary have grown increasingly non-participatory. Many significant bills passed by ruling parties (FIDESZ-MPP in Hungary and Law and Justice in Poland) are introduced as private member bills, meaning they can avoid any kind of consultation or evaluation, while public consultations on proposed laws are virtually non-existent (Bartha, Boda, and Szikra 2020). Checks and balances were eliminated as soon as possible in both countries (Foa and Mounk 2017:8). Extensive surveillance measures were adopted to control ordinary citizens, public administration, political opponents, and civil society (Nagy 2017).

State-NGO relationships is also one of the fields where signs of the discussed illiberal turn can be observed. In Hungary, governance is characterised, among other things, by centralisation, exercising a political influence on the media, attacks against civil

society, and a lack of transparency in policy processes, including preventing civil society actors from participating (Bartha et al. 2020). Anecdotal evidence suggests that similar features are becoming increasingly prevalent in Poland as well, e.g., attacking the free media (Stormont 2017) or using surveillance against NGOs (Polish Helsinki Foundation for Human Rights 2017). Law enforcement is used against NGOs (Grzebalska and Pető 2018; Nagy 2017). Organisations opposing the government are presented as threats to the nation and serving foreign interests (Gerő and Kerényi 2017). There is general hostility towards non-governmental organisations' participation in the policy process (Cooley 2015). Simultaneously, governments create parallel quasi-NGOs, ideologically close to governing parties and working in their favour to promote the governing parties' worldview centred around traditional notions of family and nation. In Poland, tendering procedures and rules are being violated in order to ensure that only organisations ideologically close to the government's line will receive support (Ágh 2016).

Hungary and Poland are frequently described as 'prominent cases' of 'democratic erosion' (Lührmann and Lindberg, 2019, p. 1105) and classified as a transitional or hybrid regime and semi-consolidated democracy, respectively (Freedom House 2020:3). Meanwhile, in Czechia and Slovakia, the signs of illiberal turns seem to be much less advanced, with both countries still considered consolidated democracies in 2020 (Freedom House 2020:12).

Given all the above, the four selected countries are an excellent geographical scope for comparative research. To sum up, we face an exciting puzzle here – a policy field where especially policy implementation requires strong cooperation with NGO-type entities on the one hand, and policymaking context, which does not favour such cooperation. Additionally, in two out of four chosen countries, the environment of non-governmental organisations recently turned from disregarding to openly hostile, and policymaking became even less participatory than before. Such a seemingly contradictory situation provides a fascinating context for the investigation set out in this dissertation, that is, the study of what and how influences policy performance.

Before we move to the chapters addressing specific aspects of the phenomenon, we provide a review of relevant scholarship, present our analytical framework, and briefly describe each of the main chapters in a broader theoretical context.

1.2. Policy implementation – theory and concepts

As a focus of interest in policy analysis, implementation science is a relatively new phenomenon, dating back to the late 1960s. Although many works in social sciences have addressed important implementation-related themes before, as argued by Van Meter and Van Horn (1975), in policy studies, implementation was a marginal issue (O'Toole 2000). Starting from the 1970s, three generations of implementation research emerged: the first generation focusing on single-case studies, the second generation aiming to develop analytical frameworks and methodological approached (top-down versus bottom-up), and the third generation synthesising the two methodological approaches (Birkland 2010).

1.2.1. The first-generation research

Political scientists in the late 1960s noticed the 'missing link' (Hargrove 1975) between the policy adoption and its results. This resulted in incorporating the concept of implementation into policy analysis and the proliferation of the first generation of implementation research. The first-generation studies focused primarily on in-depth analysis of specific individual cases (often of policy failures), the most notable works being the analysis of the job-creation programme in Oakland (Pressman and Wildavsky 1973) and a federal-level communities-building programme of President Lyndon Johnson's administration (Derthick 1972). Such researches had largely top-down prescriptive character – taking the goals defined in a policy as the starting point, they identified factors relevant for implementation and developed approaches for improving the effectiveness of implementing the policy-defined goals (Schofield 2001). Due to their narrow, one-case scope, these studies' results did not possess the quality of empirical generalisability (Smith and Larimer 2009:162). Still, they have laid a path for the second generation of research.

1.2.2. The second-generation research

The second generation of implementation studies, starting in the mid-1970s, took a closer look at causal relationships and attempted to develop models and theories of the policy implementation process. This period is characterised by the evolution of two main methodological approaches to analysing implementation.

The top-down approach argues that the best way to understand policy implementation is to look at it from the perspective of policy goals as they are (or should be) explicitly specified in an adopted act of law or other policy sources. The investigation, then, focuses on these goals' application down the implementation chain towards outputs and outcomes. The subject of attention here is the discrepancies between the stated objectives of adopted policies and their final outcomes (Birkland 2010:265). Some of the most noteworthy top-down models developed during the second-generation implementation research are van Meter and van Horn's conceptual framework of the policy implementation process (1975), Bardach's game framework (1977) and the four-step model of Mazmanian and Sabatier (1989). Although certainly contributing to the advancement of the scholarship on policy implementation, the top-down approach was criticised, among others, due to its firm belief in the rational model of policymaking, treating primary legislation as the manifestation of the policy goals, and failure to appreciate the role of street-level public administration in interpreting the centrally adopted policies (Schofield 2001:251).

The bottom-up approach to implementation specifically addresses this last criticism. Recognising that policy goals are often vague or even conflicting, the policy is scattered rather than assembled in a single policy document, the bottom-up approach sees the implementation '*as working through a network of actors—much like an issue network or policy community— rather than through some rigidly specified process that fails to account for the richness of the policy-making environment*' (Birkland 2010:268). The 'street-level bureaucrats' (Lipsky 2010), it is argued, have significant discretion and flexibility in deciding about the final shape of policies as those who ultimately deliver policies. Policy objectives can then be altered during the implementation. Consequently, street-level bureaucrats should be involved in all policymaking stages, including the policy formulation process (Smith and Larimer 2009:168).

In short, we can distinguish three main features of the bottom-up approach: (i) focus on behaviour and motives of the street-level implementers, (ii) emphasis on the policy problem as a measure of policy effectiveness (as opposed to policy objectives formally specified on the central level of government) and (iii) networks as the object of interest (Schofield 2001:251). Besides Lipsky's work discussed above, essential contributions to the bottom-up approach include the work on implementation structures (Hjern and Porter 1983) and studies emphasising action, dynamic nature of policy and the political process taking place during implementation (Barrett and Fudge 1981b, 1981a).

The main criticism of the approach argued the underappreciation of the central government and its role in shaping street-level bureaucrats' working environment and, therefore, limiting their autonomy and discretion through a system of norms, control mechanisms, and sanctions (Birkland 2010:269).

1.2.3. Third-generation research

Scholars writing about policy implementation since the end of the 1980s through 1990s primarily focused their efforts on synthesising the conflicting top-down and bottom-up approaches, trying to combine the aspect of policy formation at the level of central government with the aspect of its possible modification in the course of implementation.

For example, in one of the most notable works of the generation, Richard F. Elmore addressed the conflict between top-down and bottom-up arguments by suggesting an approach combining 'backward mapping' with 'forward mapping' (Elmore 1985), which allows for focusing on perspectives of policymakers and lower-level implementers alike.

Further important works within this generation of research include, among others, the Advocacy Coalition Framework focusing on a multitude of actors interacting within policy subsystems where the implementation takes place; works on network analysis, which also emphasised the role of various actors and highlighted the need for cooperation between them; communication model of inter-governmental policy implementation developed by Goggin and colleagues to study the relations between federal and state governments in the United States.

1.3. Analytical framework: The model of the policy implementation process

The policy implementation process model shown in Figure 1 (Van Meter and Van Horn 1975) is one of the most important models of policy implementation (Birkland 2010; Hill and Hupe 2002; Schofield 2001; Weiss, Bloom, and Brock 2014). Despite being developed several decades ago, researchers of policy implementation build on it (Carley, Nicholson-Crotty, and Fisher 2015; May, Harris, and Collins 2013; Tummers 2012), and more generally refer to Van Meter and Van Horn's work still today (see, for example: Andrews and Boyne 2012; Fox-Kämper et al. 2018; Hanssen et al. 2013; Newig et al. 2018; Skille 2011; Tummers et al. 2012; Zahariadis and Exadaktylos 2016).
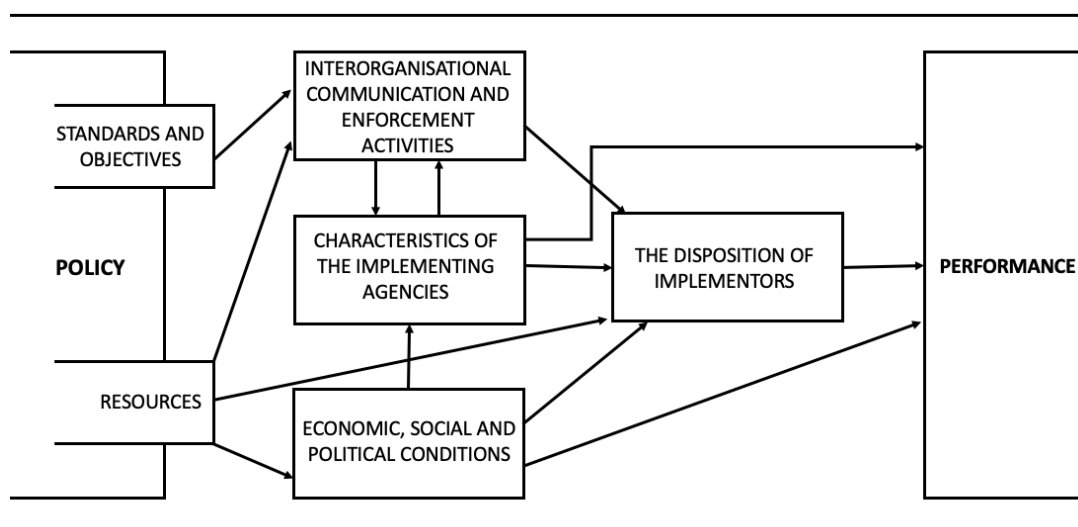
Figure 1. A model of the policy implementation process. Source: van Meter and van Horn, 1975:463.

This model's choice was motivated by its straightforwardness in the identification and conceptualisation of key factors determining policy performance and relationships between them. To a large extent, these factors correspond to independent and mediating variables identifiable in other works on implementation, too, as can be seen in a meta-analysis conducted by Hill and Hupe (2002:123). Moreover, it is one of a few policy implementation models aiming 'to direct the attention of those who study implementation rather than provide prescriptions for policy makers' (Hill and Hupe 2002:46).

In this study, we adopt the policy implementation model with several modifications aiming to simplify it. Most notably, due to the focus on organisations, our modified model does not include *the dispositions of implementers* as this factor refers to individuals' behaviour. Consequently, all relationships pointing to and from this element are also removed. The simplified model is shown in Figure 2.

Standards and objectives outline the policy's general aims, including more specific information about expected policy outcomes.

Resources refer to both funding and other incentives aimed to foster effective implementation.

Interorganisational communication and enforcement activities refer to the crucial task of providing implementing agencies with information about the policy objectives. From a normative perspective, such information should be clear and consistent in order to ensure that implementers understand those objectives. Besides, this factor also includes mechanisms and procedures aiming to monitor the implementation agencies' compliance with the policy objectives. In the context of multiple organisations involved in policy implementation, providing technical advice and applying sanctions (positive and negative) are considered to be the most significant enforcement activities. In this context, instruments within the realm of normative (e.g., persuasion, co-optation), remunerative (e.g., monetary incentives) and coercive (e.g., stipulating conditions and procedural requirements for receiving funding, introducing control mechanisms in the form of audits, on-site inspections, etc., withdrawing funds in case of non-fulfilment) powers should be mentioned as the techniques used by the central governments to ensure compliance.

Economic, social, and political conditions refer to the environment of public policy. They include a range of variables, among others: the abundance of economic resources, salience of the policy problem, public opinion on the matter, elites' attitudes towards the policy, partisan attitudes towards the policy, mobilisation of private interest groups.

The characteristics of the implementing agencies are another factor affecting policy performance. Three main categories of features can be distinguished: formal structure (e.g., the extent of hierarchical control and open communication), informal

characteristic of staff (e.g., expertise and size of human resources), and agencies' relationships with other actors in the policy implementation system (e.g., political support, connections to policymakers).
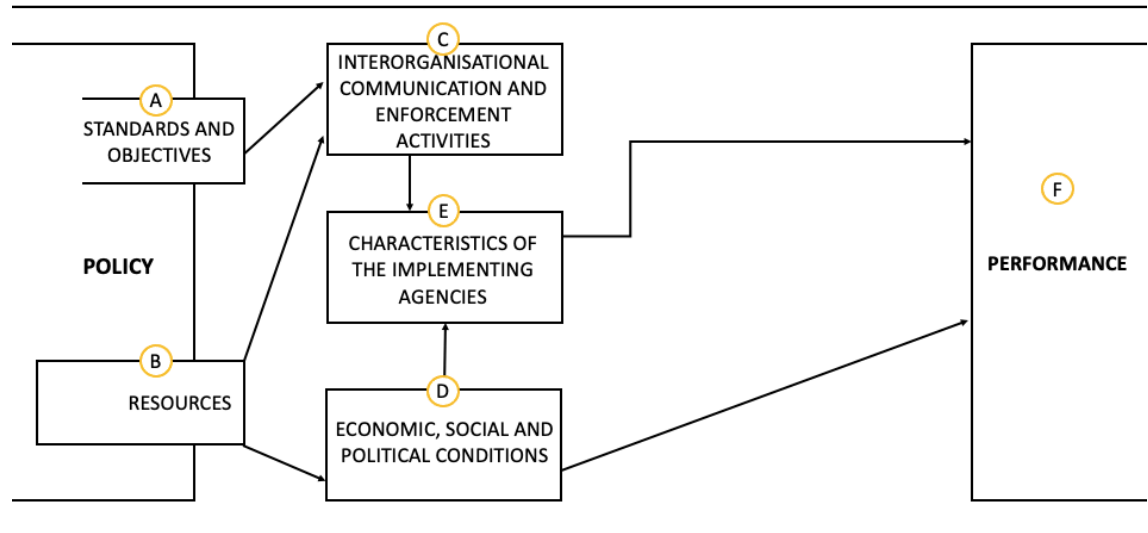
Figure 2. A simplified model of the policy implementation process. Source: Own version of the policy implementation process model (van Meter and Van Horn 1975).

1.3.1. Hypothetical relationships between the elements of the model

In our simplified model, the policy *(F) performance* is directly influenced by *(D) economic, social, and political conditions* and *(E) characteristics of the implementing agencies*. Other factors affect the *(F) performance* indirectly – through mediating variables.

(E) implementing agencies are directly affected by *(C) interorganisational communication and enforcement activities* and *(D) economic, social and political conditions* and indirectly by policy-related factors *((A) and (B))*.

The influence of *(B) resources* is direct on *(C) interorganisational communication and enforcement activities* and *(D) economic, social, and political conditions*. The former element *(C)* is also directly affected by *(A) standards and objectives* of the policy.

The context-specific description of these factors and relationships between them will follow in the next section.

1.4. Factors affecting performance in the context of drug policy

Three papers constituting the main chapters of this dissertation cover the broadly understood implementation process, starting from the policy features: *policy standards and objectives* and *policy resources,* through *interorganisational communication and enforcement activities; economic, social, and political conditions* and *characteristics of the implementing agencies,* to – finally, *performance*. The following sections describe the model elements examined in this dissertation in the empirical context of drug policy.

1.4.1. Policy standards and objectives

Starting from the law on books, we devote some attention to formal *policy objectives* as stipulated in relevant laws, regulations, and documents. In the context of drug policy, the policy objectives can be found primarily in drug-specific provisions in criminal codes and laws regulating the pharmaceutical market, in national strategies on drugs, and local strategies and programmes. These laws indirectly affect the *characteristics of the implementing agencies,* providing an overarching framework of their functioning but also determining the relationships of drug policy field to other policy fields and the relation of harm reduction area to other areas within drug policy. Specifically, *policy objectives* determine what is prioritised at each point in time, for example, whether the policy focuses on minimising negative consequences of drug use and drug policies or aims for a reduction of drug use itself through supply reduction, treatment, and prevention activities.

Further, the criminal law paradigm (e.g., stringent and harsh punishment versus restorative justice approach) is especially important in the case of drug policy. It influences the scope of allowed services to be provided, e.g., determining whether or not needle and syringe programmes are considered to promote drug use. Moreover, through enforcement activities – the incarceration of people who use drugs may negatively affect the quality and continuity of relationships of various demand reduction services with their clients, especially in cases where there are no services provided in prison settings. Indeed, the research shows that incarceration of people who use drugs results in a range of negative consequences, including restricting their access to health care services (Burris et al. 2004)

1.4.2. Policy resources

With respect to *policy resources*, we focus mainly on funding. In the context of drug policy and harm reduction, *policy resources* affect *implementing agencies* in two ways. First, they create specific economic conditions for the operation of organisations providing services. These economic conditions include two major dimensions: the amount of resources available (abundance versus scarcity) and the stability of available funds (continuity of funding with only incremental changes versus significant and/or sudden changes in funding priorities). Second, *resources* affect *implementing agencies* through *communication and enforcement activities,* determining the rules of receiving funds and accounting. Concerning non-governmental organisations delivering harm reduction services, we can distinguish two main kinds of resources: direct and indirect. The latter category involves non-earmarked financial resources that NGOs can use for purposes defined with a varying level of discretion. Such resources often come from corporate or personal income tax concessions or (more discretion) or international programmes administered by national governments (less discretion). On the other hand, the former category includes earmarked financial resources offered by the government for the provision of concrete services, for example, within the framework of contracting-out of services.

1.4.3. Interorganisational communication and enforcement activities

Following the widely accepted argument 'that policy is made in complex interaction process between a large number of actors which takes place within networks of interdependent actors' (Klijn and Koppenjan 2000:139), the main focus of our work is on the elements within the implementation process, different actors and relationships between them.

As mentioned above, *interorganisational communication and enforcement activities* include resources-related and policy objectives-related considerations. For example, they affect *implementing agencies* through issues related to providing contracted-out services by non-governmental organisations. Procedures and requirements for submitting public grant proposals and subsequent reporting are of particular interest.

Additionally, this factor includes the relationships between actors involved in policy implementation in various policy fields; in other words, the extent of integration versus fragmentation of policy. Here, one can think of considerations such as: What is the number and scope of joint operating procedures between drug-related services and health or social services? Is the inter-sectoral cooperation institutionalised/formalised? Are drug harm reduction services complemented by housing programmes, legal help, or employment support services?

The possible conflict between various implementers should also be emphasised. It seems that in many countries, elements of drug policy may be contradictory; most notably, frequently, there seems to be a conflict between law enforcement agencies (which aim to arrest people using or possessing prohibited substances) and harm reduction services (which, as mentioned before, do not interfere with individuals' substance use). The evidence shows that effective provision of harm reduction services can be impeded by the police harassing and/or arresting services' staff (Bluthenthal et al. 1998). On the other hand, comparative research on legal and illegal needle exchange programmes shows that the policy objectives (the law) and their enforcement can also affect the scope of services provided and other service providers' characteristics. Namely, programmes with legal status were more likely to provide additional services (e.g. HIV counselling), to have established formal relationships with other services (e.g. treatment) and to have problems with lack of financial or human resources (Paone et al. 1999).

Further, from the perspective of inclusiveness in policymaking, relevant aspects include mechanisms of NGOs' involvement in the policy process. Are non-governmental organisations engaged in the process of policy formulation? What is the extent of such involvement (e.g., information sharing or fully-fledged collaboration)? Is it formalised/institutionalised or ad hoc and informal? Are NGOs involved in policy implementation? What is the nature of this involvement? Etc.

1.4.4. Economic, social, and political conditions

The *economic, social, and political conditions* receive considerable attention as well. Our work includes a focus on societal attitudes and public opinion regarding the policy

problem, issues related to central- and local- level politics, local conditions, and relationships with local communities.

The literature on the structural determinants of health focuses primarily on how the environment affects individuals' health behaviour. Some of the significant relevant risks in the context of HIV in people who use drugs include inequalities (e.g. economic, gender, ethnic), stigma around drug use and people who use drugs, weakness of civil society, and health services revenue and spending (Paquette, Syvertsen, and Pollini 2018; Rhodes 2009). The influence of factors, one can easily imagine, is not limited only to individuals but also organisations working in a given environment – in our case, NGOs providing harm reduction services. For example, the environment can reduce services' capacity for development (Rhodes 2009).

As mentioned above, vague or contradictory policy objectives can result in situations where different agencies enforcing or implementing policy undermine one another's work. More specifically, it seems that criminal law enforcement activities may contribute to creating an environment that discourages the utilisation of services (Bluthenthal et al. 1998), to hindering the efforts of harm reduction programmes through the confiscation of legally possessed sterile equipment (Beletsky et al. 2013), and to impeding the provision of health care services (Kerr, Small, and Wood 2005).

1.4.5. Characteristics of implementing agencies

One of the most important features of policy implementing agencies is their capacity. As already mentioned, the vast majority of harm reduction services are delivered by non-governmental organisations within contracting-out mechanisms. In the context of Central-Easter Europe, it is argued that NGOs are chronically underfunded (Börzel 2010), considered non-prestigious and unattractive as workplaces (Kutter and Trappmann 2010), their membership bases are small (Börzel 2010; Kutter and Trappmann 2010). The lack of funding and being staffed by volunteers seems to be characteristic also for organisations working in the drug policy field (Bastos and Strathdee 2000).

One of the most critical features of service-delivering NGOs is their capacity. In a harm reduction context, the capacity of services is affected by numerous factors; for

example, legal battles in cases of services operating in a hostile legal environment, understaffing, lack of necessary expertise (Bastos and Strathdee 2000). Policies, operating procedures and work rules and training are also highlighted as essential elements of policy implementing organisations (Burris et al. 2004:128).

Implementing agencies are affected by external factors in various ways. For example, the evidence shows that the lack of political and social support results in the minimal possibilities of services' development even in the face of evidence supporting their effectiveness (Vlahov et al. 2001). Scaling-up of harm reduction interventions is also hindered by the lack of financial resources, cultural barriers, the opposition of political institutions, public opinion, and unclear legislation (Tkatchenko-Schmidt et al. 2008).

Therefore, the issues of interest include questions on whether the analysed harm reduction NGOs possess sufficient financial resources and necessary, well-trained staff, and how do the external factors described above affect their characteristics.

1.4.6. Policy performance

The dependent variable – *performance* – is understood in this work as relating to policy outputs. In drug policy, the indicators of performance highly depend on the policy paradigm adopted. Concerning policy outcomes, it is usually the epidemiological data on drug use in the general population and specific at-risk groups that are of interest. Low prevalence of drug use is usually the primary goal of drug policies, and three policy pillars – prevention, treatment, and law enforcement, serve in achieving this purpose. In the case of harm reduction, however, the situation is different. Here, the policy outcome indicators include the prevalence of blood-borne viruses among people who use drugs, the number of overdoses, health-related data, etc.

In a similar manner, we can talk about different focus at the level of policy outputs. For example, in the case of 'zero tolerance' policies and focus on law enforcement, the number of illicit drug seizures, the number of arrested and/or incarcerated people who use drugs, and similar output indicators will be of interest. On the other hand, in case of harm reduction focus, policy outputs include the number of people with opioid dependence receiving opioid antagonist treatment, the number of people injecting drugs receiving HIV and viral hepatitis treatment, the number of needles and syringes

distributed to people who inject drugs, etc. In this work, we focus on two main aspects of policy performance in terms of its outputs – services coverage and availability. We understand the coverage as the proportion of the intended target population that receives the intervention. Availability, in turn, refers to the number and scope of existing services and their geographical distribution.

1.5. The structure of the dissertation

This section presents individual articles making up this dissertation. The aims, concepts, methods, and findings of each article are briefly discussed. We also discuss the overall contribution of the dissertation, its relationship to the broader theoretical framework and relationships between the articles of the dissertation.

The dissertation work consists of three main chapters – independent comparative papers published in peer-reviewed journals. This work's novelty lies in its focus on a relatively distinctive context compared to the majority of implementation studies.

First, the dissertation is concerned with drug policy, a policy field that is remarkably complex and interdisciplinary, including aspects falling within the area of health and social policy, national security, international relations, and others. Specifically, we focus on harm reduction services distributing sterile injecting equipment to people using drugs intravenously, which 'continue to be politically charged, despite a consensus among health care experts, because of value conflict, electoral concerns, and conflicting narratives' (Clemons and McBeth 2017:34).

Second, the complexity of the drug policy field results in a multitude of policy sources. Moreover, policy objectives regarding the narrow area of harm reduction tend to be general and/or vague. In the face of these challenges, we have decided to use policy performance indicators recommended by the international organisations in the aftermath of adopting a Political Declaration on HIV/AIDS by the UN General Assembly in 2006.

Third, we address the relationships between the state actors and non-governmental organisations in a challenging environment. Our geographical scope is Central-Eastern

Europe, represented by four countries belonging to the Visegrád Group: Czechia, Hungary, Poland, and Slovakia. What differentiates these countries from, for example, Western European democracies is the relative weakness of civil society, including NGOs, and the very recent emergence of illiberal governance in two of them: Hungary and Poland. Hence, our focus is on NGO-type street-level implementers and their environment determined mainly by central and local governments. An environment, which in two out of four cases (Czechia and Slovakia) is characterised by relative disregard towards non-governmental organisations, while in the two other cases (Hungary and Poland) by an outright hostility towards NGOs.

In sum, therefore, we look at the states' commitment towards achieving the internationally agreed policy objectives, focusing primarily on the governments' activities, facilitating or impeding the work of NGOs. Each paper's contents and its place within the model (Figure 3) are discussed in the following sections.
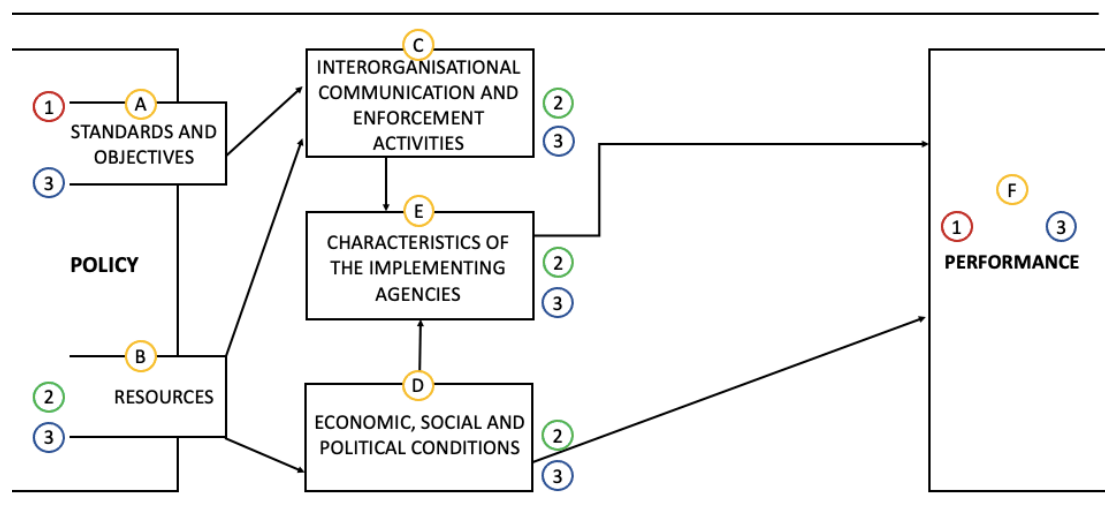
Figure 3. The articles comprising the dissertation within the simplified model of the policy implementation process. Source: Author.

1.5.1. Article on the relationship between policy formulation and policy performance

Chapter 2. includes the article 'A sin or a health issue? Morality policy framing and the state of harm reduction in Central-Eastern Europe' published in Intersections. East European Journal of Society and Politics 7(1) in 2021. The article explores the

relationship between policy formulation and policy performance in the context of drug policy and harm reduction, therefore addressing our second research question and *(A) policy standards and objectives* and *(F) policy performance* elements of the policy implementation process model.

Harm reduction policies are a widely accepted and implemented element of drug policies globally, with recognised effectiveness in preventing blood-borne viruses and evidence supporting their cost-effectiveness. International organisations like the United Nations and the European Union support harm reduction policies and include them in relevant documents, for example, the EU Drug Strategy and Action Plan on Drugs (Council of the European Union 2013, 2017). However, despite this broad agreement on the importance of harm reduction, the implementation of policies and interventions within this area is characterised by a significant variance between countries, including in the Eastern-European region. Chapter 2 addresses this puzzle of different harm reduction policy performance in four highly similar countries.

The article aims to explore the relationships between policy formulation and policy outputs through (1) identifying the dominant frame used to outline drug policy in a country (the explanation of policy framing follows in the following paragraphs), (2) assessing the performance of harm reduction policy, (3) identifying possible relationships between (1) and (2). The article's research question is: What, if any, is the relationship between drug policy framing and the harm reduction policy performance? The two auxiliary research questions are: What are the frames used to describe drug policy in analysed national drug strategy documents? And: What are the outputs of harm reduction policy in analysed countries?

The article uses a theoretical framework based on the conceptual literature on morality policies, understood as those policies, where 'conflicts over fundamental values are the central feature' (Euchner 2019:7). Regarding the content of morality policies, it is argued that frequently regulation is based on general criminal law (and not regulations specific to the addressed issue), that criminal prosecution constitutes their significant content, and that they are likely characterised by vagueness resulting in substantial freedom during policy implementation (Knill 2013:315). Drug policy is considered

one of the typical examples of morality policies (Euchner 2019), next to, for example, sex work, gambling and abortion.

To answer the research question, the article uses an analytical framework on policy framing borrowed from Euchner and colleagues, who differentiate between four frames: morality, health and social, security and public order, and economic and fiscal (2013). The assessment of the policy performance is based on selected indicators of needle exchange services' availability and coverage developed by The World Health Organisation, The United Nations Office for Drugs and Crime and The Joint United Nations Programme on HIV/AIDS (WHO, UNODC, and UNAIDS 2012)

Such a decision regarding the definition and operationalisation of the dependent variable results from the high level of complexity and, especially in the case of harm reduction objectives, a high level of generality of the policy goals. We follow the reasoning of Matland, who argued that:

> '[W]hen policy goals explicitly have been stated, then, based on
> democratic theory, the statutory designers' values have a superior
> value. In such instances, the correct standard of implementation
> success is loyalty to the prescribed goals. When a policy does not
> have explicitly stated goals, the choice of a standard becomes more
> difficult, and more general societal norms and values come into
> play.' (Matland, 1995, p. 155)

Moreover, using the uniform definition and operationalisation of policy performance serves the comparative aim of the study.

The article includes a quantitative content analysis of relevant parts of countries' national drug strategies to classify them into policy frame categories. The policy performance was assessed based on country-level data of the European Monitoring Centre for Drugs and Drug Addiction.

The analysis results suggest the relationship between morality policy framing and poor policy performance as well as between strong health-social framing and high

performance of harm reduction. With respect to its theoretical contribution, therefore, the article supports the thesis of Meier that morality policies involving one-side issues and virtually no opposition and expertise 'will not work because the policy proposals have not been tampered by informed debate' (Meier 1994:247)

1.5.2. Article on collaborative governance in the illiberal context

Chapter 3. contains the article 'Collaborative governance regimes in illiberal democracies: A comparative case of drug harm reduction policy in Central-Eastern Europe', published in Transylvanian Review of Administrative Sciences 62 E in 2021. It covers the period 2010-2019 and addresses the problem of inter-sectoral cooperation in service delivery in a policy field *'that typically requires the collaborative efforts of different ministries and agencies to implement it properly due to its intersectoral character (...)'* (Knill and Tosun 2012:151).

The need for focus on coordination, collaboration and networks in policy implementation, including the exploration of factors facilitating and undermining collaborative efforts, was emphasised by numerous synthesisers – the third-generation implementation researchers like Fritz Scharpf, Laurence O'Toole, and Walter Kickert, Erik-Hans Klijn and Joop Koppenjan (Hill and Hupe 2002).

The research focuses on governance. The concept of governance turns away from the idea of government as the sole policymaker and actor delivering public services, shifting the focus to non-state actors (business and non-profit organisations alike) as important actors of the policy process. Consequently, a shift from the hierarchical exercise of power towards more horizontal coordination also takes place, giving considerable attention to policy implementation (Hill and Hupe 2002:105).

However, as noted in Section 1.1.3., countries in Central-Eastern Europe are generally characterised by the central government's dominance in policymaking and monopolisation of public service delivery by the state. Furthermore, Visegrád Group is the central locus of the shift towards illiberal governance, which makes policy processes even less transparent, accountable, and participatory than in the case of customary features prevalent in the region. This context provides an excellent

opportunity to learn about the still largely unexplored effects of the illiberal turn on collaborative governance.

Addressing our first overarching research question exploring the factors affecting policy performance, the article asks: What are the ideal types of collaborative governance regimes? And: How do CGRs within drug harm reduction policy differ in illiberal democracies compared with their non-illiberal (or less illiberal) counterparts in CEE? Substantially, we address the problem of policy implementation in a collaborative field, looking at how types of collaborative governance depend on the essential contextual macro-political and policy features, which are the key factors affecting policy performance.

We adopt a qualitative comparative case study design complemented by congruence analysis.

The study focuses on the *(E) implementing agencies* – non-governmental organisations, as the main responsible actors in delivering harm reduction services. Studying the government-shaped environment of these NGOs, the paper takes a closer look at three model elements. First, it addresses the *(B) resources*, analysing direct and indirect sources of organisations' funding. Second, within the *(C) interorganisational communication and enforcement activities* factor, it explores mechanisms for NGOs' involvement in policy formulation, mechanisms for NGOs' involvement in policy implementation, joint operating procedures, and trust-building activities on the side of the government. Finally, within the *(D) economic, social, and political conditions* category, it addresses NGOs' operational space and the stability of the policy system.

The theoretical contribution of this chapter is threefold. First, it explores policy implementation by non-state actors, namely, non-governmental organisations, as the ones who are primarily responsible for the delivery of harm reduction services. In this respect, it differs from most implementation studies, which focus on public entities as implementers. Secondly, it uses the framework of collaborative governance and applies it to analyse the phenomenon in illiberal regimes – contexts characterized by general hostility towards NGOs. Therefore, the novelty of the chapter lies in examining a policy field where the collaboration between the government and NGOs is crucial in

regimes, which not only do not foster such collaboration but often outrightly undermine the very organisations responsible for the policy implementation. Last but not least, the paper develops a typology of collaborative governance regimes, describing their features across a set of variables included in the policy implementation process model.

1.5.3. Article on structural barriers and facilitators of effective service delivery

The article 'Needle exchange programmes in Visegrád countries: A comparative case study of structural factors in effective service delivery', published in Harm Reduction Journal 16(1) in 2019, constitutes Chapter 4 of the dissertation.

Similar to the analysis of the relationships between policy framing and policy performance, the article addresses the puzzle of significant between-country differences in drug policies and the development of harm reduction services in Central-Eastern Europe, notwithstanding the overwhelming similarities between the countries in terms of history, culture, and political situation. Contrary to the article 'A sin or a health issue?' article addressing only policy formulation and policy performance, the focus here is precisely on the policy implementation processes.

This paper aims to contribute to the understanding of policy implementation by determining: (1) what are the structural factors affecting the functioning of needle exchange programmes, (2) how they vary between examined countries, and (3) how they affect the performance of needle exchange services.

The theoretical foundation of the study is based on Bronfenbrenner's ecological framework developed for analysing external determinants of human behaviour across three levels: the macrosystem, the exosystem, the mesosystem and the microsystem. The article also uses the concept of 'risk environment', which, in the context of HIV prevalence among people who inject drugs, emphasises the role of environmental factors like migration, culture and social norms, policy and legislation. The inclusion of multiple interrelated and interacting levels of implementers' environment corresponds to McLaughlin's observations about policy implementation:

'Implementors at all levels of the system effectively negotiate their response, fitting their action to the multiple demands, priorities, and values operating in their environment and the effective authority of the policy itself. Further, this bargaining or negotiation is a continuous process, proceeding overtime as policy resources, problems, and objectives evolve and are played against a dynamic institutional setting.' (McLaughlin 1987:175).

In the quest to find answers to both of our overarching research questions, the article utilises a comparative multiple case study design with embedded units of analysis complemented by within-case analysis. Based on documentary analysis and interviews with employees of NGOs providing needle exchange services, we identify 24 themes (structural barriers-facilitators) across eleven categories.

First, *(A) standards and objectives* include the following themes: 'legal status of drug possession', 'competition of drug policy with other policy fields' and 'competition with other pillars of drug policy' (i.e., law enforcement, prevention, treatment and recovery).

Second, the *(B) resources* are analysed as 'amount of funds' and 'stability of funds'.

Third, *(C) interorganisational communication and enforcement activities* include the themes: 'regulations of the framework of harm reduction services delivery', 'donor-imposed limitations', 'time-consuming procedures' and 'embedment of harm reduction in policy documents and public tenders'.

Fourth, *(D) economic, social and political conditions* are discussed in terms of 'drug use as a sin' and 'addiction as a life choice' themes of 'morality' category; 'engagement', 'consensus' and 'attitudes' themes of 'state-level politics' category; 'general coverage of demand reduction services' and 'completeness of demand reduction system' themes of 'drug policy' category; 'country-level shortage of professionals' and low level of recognition/respect for social workers and outreach workers employed in harm reduction services' of 'education/labour market' category; 'motivation', 'attitudes' and 'scapegoating' themes of 'local politics' category; 'not in

my backyard attitudes', 'conflicts' and 'violence' themes of the 'community' category; and 'direct contacts with criminal underworld' theme.

Regarding the *characteristics of the implementing agencies,* the focus here is primarily on their capacity, considered by McLaughlin as one of the two major factors significantly influencing policy success (1987:172)

The results of the article confirm the influence of structural barriers and facilitators on policy performance. A relationship was discovered between the high number and severity of structural barriers and poor performance of harm reduction. On the other hand, the presence of facilitators is indeed related to high policy performance. The value of the study also lies in its choice of the theoretical framework. Namely, the article demonstrates that the ecological model can be successfully applied to studying not only individuals but also organisations. Finally, exploring factors affecting harm reduction policy performance in Central-Eastern Europe fills a significant gap in knowledge about this understudied region.

1.5.4. The relation between the chapters

The articles making up this dissertation are embedded in the field of policymaking, with a particular focus on policy performance. All three chapters aim to contribute to the understanding of factors affecting the outputs of a peculiar policy area in a collaborative field and a geographical context unfavourable to collaborative governance.

The articles are complementary in nature. Each of them takes a closer look at different aspects of the policymaking process. Taken together, they provide a comprehensive picture of factors affecting policy performance.

1.6. Overarching methodological remarks and reflections

One of the disadvantages of a portfolio-based doctoral thesis is the limited space that can be devoted to methodological considerations in peer-reviewed journal papers. This

section addresses this issue by providing a more detailed description of the methodologies used in the papers included in this dissertation.

All the papers comprising this work use the qualitative method. More specifically, all of them are, in essence, comparative qualitative case studies of exploratory nature.

The interview data used in Chapters 3 and 4 of this dissertation was obtained between 2015 and 2019 from 20 employees of harm reduction NGOs based in major cities. One of the interviewees represented an NGO working in drug policy advocacy while others were employed in harm reduction services. The key informants held various positions within their organisations (from frontline workers to directors). Four key informants from Poland, seven key informants from Hungary, four key informants from the Czech Republic, and five key informants from Slovakia were interviewed.

The preparations for interview data collection included conducting a pilot interview with a harm reduction service employee from Romania. The pilot interview allowed for identifying several additional areas of interest and ensured a clear and comprehensible formulation of questions. The actual interviews were semi-structured and conducted using an interview protocol including 15 questions relating to the daily operation of the organisations, external relations (with clients, donors, public authorities, local communities, other NGOs). Informed consent declaration, including the provisions on anonymity and confidentiality, was obtained from all interviewees. Two interviews (one Hungarian one Czech) included two interviewees due to interviewees' time limitations and language barrier, respectively. Five interviews were conducted online, and 15 were face-to-face. To ensure the comfort of the key informants, face-to-face interviews were conducted in venues suggested by them: in a neutral setting (café) in two cases and at organisations' premises in eleven cases.

All the interviews were recorded and transcribed verbatim by the author. The average time of one interview was approximately 90 minutes.

The remainder of this section is devoted to a more detailed description of the methods used in the research 'Collaborative governance regimes in illiberal democracies: A comparative case of drug harm reduction policy in Central-Eastern Europe', which is

necessary due to the conceptual complexity of the paper on the one hand, and the limited space available in peer-reviewed papers, on the other. However, before we move to the description of data analysis, several remarks regarding the development of the analytical framework would be in place to shed some light on the process of translating the broad concepts into empirically explorable terms.

The analytical framework, including a typology of 'collaborative governance regimes' (CGRs), has been developed based on an extensive review of the literature addressing government – NGO relations and collaboration in policymaking. We have identified several analytical variables operationalising key features of CGRs, which we have divided into two sets: the first set describing the political and policy environment of collaborative governance (operational space; system stability) and the second set referring to substantive features of collaborative governance (mechanisms for involving NGOs in policy formulation and design; mechanisms for involving NGOs in policy implementation; indirect resources; direct resources; joint operating procedures; trust-building: policies and government activities affecting trust).

The operationalisation of our variables was based on the analysed literature.

The indicators of operational space of NGOs were borrowed from the analytical framework of van der Borgh and Terwindt (2012a) and included:

- physical harassment and intimidation;

- criminalisation;

- administrative restrictions (e.g. restrictive NGO legislation on registration and operation; ad-hoc measures by different government agencies);

- stigmatisation (e.g. criminal stigmatisation of specific actors; social stigmatisation of the entire NGO sector); and

- spaces of dialogue under pressure (e.g. co-optation; closure of newly created spaces).

The system stability variable referred to the legal and policy framework, including changes in funding. It involved the extent of unpredictability, uncontrollability and frequency of changes in the areas most relevant for the operation of harm reduction services: criminal laws on drugs, drug strategies and funding priorities.

Mechanisms for NGOs involvement in policy formulation, design and implementation included the number and scope of formal, institutionalised spaces for NGOs to provide their input into the policy formulation and frameworks for outsourcing service provision to NGOs. The subject of focus was the formal existence of such mechanisms and their use in practice, i.e., the extent to which the NGOs involvement was meaningful, as opposed to symbolic or serving 'ticking the boxes' exercise. In addition, in the context of implementation, factors potentially hindering effective policy implementation were considered, such as relationships with different public institutions (e.g., law enforcement, health care).

Direct and indirect resources referred to the possibilities for NGOs to acquire funding for their operation and included the munificence of resources (only in case of direct resources), as well as funding framework and selectivity in distribution.

Joint operating procedures referred to the degree to which the two sectors (government and NGOs) are aligned and mutually adjusted in terms of operations and decision-making processes and procedures (as opposed to disregarding one another). It concerns the number and scope of operating procedures that were adjusted in order to achieve the shared goal(s) of a partnership (Thatcher, 2007 cited by McNamara, 2012, p. 393), the degree of inclusiveness and participation of various non-governmental stakeholders in decision-making (McNamara 2012), and measures for the empowerment of the least powerful participants (Bryson, Crosby, and Stone 2006).

Trust-building: policies and government activities affecting trust are crucial for collaborative governance (Ansell and Gash 2007; Bryson et al. 2006; McNamara 2012). Trust levels can vary depending on, for example, the relationship history between the partners, i.e. previous cooperation versus conflict (Ansell and Gash 2007).

Trust-building is facilitated by direct and open communication (Ansell and Gash 2007; McNamara 2012), shared understanding, commitment and achieving "small wins" (Ansell and Gash 2007; Bryson et al. 2006; McNamara 2012), as well as reciprocal orientation (bilateral actions) (Bryson et al. 2006).

The first stage of literature-based operationalisation of our dimensions focused on differentiating between two extremes of the continuum, which, at the time, were fully collaborative regime and non-collaborative (neutral) regime. As to the former end pole, we have a regime of where NGOs have broad operational space and work in a facilitating (policy and political) environment, i.e., such (policy) environment which takes into consideration characteristic features of NGOs (as opposed to government and business sectors). The policy framework is clearly defined; the government is protective towards the third sector and supportive of inter-sectoral partnership. The amount of direct financial resources is high, and their allocation (distribution) is balanced and based on needs and merits. The scope of the possibilities of acquiring indirect financial resources is significant, and the system is stable with no unpredictable and/or uncontrollable and/or frequent changes in neither legal regulations nor resources distribution. There are mechanisms and institutions for the involvement of NGOs in policy design, implementation and evaluation in place and working effectively. On the other hand, the sectoral/organisational autonomy is limited, with at least some joint operating procedures adjusted to achieving shared goal(s) and not entirely independent decision-making processes. The Trust level is high, and considerable trust-building efforts are in place. NGOs are meaningfully involved in policy design, implementation and/or evaluation.

As for the latter end, we have a neutral regime where NGOs have work in an ambiguous environment. The extent of government protection of NGOs is minimal or non-existent (either because of the government unwillingness or incapacity), and legal and policy frameworks are often vague or missing. The government neither facilitates nor impedes collaborative governance; however, the system's stability may be low. The amount of direct financial resources is low, and/or they may be allocated in a discretional way (e.g., clientelism, corruption). The number/scope of the possibilities of acquiring indirect financial resources for NGOs is limited, and their distribution tends to be affected by the same phenomena as in the case of direct resources. There

are either no mechanisms or institutions for NGOs involvement in policy design, implementation, and evaluation in place or, if such mechanisms are formally in place, they are not working properly. Sectors/organisations are fully autonomous and independent. There are neither joint decision-making or planning nor joint procedures of operation. Actions are unilateral. Trust level is low with a high level of government control over non-state actors, trust-building efforts are missing.

The data analysis involved hand-coding using qualitative data-analysis software MaxQDA, following a code system based on the developed analytical framework.

The concept-driven coding process involved the identification of the relevant themes in textual segments. The literature defines a *textual segment* as 'a segment of text that is comprehensible by itself and contains one idea, episode, or piece of information' (Tesch 1990:116). In our coding process, due to the nature of the spoken language and a relatively informal atmosphere during the interviews, the textual segments were – where necessary – coupled or complemented with the information from other segments in order to ensure their comprehensibility. For example, in the segment: 'And this [drug policy field] is the last level of interest of our town, land, and government politicians. It's still not interesting agenda, something to pick up this topic and make a flagship from this', the '[drug policy field] information was added to maintain the meaning.

The coded meaning units ranged from a sentence fragment to several sentences addressing a specific topic. Subsequently, synthetic summaries were developed for each case per dimension. These summaries served as the basis for categorizing the countries into one of the three regime types through the pattern-matching procedure. Table 1 below presents the code system used and examples of text segments.

Table 1. The code system and examples of coded text segments in the paper 'Collaborative governance regimes in illiberal democracies: A comparative case of drug harm reduction policy in Central-Eastern Europe'.

Category	Sub-category	Examples:
Operational space	Hindering	'You know, this divide and rule thing, divide the people so you can go upon them. So first they [the government] decrease the money, so then everyone is in danger, you have to get source to pay the rent or anything, or to eat, so if there's less money in the field then everyone would grab their seats and stick to them, and they will be less brave to say what they want… So, you know, it was like that. And if you hit some organisation like Blue Point then you make an example that if you fight for your rights then you will be punished.' (Hungary)

'It's a certain socio-political context, which we can draw since the transformation. What transformation did with people with addiction and the socially excluded ones, how the state deals with them or rather completely ignores them, doesn't care about them, in very general terms.' (Poland)

'And this [drug policy field] is the last level of interest of our town, land, and government politicians. It's still not interesting agenda, something to pick up this topic and make a flag ship from this'. (Slovakia) |
| | Promoting | 'For example, we had the Prime Minister here in the drop-in, and he was interested in the addictology services. (…) But he's deciding if we get the funds or not, so we did for him a nice meeting and I had to welcome him here, and explain how meaningful is harm reduction, what does it mean, etc. And he was open-minded and… He never heard of harm reduction before, but after the meeting he even posted some post on the Facebook, made some video about how important is to have harm reduction services and other drug services in [the] Czech Republic'. (Czechia) |

System stability		'I Think it's [the policy field] quite stable' (Czechia) 'Government policies are ad hoc; they're not really based on drug strategy but on political orders' (Hungary) 'I have to say that for the time being, I guess I feel safer due to the introduction of three-years project, so for now, we hope that what we started can continue at least for the next three years'. (Poland) 'This was about funding, it's a huge chapter and it's been like that since eight years ago or even nine years ago when the funding system changed'. (Slovakia)
Mechanisms for involving NGOs in policy	Design	'We are joined in Association of Non-Governmental Organizations which consists of every service within the drug field (…). [It] influence[s] not only the national drug strategy but also some laws. They go to the Parliament, so within this association I can see strong influence on this [the formulation of policies]'. (Czechia) 'We can influence it pretty much in a big way because they can see us as experts. Often with some controversial topics it always depends on the head of the Governing Council (…)'. (Czechia) 'And this all was like we went back in time to 1950's. You can't say what you want, we started to be afraid, terrified about who hears what, who says what, it was terrible. It was very paranoid. (…) And we tried everything, and then we decided to shut up and do our job in silence'. (Hungary) '(…) it was about projects and about the grants from the side of [state] departments (…) and it was a kind of your put your comments that were… how does it work now, and so on. And you could make some changes and some new approaches. But since that time, it's already two years, nothing has changed'. (Slovakia)
	Implementation	'We're quite like experts for the [state] donors and the [state] donors quite respect us as experts'. (Czechia)

		'You cannot explain the police hostility towards harm reduction with the law. So that must be politically motivated attacks against harm reduction'. (Hungary) 'We, employees here are operating on the border of the law and illegality, we actually need to be very sensitive in many aspects not to unintentionally break the law (…) And this ghost of the police wandering around here, terribly damages our relationship with clients, which is based on trust'. (Poland) 'We had reports from clients that they're [the police] violent, kicking them, hitting them, using their power…' (Slovakia)
Direct resources	Funding framework	'The financing in Czech Republic is on one year-based cycle. So, you have to write to all the subjects you want money from. You have to write your own project when you request funding. And this project is every year, [it] goes through the process of deciding if they will give you the money or not'. (Czechia) 'So, on the state level, for sure they started to undermine, first with psychiatric patients, and then with cutting down the needle exchange. And the fact that "harm reduction", "needles", "needle exchange", nowadays can't even be included in a project as an expression, as a word, we can't write them in, it's a nonsense. (…) And this situation that we can't speak openly about it, that there are no separate funding possibilities for that, but we have to avoid these words in every possible way and use "drop-in", "low-threshold service" expressions, this also shows [how bad the situation is]'. (Hungary) 'Unfortunately, to even submit a project proposal, you need to have premises. It's not like the city [authorities] will give you the money for a venue, and you will rent it [after the project is accepted], but it's a precondition to take part in the procedure that you have it beforehand'. (Poland)

		'Normally, the grants, for example the minister[ial], there are new grant opportunities by the end of the year, so you have to write the project and then you are waiting until they approve'. (Slovakia)
	Munificence	'It's true that we are blessed that we have the money and there's no struggle if we will exist or not exist. Of course, there's always this trouble a little, but it's not like fighting every day for the survival.' (Czechia) 'Yes, [the main problems are] money and possibilities, from political point of view. If it wouldn't be a political question, but professional, I think it would be much better'. (Hungary) 'Here, as harm reduction, we operate a drop-in, which is open six days a week, including Saturdays, from 11:00 until 17:00. Our clients can use a shower, get help of a lawyer who is here twice a week, also a job counsellor'. (Poland) 'Our main donor, self-governing region of Bratislava, they have been our most stable and most supportive donor of all, and basically, they give us usually around one-third of the budget that we need for one year, so it's around 30 000 euros' (Slovakia)
	Selectivity in distribution	'It's a balanced approach and we have probably some four basic stones [pillars]. It's primary prevention, harm reduction, treatment and law enforcement-repression'. (Czechia) 'Blue Point needle exchange didn't get these grants. When they were already in a very critical situation, they didn't get the annual grant from the government, which was really bad. So that you can say it was on purpose by the government to press them to close down'. (Hungary)

		'The level of funding, for example by the National Bureau [for Drug Prevention]. This year, all the money was awarded to Monar and Karan [two biggest abstinence-based organisations]. Listen, well, harm reduction is really tiny. This is a barrier'. (Poland)
		'With the Ministry of Health there is a suspicion of corruption. I mean, each ministry is, they have this budget for these calls for support NGOs and civil society and the services, but every ministry has its own competence to deal with this money, and for example in the Ministry of Health usually the highest sums for the projects go to private companies'. (Slovakia)
Indirect resources		'We have money from donations or the assignation of the taxes – two per cent'. (Slovakia)
Joint operating procedures		' The prison service or the people from probation send us drug users here and I can offer them a job for the community (…) [we cooperate] with the probation centre and we're quite in touch'. (Czechia)
		'So, this kind of process has started. It's very good that we managed to find such professionals to whom we can send our clients directly. And now in April we will have a 2-days training with the people who used to operate needle exchange, and also hepatologists will come, doctors, and together we will try to work out [the system]'. (Hungary)
		'The doctor speaking even with me, the foundation employee, when I introduce[d] myself and describe[d] the situation, describe[d] what had happened here in the drop-in (…), she says that there is no bleeding and who am I in the first place, and she hung up on me'. (Poland)

		'We are cooperating with some doctors, because the (…) program (…), the social assistance, is that we're going with our clients to get the documents, get ID or go to the doctors and also we have the doctors, we have our gynaecologist (…) we have like one, so when we have a client who needs to go, we're going with them'. (Slovakia)
Trust-building: policies and government activities affecting trust	Commitment	'I think we have this cooperation. For example, someone is complaining like for drug users gathering at some places. The municipality asks us to do something about it. And we say, "yes we will be there three times a week, we will collect your syringes, we will tell the people not to stay there". The municipality is happy and the people complaining they are happy also'. (Czechia)

'Needle exchange programs were not closed because of the law. They were closed because the local government just did everything to find a hole in the shield to make the work impossible'. (Hungary)

'No mayor will convince hysterical mothers with children in their arms, that a place for addicted people, where they will come and exchange syringes, is okay. Because when they hear "syringes", the mere word "syringes", no matter in what context, they get nuts. So, I think, it's mostly the society [that is opposing harm reduction], and the authorities can't do too much, actually. Even if someone is more in favour, they won't say it out loud. This mayor later talked to us one-on-one and threw his hands up, but it's clear that he's afraid for his head [position], and I understand this'. (Poland)

'She [the director of the Bratislava region Social Department] is quite well-educated in the topics and also in harm reduction because she's been cooperating with us almost from the beginning, so she has this experience of why it's |

		important to have harm reduction services, why it's important that we work this way and that way, and she understands we have no systematic support from the government'. (Slovakia)
	Trust-building	'For example, we had the Prime Minister here in the drop-in, and he was interested in the addictology services. (…) he's deciding if we get the funds or not, so we did for him a nice meeting and I had to welcome him here, and explain how meaningful is harm reduction, what does it mean, etc. And he was open-minded and… He never heard of harm reduction before, but after the meeting he even posted some post on the Facebook, made some video about how important is to have harm reduction services and other drug services in [the] Czech Republic'. (Czechia)

'The thing is that we received a notice in 2014 November that it's not okay [the very high client turnover] (…), so the whole process started. They [local authorities] said that we didn't have a permission to do this work [needle exchange], which is interesting, because (…) they issued the operating permission for the 13th district drop-in (…). They said that they didn't know about this [needle exchange service operation], while there was a stamped document'. (Hungary)

'[The police come] to get to know each other, to know, to exchange phone numbers in case there's a need to contact each other, to let us know that they're here at the station [if we need them]'. (Poland)

'He [district mayor] declares to support us, he declares to be interested in opening drug consumption room in the community, he claims to be interested in supporting the centre, but it's all words, just words, and basically we didn't have any kind of financial or any kind of other support with opening the centre'. (Slovakia) |

	Trust level	'For example, last year I wrote in my project of the drop-in, of the needle exchange program, that in special cases for some people in case management, we can do OST right here in the drop-in, even though typical OST is another program. But the donors do respect my argumentation, why it's good for the clients. So, at this point, they quite respect it'. (Czechia)
		'I think social workers have a huge responsibility in this because if government is government, power is power, and if you attack, they will attack back. So, if you're always just shouting, you know what I mean. So, I'm not telling that we have to shut our mouth, but if they see that the only thing we do is attacking their policy, then they are going to fight back'. (Hungary)
		'The more you do with a client, the more they [state donors] want to always have a [client's] signature, on everything. (…) You always have to have some papers on you, because, God forbid, someone [a client] will die, and you're screwed. It's such an absurd, it was not like that back in the day. In the past, I just wrote, and I signed. My signature used to mean something for the [state] donor, that I have my reports, I sign them with my own name, that I did this job. Now it's not enough'. (Poland)
		'She [the NGO director] has many contacts all around in all departments. Maybe she trusts all these contacts and they trust her. It's this kind of relationship'. (Slovakia)

Admittedly, the operationalisation of the presented variables was a laborious and challenging task that required compromises. Indeed, some of the indicators used to measure the variables could have been more precise. For example, administrative restrictions could have been further specified into their number, severity and kind; relationships with different public institutions could have been divided into the number and scope of instances of cooperation and conflict; direct and open communication could have been specified into the number of institutions engaged in such communication and the content or topics of such communication. Although technically possible, achieving such a level of detail and precision was not feasible. Conceptualisation and operationalisation of variables is an exercise requiring compromises and finding a balance across the continuum of generality. In this particular case, it meant that some of the variables' components remain implicit.

2. CHAPTER 2: A SIN OR A HEALTH ISSUE? MORALITY POLICY FRAMING AND THE STATE OF HARM REDUCTION IN CENTRAL-EASTERN EUROPE

2.1. Introduction

The harm reduction approach to drug use, although still relatively new compared to the other three pillars of drug policy (law enforcement, treatment and prevention) (McCann 2008), has already secured a well-established position in many developed countries, especially in Western Europe. It is understood as 'policies, programmes and practices that aim to minimise negative health, social and legal impacts associated with drug use, drug policies and drug laws' (Harm Reduction International 2020). Based on public health and human rights considerations, and promoting pragmatic solutions, it aims to minimise the adverse health and social consequences of substance use instead of attempting to eliminate their use (Single 1995). Initially controversial and contested by many as potentially promoting drug use, harm reduction approach has slowly made its way to the mainstream of policy interventions.

Today, there is a plethora of evidence on the effectiveness of harm reduction services in preventing infectious diseases (see, for example, Hurley, Jolley, & Kaldor, 1997; MacDonald, Law, Kaldor, Hales, & J. Dore, 2003; Vlahov & Junge, 1998; Wodak & Cooney, 2006). Such interventions have also proven to be cost-effective (Andresen and Boyd 2010; Wilson et al. 2015). Some scholars claim that in the face of this evidence, '[t]he prolonged scientific debate about harm reduction is over' (Wodak, 2007: 60).

This view seems to be shared by major international organisations. United Nations, in the Resolution adopted by its General Assembly in April 2016, highlights the need for

a balanced approach to drug policy and 'Invite[s] relevant national authorities to consider (…) effective measures aimed at minimizing the adverse public health and social consequences of drug abuse, including (…) injecting equipment programmes (…), as well as consider ensuring access to such interventions (…)' (United Nations, 2016: 6). European Union goes even a step further, calling in its Action Plan on Drugs 2017-2020 for 'Scal[ing] up where applicable, availability, coverage and access to risk and harm reduction services, e.g. needle and syringe exchange programmes, opioid substitution treatment, opioid overdose management programmes' (Council of the European Union, 2017: 7).

Notwithstanding this international agreement on the role of harm reduction in drug policies, significant differences in the availability of various interventions across countries can be observed. For example, while needle and syringe exchange programs (NSPs) are available in 29 out of 30 countries reporting to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), take-home naloxone programs are implemented in only ten, drug consumption rooms in eight, and heroin-assisted treatment in five countries (EMCDDA 2019b).

Differences are also apparent in terms of perceived access to services. According to civil society experts, while the accessibility of drug prevention and treatment responses in Central-Eastern European countries is similar to Western Europe, the accessibility of harm reduction programmes is seen as significantly lower (Kender-Jeziorska and Sárosi 2018:43).

One of the explanations behind this phenomenon can be the role of values and social norms – drug policy, addressing addictive behaviour-related matters, is considered one of the typical examples of morality policies (Euchner 2019). Hence, in order to shed some light on possible reasons behind abovementioned differences, this paper examines, through the lenses of the morality policy framework, the state of harm reduction services for people who inject drugs (PWID) in Czechia, Hungary, Poland, and Slovakia. Exploring the variation in policy effects, this paper asks: What, if any, is the relationship between drug policy framing and the state of harm reduction?   . The inquiry involves three main steps: (if) determining the dominant frame used to

describe drug policy in a country, (ii) assessing the state of harm reduction in a country, (iii) identifying possibly existing relationships between the two.

To that end, the following section presents the analytical framework, research question, and expectations. Subsequently, data and method are discussed, followed by empirical analysis and conclusions.

The study uses technical guidelines developed by the World Health Organization, United Nations Office on Drugs and Crime, and Joint United Nations Program on HIV/AIDS (2012) in order to help countries in implementing and monitoring HIV prevention interventions, as a point of reference. The analysis will focus on needle and syringe exchange programs (NSPs) for people who inject drugs.

2.2. Analytical Framework, Research Question and Expectations

2.2.1. Morality policy

The analytical framework of this inquiry derives from the studies on morality policy. Since the proliferation of research on the topic is a relatively new phenomenon within the area of policy studies, theories and frameworks in this area are continuously developing, resulting in various approaches to the problem (Euchner 2019). The primary definitional criterion of morality policies, differentiating them from other kinds of policies, is that they essentially include conflicts of fundamental values, as opposed to instrumental conflicts on wealth redistribution (Knill 2013; Meier 1999; Mooney 2001).

There is no agreement, however, regarding specific criteria of classifying policies as morality ones, and on whether specific policies should be defined as morality policies *a priori* or *a posteriori*. Defining morality policies *a priori* is represented by a policy-based approach that classifies policies as morality ones 'if they address topics that are generally assumed to refer to decisions and conflicts about societal values' (Heichel et al., 2013: 319). It focuses on the regulated policy area and differentiates between four main categories of moral policies: (a) matters involving life and death (e.g. abortion), (ii) sexual behaviour (e.g. same-sex marriage), (iii) addiction and (iv) restricting

individual self-determination by the state (e.g. firearm control) (Heichel et al., 2013: 320).

A posteriori approach to defining morality policies, on the other hand, includes two main approaches. Politics-focused one considers morality policy a distinctive policy type with political 'process patterns that reach beyond existing policy typologies' (Knill 2013:310). In other words, morality policies can be identified based on politics surrounding them, and they are characterised technical simplicity, saliency to the general public, and high citizen participation (Mooney, 2001: 7–8).

The second *a posteriori* approach defines policy as morality one as a result of framing as such by policy actors. In other words, in the case of morality policy, 'those who frame the issues place adherence to moral principles above alternative considerations' (Mucciaroni, 2011: 191). This paper adopts the framing approach, classifying drug policy as a morality policy type not *a priori,* but based on how policy actors treat it. While various policy actors can use different frames, and specific frames may likely have different reception and support among various social groups, this paper focuses on the government as the actor framing policies.

2.2.2. Research ambition and analytical framework

By adopting the framing approach, this paper assumes that: (if) the framing of drug (and within it, harm reduction) issue may vary between countries, and (ii) one-sided morality issues (with high-risk drug use among them) tend to have poor results. Therefore, we ask: What, if any, is the relationship between drug policy framing and the state of harm reduction?

Auxiliary, specific questions are the following:

What are the frames used to describe drug policy in analysed national drug strategy documents?

What are the outputs/outcomes of drug policy in analysed countries?

In the attempt to identify the framing of drug policy, this paper borrows the typology from Euchner and colleagues, who – in their study of drug and gambling policies – identified four policy frames summarised in Table 2 (Euchner et al., 2013: 378).

Table 2. A sin or a health issue? The summary of the analytical framework. Source: Euchner at al. 2013:378.

Frames	Features	Examples	Policy outcomes for harm reduction
Morality	Drug use as inherently bad behaviour that (a) does not conform to societal norms and values, and (b) threatens the user in a fundamental and existential way	Drug use contrasts with a positive way of life and traditional norms and values	Low level of availability and coverage of needle exchange services.
Health and social	Drug use as threats to a user's health and social conditions	The main task of drug policy is to control the negative consequences that affect the consumer's health	High level of availability and coverage of needle exchange services.
Security and public order	Drugs as threats to public security and order because of illegal activities or nuisance committed by (a) users/addicts, or (b) suppliers	The trade in illegal drugs and drug-related crime are a serious disturbance of public order and security; public order and security have to be defended	Low level of availability and coverage of needle exchange services.
Economic and fiscal	Drugs as damage (healthcare costs, missing workforce caused by addicts) or benefits (revenues through licensing, taxation) to the national economy	Drug abuse and addiction cause significant economic damages	Moderate level of availability and coverage of needle exchange services.

Further, this paper follows the conclusion of Meier, who differentiates between two kinds of morality policies. In two-sided morality policies, various interest groups actively compete for domination. One-sided morality policies, in turn, cause unanimous opposition, resulting in the lack of informed discussion and involvement of professional expertise and, in consequence, poor policy design and effects (Meier 1994). Meier considers 'drug abuse' to be a one-sided morality policy issue. Needle exchange services analysed in this paper serve the population of people who inject drugs and injecting psychoactive substances is one of the types of high-risk drug use (or 'drug abuse' in Meier's terminology). It would follow, therefore, that where drug policy is framed as a moral issue, policy effects in the area of harm reduction will be poor.

On the other hand, it can be assumed that where drug policy is not framed as morality policy, it is – as a rule – two-or multi-sided, involves debates and professional expertise, and depends to some extent on the current political landscape in a country. Regarding possible policy results in case of the 'security and public order' framing, it is likely that harm reduction interventions perform poorly due to policy focus on law enforcement and incarceration. On the other hand, it can be assumed that dominant 'health and social' framing will result in a high level of outcomes since the primary goal of needle exchange programmes is to improve or prevent the deterioration of the health status and general well-being of people who use drugs. Finally, for the 'economic and fiscal' framing, it is plausible to predict a moderate level of services' performance. On the one hand, NSPs are 'one of the most cost-effective public health interventions ever founded' (Wilson et al. 2015:S6) and allow for saving significant public resources for HIV and Hepatitis C treatment (Kwon et al. 2012), which would suggest a high level of NSP outputs. On the other hand, however, the framing of the entire policy field likely focuses on the economic damages caused by drug use, which can counterweight the argument on the efficiency of services.

2.3. Methods and data

In order to answer the research questions, this paper adopts an exploratory study design with a cross-country comparison.

The geographical scope includes the Visegrád Group states: Czechia, Hungary, Poland, and Slovakia. The chosen countries share numerous cultural, social, and political similarities on the one hand, and face relatively similar challenges regarding drug use on the other.

Identification of the policy frames was conducted using framework borrowed of Euchner and colleagues (2013). An analysis of relevant and corresponding parts of national drug strategies (Table 2) was performed[1]. Words and phrases (i) referring directly to the types of frames (see the analytical framework) and (ii) used in the

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[1] The qualitative data analysis software MaxQDA was used. The analysis focused on identifying segments referring to predefined themes.

context of describing drug policy goals and functions) were counted to determine the dominant policy frames.

Table 3. *The list of documents analysed for identification of policy frame. Source: Author.*

Country	Analysed document	Analysed sections
Czechia	National Drug Policy Strategy for the Period 2010-2018	Preamble, General background, Principles, Objectives
Hungary	The National Anti-Drug Strategy 2013-2020	Introduction, Basic values, Vision, and objectives
Poland	National Programme for Drug Prevention 2011-2016	Entire document
Slovakia	National Anti-Drug Strategy of the Slovak Republic for the period 2013-2020	Preamble, Introduction

The unit analysed was a word or – where necessary – a phrase, while both were given the same weight, i.e., one word counted the same as one phrase. Consequently, multiple counts and even multiple frames could be coded in a single clause. For example, in the sentence 'Both in our country and globally, the use of addictive substances and their illicit handling is perceived as a serious problem which continues to pose a threat to the health, safety, well-being and prosperity of the population, in particular young people.' (The National Drug Policy Strategy for the Period 2010 to 2018, 2010:3), there were three frames identified, with multiple counts of the 'health and social' frame:

Table 4. *A sin or a health issue? An example of coding. Source: Author.*

Keyword/phrase	Frame
'health'	Health and social
'safety'	Security and public order
'well-being'	Health and social
'prosperity of the population'	Economic and fiscal

Additionally, following the definitional criteria of morality policies, the analysis included the quantification of the appearance of the word 'value' in analysed documents, in the meaning covered by this paper, i.e., excluding phrases like 'prevalence value' or 'added value'.

The 'state of harm reduction' assessed in the second step is understood as the immediate outcome of the policy. For feasibility reasons, the scope of policy outcome

was narrowed down to one type of harm reduction service: needle exchange programmes. Thus, needle exchange services in a country serve as the unit of analysis.

The assessment of the state of harm reduction was done based on the official aggregate data collected by the National Reitox Focal Points for the EMCDDA – government agencies responsible, among others, for the data collection in the drug policy field. The following sources were used:

For Czechia, Annual Report on the State of Drugs in the Czech Republic in 2017 (Mravčík et al. 2018).

For Hungary, 2018 Annual Report (2017 data) for the EMCDDA (Bálint et al. 2018b).

For Poland, Poland 2012 National Report to the EMCDDA (Malczewski et al. 2012) and Report on the State of Drug Use in Poland in 2018 (Malczewski 2018).

In the case of Slovakia, country-level reports do not include the necessary data, except for the number of needles distributed (EMCDDA 2019e; Kastelová et al. 2014). Therefore, organisation-level data were collected from all three needle exchange programmes operating in 2019 from organisations annual reports published online (OZ Odyseus 2017; OZ Prima 2017; Združenie Storm 2017) and through direct inquiries with data requests sent to organisations' directors or managers.

The choice of output[2] indicators for needle exchange services for PWID was informed by the WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users[3] (2012) – a document developed in the aftermath of adopting the 2006 Political Declaration on HIV/AIDS by the UN General Assembly (2006). The guide introduces a comprehensive package of interventions to address HIV among people who inject drugs, including, among others, needle exchange programs, opioid substitution treatment, HIV testing and counselling, and antiretroviral therapy. It also provides a

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[2] The performance of services is a policy outcome. However, from the perspective of concrete services, values for specific indicators are service outputs.
[3] While some indicators were borrowed directly from the Guide, some additional ones were developed to provide a fuller picture of the phenomenon. Own indicators (including discretionally selected benchmarks) are marked by '*' in the summary tables.

range of indicators to monitor the level of implementation of specific services. Following the Guide, the analysis focused on two main aspects of needle exchange service-delivery:

(i) Availability understood as the geographical coverage of needle exchange services.

(ii) Coverage understood as 'the extent to which an intervention is delivered to the target population' (WHO et al., 2012:35).

An auxiliary variable – estimated number of people who inject drugs – was used to enable the estimation of the services' coverage. Variables were measured across a range of indicators chosen based on the availability of the data and feasibility of the study. The table below presents the conceptualisation and operationalisation of the variables. (The summary of specific indicators and, where applicable, benchmarks for each variable can be found in Appendix 1.)

Table 5. A sin or a health issue? The conceptualisation and operationalisation of the main variables. Source: WHO, UNODC and UNAIDS 2012.

Variable	Conceptualisation	Operationalisation
Population size	The magnitude of the injecting drug use phenomenon in a country.	Estimated number of people who inject drugs (PWID)
Availability	The geographical coverage of needle exchange services.	Number and location of sites where needles and syringes are available
Coverage	The extent to which an intervention is delivered to the target population	Quantity of needles–syringes distributed; number of PWID reached by NPSs, NSP occasions of service (total client contacts)

2.4. Results

This section presents the results of the data analysis. First, a within-case analysis was performed for each country, focusing on the current situation. Subsequently, a comparative perspective was adopted, briefly discussing the current (2017) situation, but also addressing trends in the NSPs performance during the implementation of analysed drug strategies.

2.4.1. Identification of policy frames

In the Czech national drug strategy, the 'health and social' frame strongly dominates. It appears 29 times in the analysed parts of the document, in forms such as 'well-being', 'loss of people's lives', 'public health', 'protection from the harm', 'healthy development of (…) individuals. The second most present frame is the 'security and public order' one, with 14 keywords (primarily 'safety' and 'security', but also 'political stability' or 'rule of law'). The word 'value' appears in the Czech drug strategy once in the context of European values the document promotes.

In Hungary, the 'morality' frame seems to appear the most frequently – 36 times. However, the interpretation of the language used in the Hungarian national drug strategy is not straightforward. There are numerous references to health and social issues. However, it seems that in Hungary, it is the health and well-being of the society at large that is being protected, while people who use drugs are considered a threat. They are a 'burden' which, 'by abusing substances', 'can harm themselves and their environment', while drug use itself is 'harming human dignity'. As a result, since rejecting drug use 'is a value in itself', 'the state is obliged to take action against the vulnerability of the individual' by adopting a 'recovery-oriented approach', 'fight[ing] against drug consumption' and 'spreading of lifestyles representing clear consciousness' to 'popularize the drug-free lifestyles'. Further, while 'those people who refuse to use drugs (…) are doing it right' and 'represent something worth giving to other people', people experiencing drug dependency should 'hope that their recovery is possible'. Such and similar formulations involve a relatively strong, though implicit, critique of drug use as not conforming to the decisionmakers' vision of the society and supported norms and values. The 'health and social' frame is the second dominant in Hungarian drug strategy, with 22 references of neutral character.

Throughout the entire document, the word 'value' (excluding the instances where it refers to numerical values) appears in the document 31 times. In fact, the Hungarian drug strategy includes an entire chapter describing its basic values. The value-oriented approach is expressed by formulations like 'clear consciousness and sobriety as basic values', 'the spread of addiction can be interpreted as the lifestyle and values crisis', 'loss of values (…) of the youth', 'traditional values, behaviours, way of life', 'keeping

the previous values'. Although in several instances 'value' refers to the health, one can also find much more morality-based phrases, e.g., regarding the importance of religious communities 'in transferring values ensuing from their teachings regarding life, health, responsibility and human dignity'.

In Poland, there is currently no drug strategy, and drug policy area is briefly addressed in the National Health Program. Therefore, the last available relevant document was chosen for the analysis. Polish National Programme for Drug Prevention 2011-2016, however, is a purely legal and very technical document and, as such, it does not include any narrative elements describing ideas, goals, or approaches. As a consequence, it was not possible to identify drug policy framing in Poland.

In Slovak drug strategy, similar to Czechia, the 'health and social' frame dominates with 13 references to 'welfare', 'public health' and 'reduction of risk', among others. The only other frame present in Slovak document is the 'security and public' order one, with two references in the text. The word 'value'– in the meaning covered by this paper – appears in the document once, in the context of the EU values.

The table below summarises the dominant drug policy frames identified in analysed drug strategies.

Table 6. The dominant drug policy frames. Source: Author.

Country	Analysed document	Dominant frame
Czechia	National Drug Policy Strategy for the Period 2010-2018	Health and social
Hungary	The National Anti-Drug Strategy 2013-2020: Clear consciousness, sobriety and fight against drug crime	Morality
Poland	National Programme for Drug Prevention 2011-2016	None
Slovakia	National Anti-Drug Strategy of the Slovak Republic for the period 2013-2020	Health and social

2.4.2. Needle exchange programmes

2.4.2.1. Czechia

In 2017, 108 needle exchange programmes were operating in Czechia   in 138 cities and villages. This accounts for one-third of all cities and towns in the country. Needle

exchange programmes were found to be available in all of the biggest cities and the vast majority of smaller cities (up to 100 000 inhabitants). In the capital, Prague, and a few other biggest cities, several services operated in different parts of the city. Services, to a more modest extent, also operated in smaller towns and villages, which indicates a high level of programmes' geographical coverage.

More than 32 000 PWID used services in Czechia in 2017, accounting for 74 per cent of the estimated PWID population. In 2017, PWID interacted with services on almost 470 000 occasions. In other words, Czech NSPs provided over a thousand services per every hundred people who use drugs, which is a very high result.

Approximately 6.5 million needles-syringes were distributed in the country. This means 198 units of equipment for every NSP client or 146 needles per person who uses drugs, indicating medium coverage.

Overall, the 2017 availability and coverage of NSPs in Czechia were found to be high, with a room for improvement in case of the number of needle-syringes distributed per client.

2.4.2.2.   Hungary

In 2017, 40 NSP sites were operating in 20 Hungarian cities and towns (Bálint et al. 2018b:124)   , which accounts for one-fifth of all cities and towns in the country, including several NSPs operating in the capital, Budapest. Overall, the geographical coverage of services was low and somewhat uneven, i.e., needle exchange was not available in more than a half of Hungary's biggest cities, and completely absent in the smallest ones (up to 20 000 inhabitants).

Over two thousand PWID used NSPs, which indicates medium coverage of the target population – approximately one-third[4]. In 2017, clients came into contact with NSPs on nearly 14 000 occasions. It is a high number of service units provided (207 per 100 PWID).

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[4] The most up-to-date PWID population estimate for Hungary is from 2015 (EMCDDA 2020).

The number of provided injecting paraphernalia was 66 per services' client in 2017, which translates to only 21 needles-syringes per PWID – an extremely low coverage.

In sum, the geographical coverage of NSPs in Hungary was uneven. The coverage of the target population was medium concerning the number of PWID in contact with services and high concerning service occasions per 100 PWID. The coverage in terms of distributed equipment was highly deficient.

2.4.2.3. Poland

In 2017, 12 needle exchange programmes operated in 10 Polish cities, which equals 7 per cent of the cities and towns in the country. NSPs were provided primarily in the biggest cities, but even in this case, only nearly one-fifth of cities were covered. There were two organisations operating NSPs in the capital, Warsaw. In cities and towns smaller than 100 000 inhabitants, services were virtually absent.

Over 1700 clients used needle exchange services in 2017, i.e., approximately one-fourth of the estimated target population[5].

The data on client contacts were not available from the official government sources. Meanwhile, the data shared by two NSPs located in Warsaw show that in 2017, only 50 service units per 100 PWID were provided. This result should be, however, taken with a grain of salt since the performance of two services (out of 12) is hardly representative for the entire country.

All Polish NSPs distributed approximately 60 000 needles-syringes in 2017, which is 35 units of injecting equipment per NSP client per year. Concerning the entire PWID population, this translates to barely eight needles-syringes per person annually.

Overall, the availability of NSPs in Poland was extremely low and concentrated in the biggest cities only. Even there, however, the geographical coverage of NSPs was

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[5]. The estimates of PWID population can be found in two Polish reports to the EMCDDA. One of them sets the mean of estimates at 7 170 (Malczewski & Misiurek, 2013:13) and the other at 7 285 (Malczewski and Misiurek 2014a). The median value of these numbers (7 228) is used for the analysis.

limited to only a few settlements. Polish services reached out to nearly a quarter of the target population, client contacts were rare, and a very low number of injecting equipment was provided.

2.4.2.4. Slovakia

Nine NSP sites operated by three harm reduction NGOs existed in Slovakia in 2017. Two organisations operated fixed location and outreach programmes in the capital, Bratislava, and one organisation operated services in Nitra and outreach in several neighbouring cities. Altogether, NSPs were available in 5 cities and towns, which accounts for low geographical coverage of 17 per cent.

According to the data obtained from all organisations operating NSPs in 2019, nearly 2200 PWID used NSP services (almost one-third of the estimated PWID population[6]), which indicates a medium level of coverage.

Clients contacted all NSPs on over 16 000 occasions, which translates to 240 contacts per 100 PWID – a high result for this indicator of coverage. All three organisations gave away almost 400 000 needles-syringes in 2017. The number of needles-syringes distributed per client per year was 180, however, due to medium level of the target population coverage, the number of injecting equipment distributed among PWID was low, with 58 units per person. Given a highly imperfect and outdated data on the target population, however, the real coverage concerning paraphernalia distributed was likely somewhat higher.

Overall, the availability of NSPs in Slovakia was low, with services in only a few locations in the western part of the country, with central and eastern Slovakia having no NSPs at all. With respect to coverage, the picture is complex, with generally meagre performance on the country level and in the context of the entire population of people who use drugs. On the other hand, at the organisation level, the performance of Slovak

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[6] The most up-to-date estimation of the population size is from 2008: 6 800 value (Reitox National Focal Point Slovakia, 2009:67).

needle exchange programs seems much better, primarily in term of the number of distributed injecting paraphernalia per NSP client.

2.4.3. Cross-country comparison

This section applies a comparative perspective in an attempt to identify the similarities and differences between the state of needle exchange programmes in examined countries. Only comparable indicators (ratios) were analysed, and benchmark levels were used next to of absolute numbers.

2.4.3.1. *Availability of needle exchange programmes*

An important note regarding the denominator of NSP availability levels is required. While the threshold levels were adopted directly from the WHO, UNODC and UNAIDS Technical Guide (2012), the denominator differs. Due to the lack of data on the number of cities where PWID are present, the availability rate was calculated using the total number of cities of a specific population in each country.

Table 7. The availability of needle exchange programmes. Sources: Mravčík et al. 2018; Bálint et al. 2018; Malczewski et al. 2012; 2018; OZ Odyseus 2017; OZ Prima 2017; Združenie Storm 2017.

Indicator	CZ	HU	PL	SK	Benchmarks
Percentage of cities where NSPs are present, including[7]:					
Cities of 100 000+ inhabitants	High (100%)	Low (46%)	Low (18%)	Low (50%)	Low ← 60% ← Mid → 80% → High
Cities of 50 000-99 999 inhabitants	High (88%)	Low (40%)	Low (2%)	Low (22%)	
Cities of 20 000-49 999 inhabitants	Mid (76%)	Low (20%)	Low (1%)	Low (0%)	

Clearly, in big and middle-size cities, the geographical coverage of needle exchange programmes was by far the highest in Czechia, where services existed in all five biggest cities and the vast majority of smaller ones. In the three other countries, the

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[7] The original indicator included 'percentage of *cities/ states/ provinces/oblasts* where PWID are located and NSPs are present'. However, due to the lack of data on the geographical presence of people who inject drugs, the entire population of cities was used as the denominator. The benchmark values from the international guidelines were kept.

overall availability of services was low. Within this group, Hungary had the highest result with almost half of its 13 biggest cities operating NSPs. In Slovakia, needle exchange was available in one of the two largest cities, and one-fifth of smaller ones. In Poland, only one-fifth biggest cities had NSP, while programmes were hardly available in smaller towns.

2.4.3.2.   Coverage of needle exchange programmes

As shown in the table below, the largest number of needles-syringes was distributed in Czechia, where almost 150 units of equipment per PWID were provided in 2017. Further, taking into consideration only PWID in contact with services, the Czech result was very close to 'high' in terms of the effectiveness of HIV prevention. In Slovakia, the paraphernalia coverage was 'medium' and leaning towards 'high' among services' clients yet remained low for the entire target population. The situation in the remaining two countries was significantly worse, with exceptionally low needle coverage in Poland.

Table 8. The injecting paraphernalia distributed. Sources: Mravčík et al. 2018; Bálint et al. 2018; Malczewski et al. 2012; 2018; OZ Odyseus 2017; OZ Prima 2017; Združenie Storm 2017.

Indicator	CZ	HU	PL	SK	Benchmarks
Number of needles-syringes distributed per PWID per year	146 (Mid)	21 (Low)	8 (Low)	58 (Low)	Low ← 100 ← Mid → 200 → High
Number of needles-syringes distributed per NSP client per year*	198 (Mid)	66 (Low)	35 (Low)	180 (Mid)	

Moreover, suppose we take into consideration the period since the adoption of countries' analysed drug strategies and 2017. In that case, we can see that the situation in Czechia and Slovakia has been improving (10% and 23% increase, respectively), while in Poland and Hungary it has drastically deteriorated, with 69% and 72% decrease in distributed equipment, respectively.

In the case of reaching out to the target population, again, Czechia had the highest result, ensuring coverage at the level of 74 per cent (Table 8). The situation in Slovakia and Hungary was significantly worse, with nearly one in three people injecting drugs

contacting NSPs at least once in 2017. In Poland, the outreach was the lowest, covering almost one-fourth of the PWID population.

Table 9. *The outreach to the population of people who use drugs. Sources: Mravčík et al. 2018; Bálint et al. 2018; Malczewski et al. 2012; 2018; OZ Odyseus 2017; OZ Prima 2017; Združenie Storm 2017.*

Indicator	CZ	HU	PL	SK	Benchmarks
Percentage of all PWID who were reached by an NSP in the last 12 months[8]	74%	31%	24%	32%	Low ← 20% ← Mid → 60% → High

Regarding the trends, again, there has been an improvement in Czechia (12% increase in population coverage). Slight decrease (3%) of the indicator can be observed in Slovakia. Importantly, taking into consideration that several more services existed in 2013 when the drug strategy came into force, this result is still relatively high and may suggest that the surviving organisations overtook the clients of the liquidated ones. In Poland and Hungary, again, there has been a notable decrease in the number of clients served by NSP – 18% and 60%, respectively.

Regarding client contacts (number of service occasions), country-level data were not available for Polish NSPs. The organisational-level data was successfully obtained only from two organisations operating NSPs, which is not indicative for the entire country. Therefore, the table below presents the numbers of client contacts only in three analysed countries.

Table 10. *The occasions of service. Sources: Mravčík et al. 2018; Bálint et al. 2018; Malczewski et al. 2012; 2018; OZ Odyseus 2017; OZ Prima 2017; Združenie Storm 2017.*

Indicator	CZ	HU	SK	Benchmarks
The ratio of the number of NSP occasions of service in the last 12 months per 100 PWID	High (1 055)	High (207)	High (240)	Low ← 30 ← Mid → 70 → High
The ratio of the number of NSP occasions of service in the last 12 months per 1 NSP client*	14	7	7	Low ← 3 ← Mid → 7 → High

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[8] The data on NSP clients who inject drugs is available only in the case of Czechia. In other countries, only the total number of clients is available. The coverage of the PWID population in Hungary, Poland and Slovakia is, therefore, the best-case scenario. In reality, the level of coverage is likely even lower, as usually not NSP clients inject drugs.

The data shows that Czech NSPs provided the highest coverage of the target population in this respect as well. In 2017, the number of contacts per 100 PWID reached 1 055. If we take into consideration only PWID in contact with NSP, it stems that each client visited a service once a month on average. In Hungary and Slovakia, these numbers were significantly lower (207 and 240, respectively). Considering only NSPs' clients, each person injecting drugs in contact with services visited them roughly once every two months in Hungary, and slightly more often in Slovakia.

Notwithstanding the differences, however, in the context of the UN guidelines on HIV prevention services (WHO et al. 2012), all countries perform well, achieving high scores in the category of client contacts. The temporal analysis shows that this indicator has been stable in Czechia (-1% in 2010-2017) and noted a 55% increase in Slovakia[9]. In Hungary, on the other hand, the number of occasions of service dropped by over 70% in 2013-2017.

In sum, it is clear that in the area of harm reduction, Czechia has been leading, performing well in terms of both: services availability and coverage. In Hungary, the availability of NSP was low. Although one in three persons injecting drugs was in contact with services in 2017, and the number of occasions of service was high, an average NSP client could be provided with only a minimal number of injecting paraphernalia. In Poland and Slovakia, the availability of services was deficient. The coverage in Poland was the lowest of all examined countries. Meanwhile, in Slovakia, the situation was somewhat tricky – while the outreach to PWID was low, the injecting paraphernalia coverage of organisations' clients was close to the high level. Neither of the three countries, however, would qualify as having an effective HIV prevention system concerning needle exchange programmes.

Overall, the analysis of countries' drug strategies revealed strong health and social orientation of the Czech drug policy and somewhat weaker such orientation in case of Slovakia. In Hungary, the 'morality' frame was dominant in the country's drug policy,

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[9] Here, again, the possible explanation is related to the liquidation of several NSP providers during the examined period. Namely, clients who had previously used various services, including those analysed here and the ones closed in the meantime, could start to use the remaining programmes more often.

while in Poland, no frame was identified due to the highly technical character of the document.

The examined policy outcomes of needle exchange programmes were poor in Hungary and Poland. Moreover, the data shows that, during the period of the implementation of analysed drug strategies, the performance of needle exchange services deteriorated drastically in both countries. In Czechia, a modest improvement can be seen in terms of distributed sterile paraphernalia and coverage of the target population. In the case of Slovakia, finally, the picture is more complex, with generally meagre performance on the country level and in the context of the entire population of people who use drugs. On the other hand, at the organisation level, the performance of Slovak needle exchange programs seems much better, primarily in terms of the number of distributed injecting paraphernalia per NSP client. The temporal analysis shows the improvement in NSPs performance with respect to the number of distributed injecting paraphernalia and number of client contacts. At the same time, the coverage of the target population has decreased only slightly, despite the closure of several services during the examined period. The possible explanation may be that: (i) a proportion of clients of closed services started using the remaining ones, (ii) some of the financial resources previously distributed to services which ultimately closed down were distributed to the surviving ones, resulting in the possibility of distributing more sterile equipment to clients and, hence, more client contacts. Especially the hypothesis on client migration to surviving services needs further research, however, given the differences in the geographical location of needle exchange programmes (closed versus remaining ones).

2.5. Conclusions

This paper aimed to identify the relationships between the way of framing drug policy as health, morality, security or economic issue, and the outcomes of harm reduction policies in Czechia, Hungary, Poland, and Slovakia. The study has several limitations.

First, country-level data was not available for needle exchange programmes in Slovakia. The data collected directly from services' annual reports are, however, official in the sense that the services report the same data to the state actors funding the operation of the programmes.

Second, except for Czechia, the data quality was relatively low. The information was fragmented, incomplete and incoherent. Also, the level of detail varied significantly between countries, which made the comparison between countries highly challenging.

National drug strategies are the essential documents that provide the framework and general guidelines for drug policies in a country. As such, their analysis through the lenses of morality policy is a good starting point to gain an insight into the possible relationships between the policy framing and policy outputs. Although going beyond the scope of such a short paper, the inclusion of other sources regarding policy framing would certainly corroborate the findings and increase the overall plausibility of the study.

This paper, with its empirical scope and theoretical orientation which are highly understudied in the region, contributes to the understanding of morality policies and drug policy area. Two statements can be made. First, the case of Hungary suggests the association between morality framing and poor (and deteriorating) policy outcomes (specifically, the accessibility and quality of needle exchange programmes). Second, the case of Czechia suggests the association between strong health-social orientation and excellent policy outcomes (with modest improvement over time) in the area of harm reduction. This study opens exciting avenues for further research, including a possible stronger focus on policy implementation challenges and, perhaps most interestingly, regarding the status of morality framing as a necessary and/or sufficient condition for ineffective policies.

3. CHAPTER 3: COLLABORATIVE GOVERNANCE REGIMES IN ILLIBERAL DEMOCRACIES: A COMPARATIVE CASE OF DRUG HARM REDUCTION POLICY IN CENTRAL-EASTERN EUROPE

3.1. Introduction

In recent decades, the practice of governance and the literature on public policy design and implementation have shifted their focus from the state as the central policymaker to more participatory forms (Howlett 2014:192). One of several concepts exemplifying this general shift is collaborative governance (CG), understood here as the conscious and systematic application of various institutional arrangements for involving non-state actors in policy processes (Ansell and Gash 2007:544). Recently, this approach has been increasingly deployed in many (Western) countries and policy fields, maybe most prominently in health and social services (Rees, Mullins and Bovaird, 2012) where an increasing number of services are provided through co-production with non-profit sector involvement (Brandsen and Hout 2006:538).

Turning to Central-Eastern Europe (CEE), however, a markedly different picture appears. First, it is argued that NGOs in CEE are weaker than their Western counterparts, as has been the case since the systemic change in 1989-1990 (Howard 2003). Besides this 'base-line' difference, however, a new and remarkable trend seems to be emerging in some of the region's countries. As part of a more general turn away from liberal democratic values, virtues, and governance practices, it seems that in certain countries of CEE, the (non-deliberate) lack of NGO development and accompanying co-governance practices is evolving into deliberate underdevelopment. Behind this new trend, it is not hard to discern a change in government policy from simple disregard to outright hostility, at least with regard to certain types of NGOs and certain forms of involving them.

Scholars writing about this emerging pattern of development in the region usually focus on two countries: Hungary and Poland. Importantly, both countries are prime examples of a far broader political turn, denoted variously as de-democratization (Ágh 2015), democratic deconsolidation (Foa and Mounk, 2017), autocratisation (Lührmann and Lindberg 2019), to mention but a few terms, and illiberalism (Hajnal and Rosta 2016; Zakaria 1997).[10]

This new illiberal turn, featuring an apparently determined crackdown on certain NGOs, is still largely unexplored in terms of its implications for CG. Much of the literature on CG refers to it as though it emerges, albeit enabled by the institutional infrastructure and partly driven by the incentive system created by governments, to a significant extent spontaneously. We argue that CG is not necessarily spontaneous; on the contrary, governments can and do undertake conscious actions facilitating or preventing CG. We pursue two closely related ambitions. Firstly, our theoretical ambition is to develop a classification of collaborative governance regimes (CGRs, for conceptualization of the term see section 3.2.1). Secondly, we wish to better understand how illiberal governance affects CG.

Below we present a comparative case study of the drug policy areas in four countries in CEE: Czechia, Hungary, Poland, and Slovakia. While these countries share many historical, cultural, and political features, one essential difference is the recent illiberal turn occurring in Hungary and Poland.

In section 3.2 we briefly review the relevant parts of the literature dealing with CG, in order to derive a conceptual and analytical framework with which to describe and compare the regimes presented in our examples. To delimit and justify our research objective, in section 3.3 we summarize the latest research on how NGOs are involved in policymaking in CEE. Section 3.4 outlines our research question, and the data and

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[10] We subscribe to the approach of Lührmann and Lindberg (2019), who define autocratisation as the most overarching concept, encompassing similar phenomena contexts ranging from autocracies to high-quality democracies. In their view, Hungary falls into the terminological category of 'democratic recession' (p. 1097). Nevertheless, we still prefer to use the term 'illiberal (democracy)' to denote the Hungarian and Polish cases of democratic recession since 'recession' implies a somewhat unintended and spontaneous process which is not the case here.

method used to answer it. Section 3.5 presents the empirical findings. The paper concludes with a brief discussion of the results.

3.2. Collaborative governance: conceptualisation and operationalisation

3.2.1. Collaboration, collaborative governance, and collaborative governance regimes

Various forms of governance involving non-state actors have gained scholarly attention in the last three decades. Due to the increasing emergence of wicked policy problems (Head and Alford, 2015), the failure of hierarchical governments to address international issues (Bingham 2011:386), and criticism of the intra-governmental focus of New Public Management (Osborne 2006:380), public management has significantly shifted from hierarchical government to more participatory policymaking. Collaborative governance is one of the prominent approaches grasping this shift.

Collaboration, briefly, can be defined as a situation where 'a group of autonomous stakeholders of a problem domain engage in an interactive process, using shared rules, norms, and structures, to act or decide to act on issues' (Wood and Gray 1991:146), although many other, largely similar definitions exist (cf. Bedwell et al. 2012; Bryson et al. 2006).

However, the number of conceptual works on collaborative governance is far lower. While some authors use the term in a narrower sense (Ansell and Gash 2007) a broader conceptualization defines it as 'the processes and structures of public policy decision making and management that engage people constructively across the boundaries of public agencies, levels of government, and/or the public, private and civic spheres in order to carry out a public purpose that could not otherwise be accomplished' (Emerson, Nabatchi and Balogh, 2012, p. 2). This concept of CG does not imply being initiated by public/governmental actors, nor does it exclude informal arrangements. In this study, we apply this definition.

The concept of collaborative governance regime (CGR) was recently developed by Emerson and Nabatchi (2015) as a reasonably coherent and stable system of government policies and government actions that shape and affect CG. What we call CGR corresponds, to a large extent, to Emerson and Nabatchi's (2015) 'system context' (a broader category encompassing the environment where CGR occurs). In other words, in our approach, CGR includes: (i) the political and policy environment of CG and (ii) the government actions undertaken within CG processes.

Consequently, we attempt to conceptualize and operationalize CGRs which support CG arrangements to a varying extent, including regimes designed to undermine CG development (for details see Table 11). Our analytical framework was developed to enable differentiation between such understood CGRs.

3.2.2. Analytical framework

Based on a broad array of literature describing state – NGO interactions in policymaking, we have identified a number of analytical variables operationalizing key features of CGRs.

The first set of analytical variables includes those describing the political and policy environment of CG.

Operational space refers to 'possibilities and freedoms for NGOs to operate' (van der Borgh and Terwindt 2012:1069), and thus includes the extent of state protection of NGOs' rights to make claims vis-à-vis the government, the legal and policy framework and the political context in which NGOs operate.

System stability relates to the extent to which the operational environment of NGOs and CG (including legal and policy frameworks) is subject to unpredictable, uncontrollable and/or frequent changes. Such changes tend to destabilize the environments in which CG takes place (Bryson, Crosby and Stone, 2006). On the other hand, it is argued that high system stability increases the effectiveness of inter-organizational networks (Provan and Milward, 1995).

The second set of analytical variables refers to substantive features of CG, i.e., the government actions undertaken to initiate and maintain CG processes:

Mechanisms for involving NGOs in policy formulation and design. In addition to organizational forms, this dimension includes mechanisms (e.g., public consultations, round tables, coordination fora, etc.) for involving NGOs in policy formulation and design.

Mechanisms for involving NGOs in policy implementation. This dimension includes mechanisms (e.g., tenders, contracting, etc.) for involving NGOs in policy implementation. It also involves factors potentially hindering effective policy implementation.

Indirect resources variable refers to the non-earmarked financial resources available for NGOs to fulfil their tasks (while revenues received for direct service provision, for example, would be classified differently as direct resources). Such resources come in a variety of forms, e.g., tax concessions (corporate as well as personal income tax) or external (international) funding administered by national governments. Other factors being constant, the munificence of such financial resources has a positive impact on the effectiveness of collaborations (although abundant resources alone are no guarantee of effectiveness or efficiency) (Provan and Milward, 1995), and on their sustainability (Sharfman, Gray and Yan, 1991).

Direct resources refer to the amount of earmarked government funding provided in exchange for specific activities or provision of specific public services (such as direct earmarked financial support or service contracts). Similar to indirect resources, there is a supposed positive relationship between the munificence of direct financial resources and the effectiveness and sustainability of CG. This dimension also includes ways of allocating resources, e.g., transparency and merit based as opposed to politically or ideologically driven, or clientelist.

Joint operating procedures refer to the degree to which the two sectors are aligned and mutually adjusted in terms of operations and decision-making processes and procedures aiming to achieve common goals (Tatcher, 2007 *apud* McNamara, 2012,

p. 393), the degree of inclusiveness and participation of various non-governmental stakeholders in decision-making (McNamara 2012), and measures for the empowerment of the least powerful participants (Bryson, Crosby and Stone, 2006).

Trust-building: policies and government activities affecting trust[11] are crucial for CG. Trust-building is facilitated by direct and open communication (McNamara 2012), shared understanding, commitment as well as reciprocal orientation (Bryson, Crosby and Stone, 2006).

Based on the above variables it is possible, on the basis of their observable features, to locate actual CGRs according to the extent to which they actively promote, disregard, or openly hinder and counteract CG (situations we term, respectively, 'pro-collaborative regime', 'neutral regime' and 'anti-collaborative regime'). To this end, we have developed a prediction matrix (Hak and Dul, 2012), denoting, on the basis of theoretical considerations, specific values for each variable (feature) of the above three types of CGRs.

The summary of the features of the three examined regimes can be found in Table 11.

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[11] We adopt Hosmer's definition of trust widely cited in management scholarship: 'Trust is the expectation by one person, group, or firm of ethically justifiable behaviour – that is, morally correct decisions and actions based upon ethical principles of analysis – on the part of the other person, group, or firm in a joint endeavour or economic exchange' (Hosmer 1995:399).

Table 11. A conceptual classification and operationalization of collaborative governance regimes. Source: Developed by the authors based on the literature review referenced to in section 3.2.2 (the narrative description of the variables).

Variable	Pro-collaborative regime	Neutral regime	Anti-collaborative regime
Operational space	- clear, well-specified regulations; - NGOs can operate freely, regardless of their mission or values; - government protects NGOs' rights; and - government facilitates collaborative governance, e.g., through using collaboration-favourable rhetoric.	- regulations on NGOs can be ambiguous or non-existent, loopholes allow arbitrary administration; - NGOs can operate freely regardless of their mission, values, etc.; - there is no protection of NGOs' rights to make claims vis-à-vis government; and - government neither facilitates nor impedes collaborative governance, e.g., there are no government – NGO relations established, there is no collaboration-favourable rhetoric and/or actions.	- regulations on NGOs are stringent and hinder their operation; - freedom of NGOs' operation is limited, likely in a selective manner (political/ideological bias); - attempts to make claims vis-à-vis government are punished in a selective manner; and - government impedes collaborative governance, e.g., existing government – NGO relations are undermined, rhetoric is hostile.
System stability	- system (changes of law, policy, or resources distribution) is stable and predictable.	- system stability can be low.	- system is unstable and unpredictable.
NGO involvement in policy formulation and design	- such mechanisms are in place and are used to a varying extent, e.g., round tables, coordination bodies, public consultations.	- such mechanisms are scarce; they can be formally in place but *de facto* not working.	- such mechanisms are absent, and previously existing mechanisms are consciously weakened or eliminated.
NGO involvement in policy implementation	- NGOs are meaningfully involved in policy implementation with varying degrees of flexibility regarding shaping services; and - mechanisms for NGO involvement which are in place work effectively.	- NGOs are involved in policy implementation, but implementation is strictly controlled by the government; and - existing mechanisms for NGO involvement are questionably effective, e.g., clientelism and corruption can affect contractor selection.	- NGOs are prevented from being involved in policy implementation, possibly in an ideologically/politically selective manner.
Indirect resources	- resources are available, and their distribution is transparent and unbiased.	- resources are scarce, and limited in scope, and their distribution can be discretional, (e.g., clientelism, corruption).	- resources are virtually absent, and the distribution of existing resources (e.g., international funds) is politically biased.

Direct resources	- resources are widely available and are allocated in a transparent way and without ideological/political bias.	- resources are scarce, and their allocation can be discretional (e.g., clientelism, corruption).	- resources are virtually absent, and their allocation is ideologically/politically biased.
Joint operating procedures	- such procedures are developed based on participants' needs, implying that government actors give up some autonomy in order to develop shared rules and policies, or adjust operating procedures; and - participation in decision-making is either inclusive or centralized (decisions on partnerships are made by government actors).	- such procedures are not introduced; and - decision-making processes are independent and unrelated.	- such procedures are not introduced, and previously existing ones are consciously eliminated in a selective manner; and - decision-making processes are independent and unrelated.
Trust-building	- the government shows its trust towards NGOs, e.g., by adopting lower levels of control and by accepting flexibility; and - government trust-building efforts are present, e.g., open, and frequent communication, showing commitment and shared understanding of the problem being addressed.	- trust level is low, i.e., the government adopts high levels of control and does not allow flexibility; and - no government trust-building efforts present, e.g., lack of communication and understanding.	- trust level is very low, i.e., the government adopts very high levels of control; and - government's actions are trust-undermining, i.e., hostile communication or actions, opposite understanding of the problem being addressed.

3.3. Illiberalism, collaborative governance, and non-governmental organizations in Central-Eastern Europe

As we argued above, there is ample literature dealing with how different types of organizations operating outside the realm of both government and business are involved in governance in Western European and Anglo-Saxon countries (see, for example: Brandsen and Hout, 2006; Osborne and Strokosch, 2013; Pestoff, 2012). However, when it comes to CG in CEE, both the practice and the literature are much scarcer, for several reasons.

First, due to shared history of Soviet occupation, and rapid transformation to a market economy and liberal democracy, the countries of CEE – understood here as those in the so-called Visegrád Group – are characterized by cronyism, and the needs and interests of informal groups, rather than actual policy objectives, shape public services (Rupnik and Zielonka, 2012).

Second, over the post-transition decades, there was general consensus that civil society in CEE is weak, especially when compared with its Western counterpart (Howard 2003), although recently this view has come in for some criticism (Ekiert 2012).

Third, with respect to the role of NGOs in policymaking, several problems have been identified. NGOs have small membership bases and are chronically underfunded (Börzel 2010), and policies towards them have been inconsistent (Fric and Bútora, 2003).

Finally, it is argued that civil society and its involvement in policymaking and service provision are also restricted by centralism, with the state as a monopolistic provider of various social and health services (Fric and Bútora 2003; Rees and Paraskevopoulos 2006).

The diagnosis has thus been gloomy. However, in the context of the third sector's involvement in policymaking, some of the most recent accounts on participatory policymaking in CEE build up a picture that is gloomier even than the one suggested above.

As part of what seems to be a more global trend, in certain countries of CEE (notably Hungary and Poland), governments increasingly reject liberal democratic principles and values. This new type of politics, frequently referred to as illiberal, involves the appropriation of democratic procedures. Manifestations of this illiberal turn are also visible in the field of CG including NGOs. The attitude towards NGOs and their involvement in public policy has shifted from disregard to outright hostility (Cooley 2015). Law enforcement is used against NGOs (Grzebalska and Pető, 2018). Organizations opposed to the government are pictured as threats to the nation and as servants of foreign interests (Gerő and Kerényi, 2017).

3.4. Research questions, method, and data

3.4.1. Research questions

In the preceding sections we argued, firstly, that in a broader European perspective, recent and contemporary administrative reform practices and reform doctrines generally exhibit an ever-increasing emphasis and reliance on NGOs in designing and delivering public policies and services. Secondly, CEE, while lagging behind in this process, is further characterized by the emergence of a new pattern possibly amounting to a new, coherent doctrine, involving a radical turn away from the above-mentioned ethos of CG. Thirdly, we argued that this turn is (currently) predominantly taking place in countries undergoing an illiberal turn, and that this is not mere coincidence, but seems to be an inherent component of illiberal governance practices.

Our two research questions build upon the above arguments and include, firstly, a classification/typologizing ambition (Landman 2009): what are the ideal types of CGRs? Secondly, how do CGRs within drug harm reduction policy differ in illiberal democracies compared with their non-illiberal (or less illiberal) counterparts in CEE? By answering these questions, we expect to learn whether there is an identifiable illiberal paradigm relating to CG.

3.4.2. Data and method

We apply qualitative comparative case study design combined with congruence analysis (Blatter and Haverland, 2012). This requires (i) developing a typology of collaborative governance regimes; (ii) identifying dimensions (variables) describing collaborative governance regimes and allowing for differentiation and comparison between them; (iii) determining the values of each dimension for each type of collaborative governance regime identified. Taken together, these steps produce a so-called prediction matrix identical to the one in Table 11. Finally, (iv) we classify our cases according to collaborative governance regime type, based on empirical data.

To obtain a detailed analysis anchored in rich empirical evidence within our country cases, we focus on one specific policy field: drug policy. More specifically, we focus on harm reduction responses (so-called low-threshold services[12]) for injecting drug users.

Timewise, the analysis focuses on the period 2010-2019, with the exception of the 'system stability' dimension, which, due to its inherently long-term orientation, takes account of the last two decades.

Below we clarify and justify the logic behind our case selection in terms of (i) the countries and (ii) the policy sector chosen for comparison.

The study covers four countries: Czechia, Hungary, Poland, and Slovakia. This narrow geographical scope was chosen based on the countries' membership of the Visegrád Group, which, despite being a political entity and not an analytical category, is often the focus of scholars researching Central-Eastern Europe. Notwithstanding many historical and political similarities, these countries differ in one important aspect: the materialization of the illiberal paradigm.

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[12] Low-threshold programs are harm reduction programs with minimal or no demands towards the clients; they include needle exchange, distribution of other materials, social services (counselling, social work) and sometimes health services; limiting/quitting substance use is not a precondition for participating and use of counselling is voluntary (unlike in high-threshold programs, where it is obligatory).

As noted earlier, Hungary and Poland strongly feature illiberal doctrines in their governance transformations since FIDESZ-MPP and Law and Justice formed governments in 2010 and 2015, respectively. Hungary and Poland are often pictured as illiberal 'drastic cases' (Bochsler and Juon, 2019, p. 16) or 'prominent cases' of 'democratic erosion' (Lührmann and Lindberg, 2019, p. 1105) within the region, while in other countries 'a relatively stable but low-quality democracy is the norm' (Cianetti, Dawson, and Hanley 2018:246). Indeed, Czechia and Slovakia exhibit a large extent of continuity in terms of their governance practices and the ideological and doctrinal underpinnings thereof. According to the Nations in Transit report, in 2020, Hungary was classified as a transitional or hybrid regime, and Poland fell into the 'semi-consolidated democracy' category (Freedom House 2020:3). Meanwhile, Czechia and Slovakia are still considered consolidated democracies (Freedom House 2020:12).

Our approach in choosing drug harm reduction policies is similar to a critical case logic (Yin 2003:40), namely, harm reduction is an (ideal)typical case of a 'wicked' problem that requires the inclusion of – or possibly almost the sole reliance on – NGO-type organizations and other non-state actors (Head 2008). In order to find at least some elements of CG in a context characteristically hostile to such governance practices, it is therefore advisable to inspect this policy and service sector.

Data collection took place between 2015 and 2019. Documentary analysis primarily included the legislation and other subsequent regulations, and policy documents of the countries concerned and reports relevant to our area of interest. Although the existing sources include some information on the formal and legal frameworks and provide a picture of the field, we aimed to supplement and contrast this (official view of CG practices) with the perspectives of NGOs as entities historically being in the centre of harm reduction responses. Semi-structured interviews were conducted with 20 employees of harm reduction NGOs working locally. Key-informants were selected using purposive sampling (Tongco 2007) complemented by the snowball method (Goodman 1961) and taking into consideration convenience. Interviews were recorded and transcribed verbatim and lasted approximately 90 minutes. The data was hand-coded using qualitative data-analysis software MaxQDA, following a code system based on our analytical framework. Subsequently, synthetic summaries were developed for each case per dimension. These summaries served as the basis for

categorizing the countries into one of the three regime types through the pattern-matching procedure described at the beginning of this section.

3.5. Empirical findings

The objective of our analysis is to position each country case along the eight identified dimensions, that is, to decide which ideal type category (pro-collaborative, neutral or anti-collaborative regime) is most appropriate for each case and dimension. To this end, in the following eight subsections – corresponding to the eight analytical dimensions – we present key pieces of evidence for the Czech, Hungarian, Polish, and Slovak drug policy situations.

3.5.1. Operational space

NGOs in Czechia operate under a range of laws addressing various aspects of their activity (ICNL 2019a). Harm reduction is strongly supported as a pillar of drug policy (Government of the Czech Republic 2010) and service providing NGOs are officially recognized as social services and are subject to legislation and other subsequent regulations (Parliament of the Czech Republic 2006). They enjoy a relatively high level of operational freedom and their rights to make claims vis-à-vis government are respected; government politicians exhibit pro-collaborative attitudes towards harm reduction NGOs (KI-13).

In the other three countries, a different picture is suggested by the data. NGOs in Hungary are in the worst position, with politically and ideologically selective restrictions on their operational space, most notably through the law on so-called 'foreign agents', organizations receiving funding from abroad (Hungarian Parliament 2017). Drug policy focuses on abstinence, and harm reduction, briefly mentioned in the state anti-drug strategy, is clearly not a preferred way of tackling drug use (Hungarian Parliament 2013). As harm reduction is almost taboo, the environment created by the Government for such NGOs is extremely challenging. Some have suffered attacks and scapegoating campaigns by local authorities, allegedly orchestrated to set an example for others considering making claims vis-à-vis the Government (KI-5). As drug use is criminalized, some of the most important activities

of harm reduction NGOs (e.g., needle exchange programs) are vulnerable to accusations of aiding criminal activity.

Significant similarities can be found in Poland and Slovakia. In both countries, the operation of NGOs is regulated by a range of different laws (ICNL 2019c, 2019b). Regarding official drug policies, Governments support harm reduction as part of their national drug strategies[13] (Council of Ministers of Poland 2016; Ministry of Health of the Slovak Republic 2013). Nevertheless, drug policy is de facto largely disregarded as a policy area, which results in a non-supportive environment for CG in this area (KI-4, KI-19). In Poland, there were cases in which the state enterprise managing publicly owned real estate adopted unlawful ad-hoc measures to prevent an NGO from acquiring an office (KI-1). The rhetoric of state actors towards harm reduction services can, at times, be adversarial (KI-16).

3.5.2. System stability

Czechia is characterized by relatively high stability, both regarding the drug policy system (Csete 2012) and its funding frameworks (KI-13). Nevertheless, multisource, and tender-based funding schemes cause a degree of uncertainty and some concerns for the future (KI-13).

In Hungary, by contrast, the penal code on psychoactive substances changes frequently. Moreover, since 2010, the broader policy field and financing system of drug policy (and especially harm reduction) has also undergone radical and unpredictable changes (KI-6).

The policy system in Poland has been more stable, with criminal regulations on illicit drugs rarely changing, and with the most notable change taking place in 2000, which introduced penalties for drug possession (Konikowska-Kuczyńska 2008). Regarding the funding system, a major change supporting harm reduction NGOs was recently done introducing longer, 3-years projects (KI-4).

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[13] In Poland, there has been no separate anti-drug strategy since 2016, and drug-related issues are dealt with under the more comprehensive National Programme for Health.

In Slovakia, similarly, drug policy and legislation on drugs have been stable (Csete 2012), as has the funding framework for harm reduction (KI-16).

3.5.3. Mechanisms for involving NGOs in policy formulation and design

Data on Czechia suggest that NGOs are meaningfully involved in policy formulation and design, most notably by their representation in the Government Council for Drug Policy Coordination (Government of the Czech Republic 2016b; KI-15).

In Hungary there is no evidence of mechanisms involving NGOs in policy formulation. On the contrary, some existing mechanisms were abolished by the Government and certain harm reduction organizations were excluded from participating in the ones remaining (KI-6). Unlike earlier, NGOs nowadays feel so threatened that they are afraid to speak or conduct advocacy activities (KI-9).

In Poland, NGOs attempt to affect policy design mainly through advocacy (KI-4). The results of these efforts are disappointing, however, and it seems decision-makers largely ignore NGO requests or suggestions.

Similarly, the Slovak Government seems unwilling to involve NGO representatives in shaping policy. Although organizations are sometimes invited to formal and informal discussions with the state, it seems from the data that these approaches are more symbolic than representative of any genuine interest in meaningfully involving NGOs in policy design (KI-19).

3.5.4. Mechanisms for involving NGOs in policy implementation

In all four countries, the implementation of examined harm reduction services is done by NGOs selected by governments and based on service delivery contracts.

In Czechia, organizations are well-established and have sound relationships with the Government actors regarding implementation of harm reduction services (KI-13).

In Hungary, the general atmosphere around harm reduction hinders service delivery (KI-9). It seems that harm reduction no longer appears in tender announcements. Two

major needle exchange programs were removed from their offices based on politically driven decisions (KI-11).

In Poland, the main problematic issue regarding policy implementation seems to be interference from law enforcement. Firstly, the police presence around services can deter clients, while strict regulations, including incarceration of service clients, disrupts relationship continuity (KI-2). Moreover, implementation of services can be hindered due to challenges in securing premises[14] (KI-3).

In Slovakia, the police presence can have a negative impact on policy implementation, primarily through stigmatization of clients and occasional violence towards them (KI-17). Moreover, some actions by certain municipalities hinder the work of harm reduction NGOs (KI-16).

The examples from Poland and Slovakia, although indeed presenting hostile actions of some state actors, seem to be however scattered and arbitrary rather than representing systemic features.

3.5.5. Indirect resources

In all four countries, mechanisms are in place to reduce the taxes paid by NGOs, with varying levels of eligibility restrictions. Moreover, in all four countries, under certain conditions, NGOs may receive donations in the form of income tax relief (individuals and/or companies can donate part of their tax payment to NGOs).

In Czechia, individuals and corporations can donate 2-15% of their income, which is then deducted from their taxable income (Navrátil and Pejcal 2017:47).

In Poland, citizens can donate 1% of their personal income tax (PIT) to eligible NGOs (Ekiert, Kubik, and Wenzel 2017:78), while in Slovakia, 2% donations are possible from PIT and corporate income tax (CIT) (Strečanský 2017:96).

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[14] Organizations are responsible for securing the premises for service delivery; state-owned real estate is not governed by the same body that grants resources and service-delivery contracts, and there is no coordination; sometimes, therefore, NGOs receive funding but are not granted premises to rent.

In Hungary, the scheme is much less generous. Individuals can donate 1% of their income tax to a selected eligible organization. However, the eligibility criteria were significantly restricted in 2011 (Kuti 2017:61). The Hungarian Government even blocked the most significant international, non-state-controlled source of funding for NGOs (Nielsen 2014), resulting in these funds being withdrawn from the country altogether.

Similar attempts were made by the Polish Government, but without success (Ambroziak 2018).

3.5.6. Direct resources

Although the available data on direct resources is, in many cases, highly outdated and/or scarce, based on available information it seems that the amount of direct resources for harm reduction NGOs is the highest in Czechia. In 2017, over 66 million Euro was spent on drug policy in general (0.03% of the GDP), and the largest proportion of demand reduction budget (27 million Euro) was granted to treatment and harm reduction (EMCDDA 2019d). According to the data collected from 17 organizations operating nearly half of the country's low-threshold harm reduction programs, the average budget per organization equalled 381.000 Euro in 2017. Although these resources are not sufficient for any investments, they do enable services to run smoothly (KI-13). The allocation of resources seems to be fair and transparent, based on the assessment of needs and merits.

By contrast, the amount of financial resources in Hungary is very low: organizations constantly face financial difficulties and struggle to survive as a result of drastic budget cuts and the practical elimination of 'harm reduction' as a category from all frameworks (tenders, projects) of state financing for drug policy (KI-6). The most up-to-date official data are from 2007, when public expenditure on drug policy reached 39 million Euro (0.04% of GDP), of which approximately 9 million was spent on demand reduction, including 1.5 million allocated to harm reduction (EMCDDA 2018c). Given the aforementioned cuts in 2011, it can be assumed that current budget for harm reduction NGOs is significantly lower. Indeed, the data collected from four (out of 30) service-delivery NGOs show that the average budget per organization was

45.000 Euro in 2017. Resource allocation is ideologically driven and based on political bias (KI-11).

In Poland the amount of resources is slightly higher, so larger organizations can offer a broad range of services and have long opening hours (KI-4). The drug policy budget in 2015 was 35 million Euro (0.01% of GDP), but information on how resources were distributed within the policy field is not available (EMCDDA 2018d). Data from three (out of 12) NGOs show that the average organization's budget in 2017 equalled slightly over 56 .000 Euro. The allocation of resources favours organizations providing long-term in-patient treatment services. Although this amounts to a bias, it seems to reflect a broader conservative, abstinence-oriented paradigm of drug policy, rather than an illiberal turn.

Direct resources in Slovakia are more generous than in Hungary and Poland, yet services can afford to open only a few days per week for a few hours. The lack of up-to-date official data on public expenditure (most recently 2006, 0.05% of GDP, according to EMCDDA, 2018c) indicates rather low Government interest in this policy field. The data from all harm reduction NGOs operating in Slovakia show that the average budget per organization in 2017 was approximately 135.000 euros. The only reported bias in resources allocation is a result of alleged corruption in the Ministry (KI-20).

3.5.7. Joint operating procedures

In our understanding, autonomy refers to the number and scope of joint/adjusted operational procedures between various actors involved in CG. No such procedures exist at an organizational level in any of the four countries examined.

In Czechia, attempts have been made to establish such procedures with the prison service (KI-13).

In Hungary, there are a few activities to develop joint procedures between harm reduction and (public) addiction treatment services (KI-9).

Polish data suggest a lack of any joint or compatible operating procedures between sectors. On the contrary, it seems that attempts to cooperate with some institutions, for example hospitals, meet with outright hostility (KI-4).

In Slovakia, similar to Hungary, NGOs attempt to establish relationships with healthcare providers (KI-19).

The above-mentioned attempts to establish relationships between NGOs and other health and social care institutions are, however, based on personal relationships. Institutional forms of adjusted operational procedures are absent in all examined countries.

3.5.8. Trust-building: policies and government activities affecting trust

Trust-building activities are present in Czechia (KI-14). Communication between NGOs and the Government seems frequent and open, both sides show good intentions and a commitment to cooperation (KI-13).

The Hungarian environment is characterized by a very low level of trust. Some government activities even undermine trust (KI-11). The Government's behaviour towards NGOs is sometimes hostile (KI-7).

In Poland, trust-building activities seem to be present at local government level, though these are often restricted by state actors' concerns about their position (KI-3). Law enforcement also seems to be exhibiting trust-building attitudes (KI-1). On the other hand, strict control over NGOs activities can undermine trust (KI-3).

In Slovakia, some trust-building activities are present, mainly in the form of communication (KI-17). Showing commitment to the relationship and to the issue being addressed is also present to a certain extent (KI-16).

Table 12. The summary of empirical findings. Note: The cells in the table summarize the above empirical findings as follows: + stands for pro-collaborative, 0 for neutral, and – for anti-collaborative governance regimes. Source: Author.

Dimension / Country	Czechia	Hungary	Poland	Slovakia
Operational space	+	-	0	0
System stability	+	-	+	+
NGO involvement in policy design	+	-	0	0
NGO involvement in policy implementation	+	-	+	+
Indirect resources	+	-	+	+
Direct resources	+	-	0	+
Joint operating procedures	0	0	0	0
Trust-building	+	-	+	+

3.6. Conclusions and discussion

Three findings in particular are central to our research objective.

Firstly, taking an approach assuming significant role of governments in shaping CG (as opposed to spontaneous occurrence), and including possible neutral and hostile government attitudes towards CG (as opposed to different levels pro-collaborative attitudes existing in the scholarship hitherto), we have developed a conceptual classification of CGRs and operationalized them along a number of observable features.

Secondly, only Czechia unquestionably exhibits the features of a pro-collaborative regime. Poland and Slovakia, meanwhile, are located between pro-collaborative and neutral CGRs. Importantly, however, one case – Hungary – indisputably qualifies as an anti-collaborative governance regime – a regime that is distinctly different from the customary 'neutral CGR' characteristic for many countries in CEE (and elsewhere). This 'anti-collaborative regime' predominantly differs from earlier ones in that it openly and deliberately impedes harm reduction NGOs.

Such an anti-collaborative regime involves blatant, harsh intimidation of selected NGOs. A more serious instrument of this policy is criminal law. While in some cases certain NGO activities may be directly criminalized, in other cases the legal framework creates ambiguity, allowing authorities to interpret some NGO activities as potentially criminal (e.g., distributing sterile needles may be seen as being an 'accessory to

crime'). The legal and policy framework is subject to frequent, unpredictable and/or uncontrollable changes. There are no institutional mechanisms for involving NGOs in policy formulation. Moreover, government policy consciously eliminates any pre-existing mechanisms. Service delivery through NGOs is blocked through semi-formal (sometimes even illegal) administrative measures. The anti-collaborative regime includes funding mechanisms that not only lead to severe under-resourcing of NGOs but involve a strongly and openly selective funding process, favouring NGOs aligned with government ideology. Moreover, conscious measures are undertaken by the government to cut the funding of hostile NGOs received from other, non-governmental sources. As for direct resources, services and operations are directly funded at the minimum level possible, which is sometimes zero. Finally, not only is there a lack of trust between governmental and non-governmental parties, trust-building activities are absent, but there are even conscious government activities deliberately undermining trust.

The primary motive for doing so seems to be ideological (rather than material): the governing forces equate harm reduction activities with approval of the use of illicit drugs, and thus as a means of promoting 'liberal' and 'anti-patriotic' worldviews and lifestyles.

Thirdly, but no less importantly, this anti-collaborative regime appears in only one of our two illiberal cases, namely Hungary, while it is absent from Poland. Nevertheless, although not covered by our empirical research, it seems justified to mention that an anti-collaborative regime very similar to the one identified in Hungary is also present in Poland, not in harm reduction policy, but in reproductive and women's rights, and the services and advocacy activities attached to them.

In sum, it seems that the specifically anti-collaborative element of CG regimes in CEE – where they exist at all – does not appear uniformly across different policy areas. On the contrary, large segments of the NGO community and the corresponding CG arrangements operate practically untouched by illiberalism. The illiberal doctrine is found only in a few policy areas, which embody, ideologically and politically, an antithesis of the worldviews held by the ruling political parties.

These policy areas may also vary in space and time. Very recently in Hungary, for example, migration policy emerged as the latest target of the ever-harsher governmental crackdown (even including the criminalization of university study programs and public information campaigns dealing with migration) (CEU 2018). This situation opens up interesting and progressive avenues of investigation, including, most prominently, exploring and explaining this specific aspect of anti-collaborative regimes (in sharp contrast to, for example, local and territorial governance). The implications for the capacity-building efforts of (national as well as international/European) NGOs might, moreover, also be of significant practical relevance.

4. CHAPTER 4: NEEDLE EXCHANGE PROGRAMMES IN VISEGRÁD COUNTRIES: A COMPARATIVE CASE STUDY OF STRUCTURAL FACTORS IN EFFECTIVE SERVICE DELIVERY

4.1. Background

Over the last three decades, harm reduction services have been created all over the world and, especially in Western European countries, have become a well-established pillar of drug policy. There is a substantive body of evidence demonstrating both its effectiveness and efficiency (Wodak 2007). NPSs, if appropriately implemented in terms of their scope and quality, are proved to prevent the spread of infectious diseases. Hence, policy efforts should now focus on their development. Nowadays, the sound position of harm reduction in Europe is most prominently reflected by the current position of the European Union. The EU Drug Strategy for 2013–2020 is the first-ever strategic document on this level, calling for scaling-up harm reduction interventions and improve access to them as an objective of EU's drug policy (EMCDDA 2015).

However, if we take a look at East-Central Europe, a somewhat different picture emerges. According to the Global State of Harm Reduction 2018 report, harm reduction services in Eurasia are significantly less available than in Western Europe. For example, drug consumption rooms are not available in a single country in the Eurasian region (Stone and Shirley-Beavan 2018), contrary to the WE, where 89 such facilities are available in nine countries (Stone and Shirley-Beavan 2018). Moreover, in the Eastern part of Europe, there are some countries where we can talk about the crisis of harm reduction, understood in terms of declining funding and political support. Opioid substitution treatment (OST) provision is stable in the region, but its coverage is extremely low. Needle exchange programmes' operation is also restricted,

including the recent closure of some/all facilities in countries like Hungary or Bulgaria (Stone and Shirley-Beavan 2018).

The overall poor accessibility and, to a lesser extent, quality of harm reduction programmes in ECE are corroborated by the perceptions of the professionals working in the field. For example, the perceived availability of OST is seen as relatively high in Western (7.39/10) and Southern (7.34) European countries, while it is seen as significantly lower in East-Central Europe (5.49) and Western Balkans (5.27). NSPs are seen as somewhat accessible in WE (6.86) and only moderately available in Southern Europe (5.36) and ECE (5.03) (Kender-Jeziorska and Sárosi 2018).

Due to significant variation within the region, the case of East-Central Europe is especially compelling. Even more so if we take into consideration needle exchange programmes in four members of the Visegrád Group (V4): Czech Republic, Poland, Slovakia in Hungary, as countries of highly similar characteristics and history. According to the cited report of the Civil Society Forum on Drugs (CSFD), the Czech Republic is an outlier, with drastically higher than in other countries perceived accessibility and significantly higher perceived quality of NSPs (Table 12). On the other hand, Hungary's results are significantly lower in both aspects (Kender-Jeziorska and Sárosi 2018:27–28):

Table 13. The perceived accessibility and quality of needle exchange programmes in Visegrád countries, the number of needles distributed per client, the geographical coverage of NSPs and the prevalence of HCV among PWID. Sources: (Kender-Jeziorska and Sárosi 2018; Malczewski 2018; Mravčík et al. 2017)

	Perceived NSP accessibility	Perceived NSP quality	Needles distributed per client per year in 2017[15]	The proportion of cities where NPS are present in 2017[16]	Prevalence of HCV among PWID[17]
CZ	8.9	9.3	199	65%	14.7% (2017)
PL	4.7	7	35	7%	57.9% (2017)
SK	3.5	7.5	184	16%	42.3% (2017)
HU	1.8	5.1	65	21%	49.7% (2015)

This outstanding performance of the Czech Republic and poor performance of Hungary is further confirmed by some other services-specific impact indicators summarised in the table above (although, according to these indicators, Hungary is not the worst performer).

The differences presented above are quite striking, given the abovementioned high level of similarity between the V4 countries. This similarity, to a large extent, has long historical roots in the peripheral status of East-Central Europe as compared to Western Europe. This character is related to general weakness and instability of nation-states, and their subordination to core states (Wallerstein 1974) as well as general backwardness in terms of economy, technological development but also political culture and institutions (Schöpflin 1990). More recently, the experience of real socialism and Soviet influences had a significant impact on the ECE states and societies. It is argued that this experience caused 'civilisational incompetence' (Sztompka 1993), resulting in alienation, polarisation and lack of social trust, lack of tolerance, and atmosphere of competition (Sztompka 1993). Concerning more contemporary issues, the similarities lie in rapid political and economic transition after 1989 and participation in the 2004 European Union enlargement. With respect to

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[15] The calculations of the number of needles distributed per client are based on the data in countries' annual reports (2017) to EMCDDA, with the exception of: the number of needles distributed per client in Slovakia, where EMCDDA data is not available, and the information on the number of clients were obtained by the author directly from the services

[16] The calculations of the proportion of the cities where NSPs are available are based on the information retrieved from NSPs' websites and annual reports and the total number of cities in each country

[17] The data are based on countries' annual reports to EMCDDA

governance, poorly functioning policy-making processes are of concern in the region. For example, policy implementation is considered a missing link in the region (Dunn, Staronova, and Pushkarev 2006)—something crucial in the context of this study.

Another main area of similarity relevant for this inquiry is concerned with non-governmental organisations as the primary (or sole) providers of needle exchange services in examined countries and their involvement in policymaking. It is argued that in ECE NGOs often operate in a vague and/or inconsistent policy environment (Fric and Bútora 2003; Kutter and Trappmann 2010), they experience chronic underfunding (Börzel 2010) and are shoved out to play only a marginal role in governance processes (Fric and Bútora 2003).

Given that harm reduction is based on humanistic values of tolerance and respect, and delivered by civil society organisations, one would expect somewhat similar (similarly low) levels of NSPs performance across countries in question.

The final set of similarities is specific to the drug policy area. First, the East-Central European markets, including the drug market, were opened as a result of the fall of the Iron Curtain. The subsequent deterioration of the economic conditions and the level of life (Ekiert 2012) resulted in a significant increase of the drug demand and high-risk drug use in the region in the first half of the 1990s (United Nations International Drug Control Program 1995). Nowadays, in all four countries, one can see a high prevalence of the injecting use of stimulants; in the Czech Republic and Slovakia, it is methamphetamine (EMCDDA 2019a, 2019e) and in Hungary and Poland, stimulant-type new psychoactive substances (EMCDDA 2019c; Malczewski 2018). In all countries, needle exchange programmes are operated mainly (or only) by non-governmental organisations relying only or almost only on the state funds which they typically acquire via public tender procedures.

On the other hand, however, if we consider the legal regulations on psychoactive substances, those in Poland, Slovakia, and Hungary are largely different from those in the Czech Republic. Namely, the latter country decriminalised the possession of illicit substances for personal use nearly a decade ago (EMCDDA 2019a).

Meanwhile, in Poland, drug possession for personal use was criminalised (with the sanction of up to 3 years of imprisonment) by the Act on Counteracting Drug Addiction of 2001 (Article 62) amended in 2005 (Parliament of Poland 2005). The next amendment of 2011 introduced Article 62a, which gives the possibility of criminal proceedings remission given the meeting of a range of conditions (Parliament of Poland 2011).

In Slovakia, simple possession is criminalised as well and punish up to 3 or up to 5 years of incarceration, depending on the amount of possessed substance (EMCDDA 2019e).

In Hungary, the modifications of the drug-related legislature have been persistent, with the Penal Code being changed after every change of the government. The last amendment of 2013 reintroduced criminalisation of drug consumption (possession for personal use have always constituted a criminal offence in post-transition Hungary) which is punishable by up to 2 years of imprisonment. At the same time, the alternatives to criminal sanctions were significantly limited (Kender-Jeziorska 2018). Penalties for the possession of controlled substances vary depending on the circumstances and drug quantity, with up to 2 years of incarceration in case of minor quantities and even 5–15 years for large quantities (EMCDDA 2019c).

4.1.1. The ecological framework

Over several last decades, there was a shift in thinking about human behaviour (including health-related issues) and its determinants. The focus was relocated to include, besides an individual, broader social context. An increasing number of researches employed an ecological perspective on health (McLaren 2005) and social issues. Ecological perspectives assume that an individual's behaviour is affected by multiple interrelated factors on various levels, and events occurring at various levels potentially affect any other level. For example, the framework developed, in the context of human development, by Bronfenbrenner (1979) differentiates between four levels of interactions/influence: microsystem, mesosystem, exosystem and macrosystem. The microsystem and the mesosystem are characterised by the active participation of an individual in interactions in a single setting (e.g., family) or multiple

settings (e.g., interrelations between peer group and school), respectively. The exosystem includes settings interrelated with micro- and mesosystem in a way that they affect one another; however, an individual is not an active actor here (e.g., parent's workplace). Finally, the macrosystem is concerned with regularities on the level of culture (e.g. beliefs, ideology) (Bronfenbrenner 1979).

In the area of public health and the 'risk environment' and its importance in the context of HIV infections spreading among people who inject drugs was described already two decades ago. It highlights factors like migration, methods of production and distribution of drugs, social norms and culture, as well as policy and legislature (Rhodes et al. 1999). The more recent account on the risk environment (in the context of political transition) differentiates between micro- and macro-level elements of risk environment across four categories: physical, social, economic and policy (Rhodes and Simic 2005).

Concerning interventions within a health policy area, Bronfenbrenner's framework was adopted to develop an ecological framework for health promotion. Within this model, five levels influencing individuals' health behaviour are discussed. Intrapersonal factors include, for example, attitudes and knowledge. Interpersonal interactions and primary groups refer to close relationships and groups like family or friends. Institutional factors include organised social institutions, e.g., schools or workplaces. Community factors include the networks of individual's primary groups, interrelations of organisations on a local level and local power structures. Finally, public policy level includes legislature and state policies (McLeroy et al. 1988).

In this work, the focus is on structural barriers and facilitators affecting NSP delivery, i.e., meso- and macro-level factors lying outside the organisations providing services. Studies analysing the effectiveness of needle exchange programmes identify numerous relevant structural factors: from controversial status of NSPs to various levels of the international drug control regime (including drug enforcement laws, regulations and policies), to behaviours of police officers (Abdul-Quader et al. 2013; Bastos and Strathdee 2000; Davis et al. 2019), to stigmatisation and social marginalisation of people who use drugs (Strathdee et al. 2012), to a country's economic context, to

gender equality, to living conditions and opportunities (Gupta et al. 2008) and to—finally—features of the services themselves (Hyshka et al. 2012; Jones et al. 2010).

The vast majority of research on the structural barriers to HIV prevention focus on an individual and interrelations between a person's environment and their behaviour. There are barely any studies putting NSPs in the centre of attention while analysing their context (for exceptions see Bastos and Strathdee 2000; Tkatchenko-Schmidt et al. 2008; Vlahov et al. 2001).

This paper aims to fill this gap and contribute to the study of policy implementation, specifically, the implementation of needle exchange programmes. Focusing on the Czech Republic, Poland, Slovakia, and Hungary, it attempts to determine: (i) what are the structural factors affecting the functioning of NSPs, (ii) how they vary between examined countries, and (iii) how they influence the provision of needle exchange services.

4.2. Methods

This study uses an embedded multiple-case comparative case study design, complemented by within-case analysis. A case is needle exchange programmes in a country, while individual service-provider organisations serve as embedded units of analysis. The geographical scope is four East-Central European countries: the Czech Republic, Poland, Slovakia and Hungary and the temporal range encompasses 5 years prior to the data collection. The data was collected, until reaching the sample saturation, in 2015–2019 through semi-structured interviews with 20 key informants. The participants were selected using a mix of purposive sampling and the snowball method. Key informants occupy mostly managerial positions in NGOs providing needle exchange programmes.

The interviews were conducted face-to-face (in public spaces and interviewee's workplaces) and via online video chats. Informed consent was obtained from all study participants. The average length of an interview was 88 min (the shortest interviews lasted for 37 min and the longest one for 168 min). An interview protocol was used to facilitate the process. The protocol included general questions on the everyday

functioning of the organisations: the relationships of NSPs with other state actors and institutions (e.g., health care, law enforcement, other services); funding and relationships with donors; and relationships with clients. The questionnaire was slightly modified over time to address new issues emerging from already conducted interviews. The average duration of one interview was approximately 90 min. Conversations were registered (audio) and transcribed verbatim.

The data collected through interviews were complemented by analysis of relevant documents, reports, and online resources, primarily the countries' criminal codes and acts addressing controlled substances, drug strategies and action plans and reports of the Reitox National Focal Points to the EMCDDA. The analysis involved coding the segments of data, using data-derived codes in the iterative process of de-contextualising and re-contextualising data units. Subsequently, aggregated data for each country were reviewed to identify common themes and detect possible irregularities on a higher level of abstraction. Twenty-four identified coherent themes were organised into 11 categories. Subsequently, borrowing from the consolidated framework for advancing implementation science (Damschroder et al. 2009), identified themes were rated based on two aspects: the valence and the strength. In other words, it was assessed whether the influence of a factor has a positive (facilitator—'+'), negative (barrier—'− '), mixed (X) or neutral (0) influence, and to what extent it impacts the NSP implementation (on a scale from '−2' to '+2', where '1' indicates weak while '2' strong influence).

4.3. Results

Data analysis using the procedures described above allowed for the identification of 11 main categories indicating the location of the existing structural factors on the three levels of the analytical framework. The following figure presents a summary of the categories indicating the location of the identified structural factors within the Bronfenbrenner's model (Figure 4).
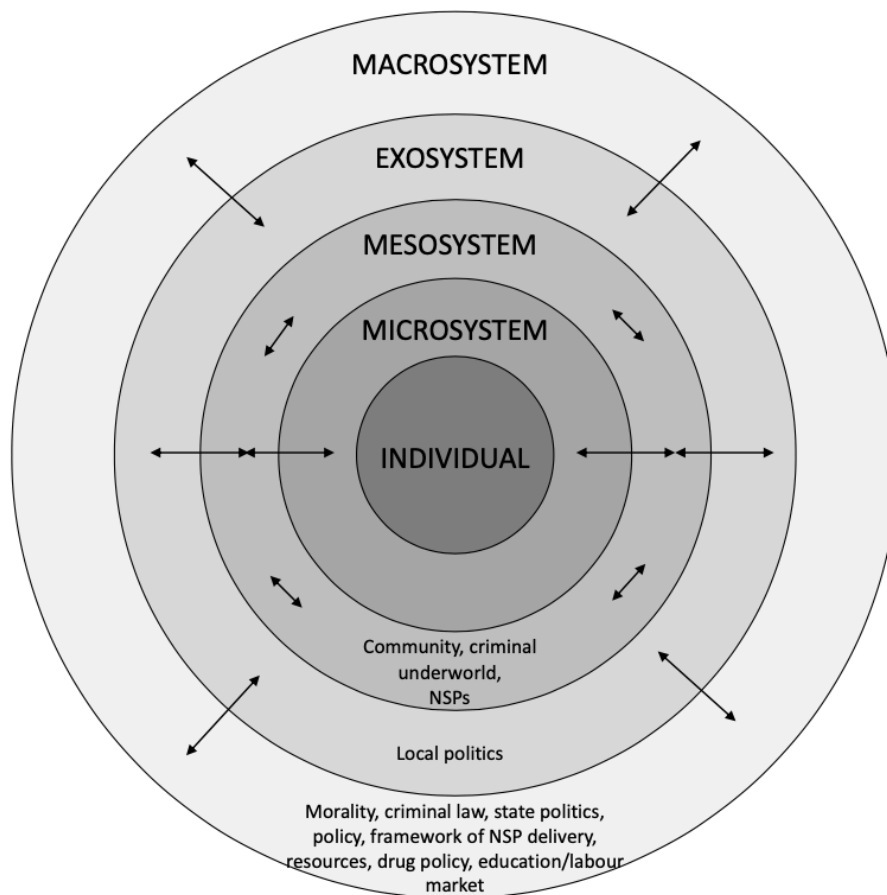
Figure 4. Bronfenbrenner U. The ecology of human development. Source: Author

As mentioned above, included categories and levels are not independent. On the contrary, they interact with one another, often are intertwined and to a large extent affect one another both within and across levels. For example, morality can play a role in determining other themes in the macrosystem but also exo- and mesosystems. At the same time, some of the state policies can affect morality through, for example, enhancing the prevailing attitudes. Furthermore, local community attitudes can influence local politics and further public policies. As a result, differentiating between the categories and classifying the themes turned out to be a challenging task, requiring a reiterative process of re-defining and fine-tuning.

Notwithstanding, 24 themes were identified across all categories. In the following paragraphs, each of them is shortly described. Subsequently, the patterns of barriers and facilitators identified in examined countries are discussed.

Morality category includes two themes: (i) the societal perception of drug use as a sin and (ii) the societal perception of addiction as a life choice (a conscious and informed decision).

Criminal law refers to the legal regulations on psychoactive substances and includes one theme: the legal status of possession and/or use of illicit drugs.

State politics refers to the attitudes of governments, politicians, and other entities involved in the world of politics; it includes following themes: (i) engagement, (ii) consensus, and (iii) attitudes.

Policy, in general, is directly related to politics and agenda-setting and involves only one theme: competition of drug policy with other policy fields.

Drug policy category focuses on the demand reduction system. It includes following themes: (i) competition with other pillars of drug policy (i.e., prevention, treatment), (ii) coverage of demand reduction services in general, and (iii) completeness of the demand reduction system.

The framework of HR service delivery by NGOs refers to the formal arrangements of services delivery as well as attitudes of state actors being responsible for the policy implementation (i.e., 'donors'). Themes in this category involve (i) regulations/policies, (ii) red tape.

Resources category captures the features of the funding system and includes following themes: (i) amount of funds, (ii) stability of funds, (iii) donor-imposed limitations, (iv) time-consuming procedures, (v) embedment of harm reduction in policy documents and public tenders.

Education/labour market focuses on the available workforce and includes: (i) country-level shortage of professionals (e.g., nurses) and (ii) low level of recognition/respect for social workers and outreach workers employed in harm reduction organisations.

Community refers to the communities of local inhabitants in the areas of NSPs operation and involves the following themes: (i) not in my backyard attitudes, (ii) conflicts, and (iii) violence.

Local politics focuses on the attitudes and actions of local politicians. The themes include (i) motivation, (ii) attitudes, (iii) scapegoating.

Criminal underworld takes into consideration the characteristics of needle exchange programmes, namely, working in the areas where the criminal activity takes place. The theme identified in this category is direct contacts with the criminal underworld.

The above list, therefore, includes 24 themes—structural factors affecting the service delivery. Here again, the themes are neither mutually exclusive nor independent. Instead, their boundaries are often blurred. For example, the donors' lack of understanding of low-threshold services can play a role in the adoption of strict reporting policies.

In the following sections, the patterns of identified factors in each of the examined countries and specific ways in which they work are described.

The following table presents the summary of identified structural factors in four examined countries (values are provided for the themes identified as either barriers or facilitators in selected cases) (Table 14).

Table 14. The summary of the identified barriers and facilitators in the four analysed countries. Source: Author.

Level	Category	Themes	CZ	PL	SK	HU
Macrosystem	Morality	Drug use as a sin	NA	-1	-1	-2
		Addiction as a life choice	-1	-1	-1	-2
	Criminal law	Legal status of drug possession (decriminalisation–criminalisation)	+1	-2	NA	-2
	State politics	Engagement (engagement–indifference)	+2	-1	-1	-2
		Consensus (consensus–opposing views)	+2	-2	-2	-2
		Attitudes (hostility–support)	+2	0	NA	-2
	Policy in general	Competition of drug policy with other policy fields	NA	-2	NA	-2
	Drug policy	Competition with other pillars of drug policy (i.e., prevention, treatment)	+1	-2	-2	-2
		Coverage of demand reduction services in general	+1	-2	-2	-2
		Completeness of the demand reduction system	-1	-2	-2	-2
	The framework of HR service delivery by NGOs	Regulations/policies (reasonable–inadequate)	-1	-1	-1	-1
	Resources	Amount of funds (scarce–ample)	+2	-2	-2	-2
		Stability of funds (stability–instability)	+1	-1	-1	-2
		Donor-imposed limitations	0	-2	-2	-2
		Time-consuming procedures	-1	-2	-2	-2
		Embedment of harm reduction in policy documents and public tenders	+2	+1	+1	-2
	Education/labour market	Country-level shortage of professionals (e.g., nurses)	-1	-2	-2	NA
		Low level of recognition/respect for social workers and outreach workers employed in harm reduction services	NA	-2	-2	NA
Exosystem	Local politics	Motivation (public good–self-interest)	0	-2	-2	-2
		Attitudes (hostility–support)	0	-1	-1	-1
		Scapegoating	NA	NA	NA	-2
Mesosystem	Community	Not in my backyard attitudes	0	-2	-1	-2
		Conflicts	NA	-1	-1	-1
		Violence	NA	NA	-2	NA
	Criminal underworld	Direct contacts with the criminal underworld	NA	0	NA	NA

4.3.1. The Czech Republic

In Czech society, there is a prevalent opinion that addiction is a blameful life choice, and PWUD are themselves responsible for their situation (KI-15). This attitude towards dependence and—more generally—substance use, does not seem to be however reflected in the country's legal regulations, where possession of illicit substances for personal use is currently decriminalised and constitutes an administrative offence (Parliament of the Czech Republic 2015). Importantly, the abovementioned attitudes are strongly demonstrated among police but especially medical professions (KI–12). People who use drugs are notoriously stigmatised in health services. Although in the Czech Republic, every citizen, regardless of their employment status, is eligible to free public health care, PWUD are sometimes denied services due to stigma and prejudices towards them. Social workers from NSPs often accompany the clients during their visits to health care institutions (KI–14). Since such visits can be time-consuming, the necessity of such interventions negatively affects the capacity of organisations, thus decreasing their accessibility to other clients.

Decriminalisation of drug possession for personal use might have contributed to the facilitation of NSP provision understood as the proportion of the PWID population covered by the services. A significant increase of coverage (almost seven percentage points) took place between 2012 and 2013, and in the following years, the coverage remained at high, approximately 73% level (Mravčík et al. 2017). Regarding the continuity of the NSPs' relationships with clients, decriminalisation may facilitate it to some extent; however, it seems that many NSP clients are imprisoned for different offences, e.g., drug manufacturing or offences against property committed (KI–13). However, it seems that organisations have the capacity to maintain relationships with incarcerated clients via correspondence or face-to-face meetings.

The police, on its management level, engages in politics by actively opposing the development of harm reductions services, especially establishing first drug consumption rooms and scaling-up the opioid substitution treatment (KI–13). Since there are still no DCRs in the Czech Republic, and the number of OSTs is stable, it is clear that these efforts are successful. Although police's actions do not aim to impede

the functioning of already existing services, they constitute a barrier in service delivery in the context of creating holistic, comprehensive public health responses.

Overall, however, it seems that on the state level, there is political support for harm reduction, and politicians treat it as an essential element of drug policy. It is also confirmed by the public expenditure: 14% of the total drug policy budget was devoted to harm reduction—more than to treatment and prevention together (Mravčík et al. 2017). Outstanding investments in research assessing the impact of various solutions (Csete 2012), as well as continuity and coherence of Czech drug policy, suggest that politicians are genuinely engaged in this policy field, with the prime minister visiting some of the services in person (KI–13).

The key-informants did not raise competition with other policy fields. Given that public expenditure on drug policy equals to almost 67 million Euro per year, i.e. 0.03% of the GDP (EMCDDA 2019a), it is justified to assume this barrier is not applicable.

On the drug policy level, interviewed experts reported some level of competition for funds between various pillars. Some level of distrust and feeling of injustice can be observed, which is mainly due to perceived unfair funds distribution, providing too much support for less effective and very much cost-inefficient services, for example, based on a therapeutic community model. However, as mentioned above, harm reduction in the Czech Republic enjoys broad support, both financial and political. The analysis of annual reports of low-threshold services listed on the website of Czech National Monitoring Centre for Drugs and Addiction (Národní monitorovací středisko pro drogy a závislosti 2018) shows that in 2017, the average budget per organisation per year equalled to 381,006 Euro[18], which translates to 243 Euro per year per client. Moreover, from 2008 through 2017, the total budget of analysed NSPs increased by 158.8%. As such, this theme is considered not applicable in this case.

Although the demand reduction system does not appear among identified factors, it deserves a moment of attention. Interviewed experts have expressed some concerns

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[18] The calculation was based on the data from 17 organisations where low-threshold NSPs are the only or main activity, or in cases of which it was possible to determine the budget attributable to the NSP service of the organisation.

about insufficient services coverage in terms of reaching the target population and waiting time to enter the treatment. However, the data from the interviews and official reports show that low-threshold NSPs cover approximately 70% of the people who inject drugs (Mravčík et al. 2017). Further, in 2017, 41,000 individuals were undertaking treatment and 5000 individuals received OST (EMCDDA 2019a)—86% and 81% of the estimated number of high-risk drug users and non-buprenorphine opioid users, respectively. Key informants' critique seems to be influenced by their context, i.e., the relatively good overall situation of the field. One can also argue that any coverage below 100% is insufficient. Nevertheless, the Czech performance, in this case, is outstanding, especially in the context of the region. For that reason, this theme is considered not applicable.

What indeed considered problematic in the Czech Republic is the fragmentation of the social care system. Some services, e.g., shelters, subsidised housing or protected workplaces for people who use drugs are not in place (KI–13). Moreover, the cooperation between various services, e.g., NSPs and hospitals or NSPs and treatment facilities, is not institutionalised. Although the system offers a range of services, cooperation between them takes place on an individual (as opposed to organisational) level and case-by-case basis (KI–14). In practice, this means that each time a client of NSP wishes to enter the treatment or use any other facility, the entire procedure of contacting entities one-by-one and asking about possibilities. This, of course, is a time-consuming activity and as such negatively affects the capacity (and, in consequence, effectiveness) of NSPs. However, numerous NPSs in the Czech Republic are established within bigger organisations offering various other interventions. Therefore, in many cases, there is a possibility to refer clients from one service to another within one organisation (e.g., from NSP to OST or abstinence-based treatment).

The framework of services delivery by NGOs has one major drawback; it does not differentiate between various types of social services in terms of the care-related requirements (Parliament of the Czech Republic 2006). As a result, NSPs fall into one category with facilities providing inpatient care for elderly or orphanages. The quality standards for social services require all social services to develop an individual plan of work with each client visiting (Ministry of Labour and Social Affairs 2002). This

misunderstanding regarding the characteristics of low-threshold NSPs (where often clients spend in the facility only a couple of minutes to exchange the equipment) results in unnecessary administrative burden for the employees of NSPs who need to comply with the regulations. Again, this negatively affects the programmes' effectiveness by decreasing their capacity.

The financing system in the Czech Republic is multi-source, based on tenders and with each donor having their limitations regarding what the money can be spent on (e.g., salaries, injecting paraphernalia). These limitations combined with short-term project tenders and lengthy grant proposal acceptance procedures (which result in the scarcity of resources in certain months of the year) result in need of extensive planning throughout the year and necessity of writing project proposals frequently. However, as mentioned above, the majority of NSPs in the Czech Republic are parts of bigger organisations which have own financial-administrative departments. As a result, the need for extensive planning only partly affects the services directly as the majority of work is done on the organisations' central level. Importantly, the Czech action plan on drugs for 2016–2018 takes the possibility of implementing multiannual funding schemes and unified project submission, including multiple donors under consideration (Government of the Czech Republic 2016a). The amount of funding for NSPs, as demonstrated above, is high. Although theoretically, the sustainability of financing is uncertain, interviewed experts see funding as stable, which allows them to plan for the future.

The country is experiencing a considerable shortage of labour force in medical professions (OECD and European Observatory on Health Systems and Policies 2017). As a result, organisations struggle to find nurse and addictology doctor employees. Hence, the labour market situation prevents NSPs from improving the quality of their services.

Nowadays, local communities are perceived to be nationalistic, xenophobic, and generally less accepting (KI–13). People who use drugs are a convenient enemy who fits people's more general attitudes. However, after many years of community work and education, the conflicts between NSPs and local communities are hardly present

(KI–12). Overall, the attitudes of local communities may affect the PWUD, but they do not have any influence on services' operation.

The political situation on the local level is somewhat differential and dependent on people holding positions in local authorities at given moment. In some cases, local politicians seem to use drug policy topic for their political goals. In others, they are perceived to be highly engaged and motivated to find working solutions. Possible instrumental use of drug topic does not affect NSPs operation, however. Experts report that in general, the attitudes of local politicians are neutral towards harm reduction services. In some cases, advocacy and educational work are necessary among representatives of local authorities (KI–15).

4.3.2. Poland

According to the interviewed experts, in Polish society drug use is perceived as sin, crime. Substance dependence is seen as a conscious choice of a lifestyle. These widely shared societal attitudes are reflected by the attitudes towards drugs in general population surveys. Although drug consumption is not criminalised in Poland, almost 80% of Poles think cannabis consumption should be prohibited, and 90% that heroin consumption should be illegal (Malczewski and Misiurek 2014b). Marginalising attitudes are also reported in medical professions, resulting in a denial of health services for people who use drugs, even in extreme situations. It is reported that NSP staff spends a considerable amount of time accompanying clients in contacts with public institutions (KI–4).

These attitudes are reflected in the legislation. The criminalisation of drug possession (any amount of any illicit substance) results in frequent incarceration of NSP clients, thus interrupting the continuity of relationships with them. Services devote their time to provide legal help for the clients to prevent their incarceration (KI–3). Such legal advice can undoubtedly be considered harm reduction activity, though it rather addresses harms resulting from certain drug policies, not the use of drugs. In the absence of the criminalisation of simple drug possession, services would enjoy more capacity for other tasks. The effectiveness of NSPs, based on trust and long-term

relationships, is being undermined by the contradicting mechanisms of law enforcement.

Politicians on the state level are perceived to be indifferent and drug policy as never being a priority in the Polish governments' agenda. Condemning public opinion on drug use makes this area even more unattractive for decision-makers; being driven by self-interest, they rather do not risk their positions addressing highly controversial policy fields (KI–4). In consequence, they tend to neglect drug policy altogether; drug policy is addressed in the programme of only one political party being currently in the Parliament, and the reference is limited to 'fight against NPSs and drug crime' (Platforma Obywatelska 2015). Occasional ad hoc activity demonstrating firm positions against substance use (e.g. raiding shops selling NSPs, a total ban on NPSs) can be observed, accompanied by morally loaded official statements in the face of some crisis, e.g. talking about 'dealers of death' in the context of rising NPS poisonings (Goluch 2018). This results in an unfavourable environment for harm reduction organisations on a national level and likely affects other structural factors, e.g., funding or attitudes of local communities. Nevertheless, harm reduction specifically does not seem to be within the area of attention of state politicians.

The lack of political interest not only in harm reduction but in drug policy in a broader sense results in the atmosphere of competition with other, more politically attractive policy fields. Interviewed experts tend to believe that even the scarce funds currently allocated to drug policy would be likely transferred to other policy areas (with possible minimal funding retained for abstinence-based treatment and recovery) if no external pressures and expectations (e.g., of the EU) were in place (KI–4). The public expenditure on drug policy in Poland was estimated at 35 million Euro or 0.01% of the GDP (EMCDDA 2019b).

Drug policy in Poland has been strongly focused on law enforcement and based on the firmly rooted abstinence paradigm. Prevention, long-term inpatient recovery services as well as abstinence-based ambulatories enjoy the highest political and social support, although support for harm reduction activities is one of the tasks included in the National Programme on Health (Council of Ministers of Poland 2016). NSPs try to

strengthen their relative position through advocacy efforts, yet harm reduction interventions are still marginal.

It needs to be noted that, recently, the situation slightly improved due to resources from so-called gambling fund partly transferred to support public health interventions (Parliament of Poland 2015), including drug harm reduction organisations. The level of financing is still very low, however. Although aggregate data on public expenditure on specific pillars of drug policy is not available, the amounts of funding planned for various interventions in public tenders are quite informative. For example, tenders funded by the gambling fund for 2019–2020 devote approximately 190,000 Euro annually for needle exchange programmes (KBPN 2018a), while over five times this amount is secured for various prevention activities (KBPN 2018b). The analysis of the data acquired from 3 out of 12 organisations officially operating NSPs shows that in 2018, the average budget per organisations equalled 57,007 Euro and the average budget per client 158 Euro.

Except being generally low, the funding is also somewhat unstable. It relies on short, mostly 1-year-long projects based primarily on tenders (EMCDDA 2018a). As a result, organisations find it challenging to develop long-term strategic plans. Applying for funding is highly time-consuming due to multiple sources of financing. Moreover, each donor has their own limitations regarding the categories of expenses. The shortage of financial resources and the design of the funding schemes result in the need for extensive planning throughout the budget year to maintain the functioning of services. Even more importantly, it also can occasionally directly impede the effective service delivery as organisations need to restrict the scope and magnitude of their services, e.g., by limiting the number of needles distributed per person per occasion (KI–1).

Demand reduction system is ineffective. The coverage of most of the services is very low, e.g. in 2017, there were 24 detoxication centres, 22 OST programmes and 28 institutions providing HIV testing (Malczewski 2018). Only 18% of high-risk opioid users were in substitution treatment (EMCDDA 2018a). Experts report that waiting time for detoxication is usually several weeks, and for treatment, it reaches even several months (despite the visible domination of this pillar of drug policy). As a result,

many of the clients who, at a certain point, are willing to enter such services, ultimately give up. As a result, and in combination with perceived hostile attitudes of various state institutions' personnel, harm reduction organisations struggle with helping their clients to step forward and ensure the access to the services clients need.

The state actors responsible for implementing the policy and allocation of funds impose strict reporting policies which are inadequate for such type of services and put a great administrative burden on NSPs' staff (KI–3). Moreover, some of these requirements (e.g., requiring a signature of a client under each intervention) are in clear conflict with the fundamental principles of low-threshold NSP, e.g., the principle of anonymity. As a result, the trust between services and their clients is put at risk. Experts report that a project, including visiting clients in prison, was terminated by the donor due to the lack of possibility of obtaining inmate clients' signatures confirming the intervention implementation (KI–3).

Elaborated time-consuming explanations are also required in cases where the number of persons using some service does not correspond precisely with the number of persons the service was planned for. Such strict approach suggests a low level of trust to professionals working in the services and lack of flexibility and readiness to take into consideration the specificity of working with PWUD.

Outreach worker profession does not enjoy much respect, especially within the demand reduction system. It seems to be perceived as the first step or a transitionary stage on a professional's way to become an addiction therapist—a role held in high regard (KI–1), likely due to the prevalent abstinence paradigm. As a result, NSPs often strive to find suitable employees. This, perhaps combined with the scarcity of funds, resulted in the decrease in the number of NSPs by almost a half (from 21 to 12) between 2002 and 2017 (Malczewski 2007, 2018).

Local communities demonstrate strong 'not in my backyard' attitudes, fuelled by the belief that it is the services which attract PWUD to certain areas (contrary to the actual practice of establishing facilities in places where PWUD are already present). Numerous protests have been organised in locations cities where either NSPs or treatment ambulatories have been (planned) to open (Chełminski 2018; Gaudenty

2018; Nowacka-Goik 2013; Sapkowska 2011; Zasadzki 2019). Such attitudes, moreover, are not only manifested against drug-related services but also interventions for other marginalised groups. Local inhabitants protest against social cooperatives employing socially excluded populations (Tarski 2018), shelters for homeless (Malec 2010; Rąpalski and Karkosza 2015) and psychiatric wards in hospitals (Polechoński 2009). Conflicts between local communities and NSPs are thus not exceptional. In the experts' opinion, confirmed by the above sources, attempts to discussing the problems often fail due to high levels of fear, prejudice, and stigmatisation. Organisations need to actively engage in extensive community work to be able to establish services in the first place and not always successfully.

Local politicians exhibit a variety of attitudes, typically consistent with their parties' orientation, with conservative ones being especially active against NSPs (Praga-Południe District Council 2015). Overall, they seem to be primarily motivated by self-interest and keeping their positions, thus maintaining a safe distance from NSPs. As a result, the situations can happen when, being under the pressure of the local community, local politicians favourable to NSPs, do not agree on establishing services in areas of their responsibility (Praga-Południe District Council 2019).

In some cases, organisations deliver their outreach services in zones where selling drugs also takes place. Local dealers exhibit a distrust and hostility towards the outreach workers, resulting in potentially dangerous situations which, if not being dealt with professionally, can result in physical violence (KI–3). Work in such surroundings requires careful and significant engagement in the interactions/relationships with local dealers to provide the organisation's employees with a relatively safe working environment.

4.3.3. Slovakia

Thinking about drug use in Slovak society is dominated by its perceptions as a weakness or crime. Slovak society exhibits attitudes supporting criminal law as the most effective way to tackle drug use, and PWUD are often alienated (Fedačko 2006; Reitox National Focal Point Slovakia 2009a). These cultural-societal factors, to a large

extent, determine the paradigm adopted in the drug policy field and influence services' working environment in numerous ways (Klobucký 2013).

Decision-makers on the state level have little interest in the area of drug policy, which has never been a priority issue in Slovakia, likely due to its political unattractiveness (KI–16). For example, at the beginning of the 2010s, a transfer of authority took place, placing the responsibility for drug policy under the Ministry of Health, instead of the Government Council for drug policy, which was in charge of it before (Kastelová et al. 2014; Reitox National Focal Point Slovakia 2013). It is argued that the Ministry of Health is characterised by lower political influence and lower capacity (Folk 2015), which may suggest modest interest in this policy area. Interviewed experts see politicians as being populist and driven by the self-interest of gaining and keeping the power. For that reason, they argue, the plans of drug decriminalisation were abandoned (European Liberties Platform 2018). High fragmentation of the availability of data from the country's reports to EMCDDA can also suggest low interest in drug policy altogether.

Although drug possession is criminalised in Slovakia, it was not identified as a barrier in service delivery. This may be due to somewhat different focus and methods of work of Slovak NSPs. Contrary to Polish, Czech and Hungarian programmes, which develop long-term relationships with clients and attempt to provide the most comprehensive care possible, Slovak organisations focus mostly on the needle exchange and accompanying social work of modest scope. They normally do not assist clients in contacts with various institutions, and they do not develop individual re-adaptation work plans with clients.

Low-threshold harm reduction programmes are seen as competing for funds and political support with other types of interventions in the field (KI–15). Harm reduction is marginal, while the policy focus is on prevention and treatment. In 2006 (the most up-to-date comprehensive data on public expenditure in Slovakia), the public expenditure on harm reduction was approximately 97,000 Euro, while almost 570,000 Euro was spent on prevention, 380,000 for treatment and social reintegration (Kiššová and Kastelová 2006). In 2017, the Ministry of Health, based on a public tender, supported NSPs with 53,000 Euro—50% less than originally requested by the

organisations and nine times less than was provided for prevention and treatment (Ministerstvo zdravotníctva Slovenskej republiky 2019).

The demand reduction system is highly incomplete and deficient. OST has very low coverage, with only 620 clients, i.e. approximately 12% of the estimated number of high-risk opioid users were receiving such treatment in 2017 (EMCDDA 2018b; Reitox National Focal Point Slovakia 2009b). Interviewer experts report that there is no housing and work support for people who use drugs. Moreover, health insurance is required for receiving Hepatitis C treatment, which makes most of the NSP clients ineligible. At the same time, HCV prevalence among treatment clients in Bratislava was over 40% in 2017 (EMCDDA 2019e).

Interviewed experts notice a crisis of social work in Slovakia. The problem with the adequacy of education has been raised in the scholarly literature as well (Matulayová, Hrušková, and Pešatová 2013). It is argued that the high popularity of this profession several years ago resulted in the emergence of colleges offering poor-quality education and issuing numerous diplomas with students' minimum effort. As a result, societal respect for social work has drastically decreased (KI–16). The current consequence of this process is a shortage of well-qualified personnel willing to work with people who use drugs. On the other hand, legal regulations on social services (National Council of the Slovak Republic 2008) make it very difficult to hire peer workers who usually have a criminal record (KI–14), the ones who are the most effective in reaching out to hidden populations.

State actors responsible for policy implementation, according to the interviewees, impose extensive reporting requirements. The considerable amount of time that NSPs employees need to devote to project-writing and reporting is at the expense of organisations' clients (KI–14). Interestingly, one of the strategies adopted by one of the organisations is not taking part in tenders, where donors have requirements perceived as unreasonable (KI–16).

The amount of funds available from the state is perceived as insufficient. The organisations need to fundraise continuously (KI–15). However, the absolute numbers are relatively high in the context of the region. The analysis of organisations' annual

reports published online shows that in 2017, the NSPs funding equalled to approximately 135,000 Euro per organisation (OZ Odyseus 2017; OZ Prima 2017; Združenie Storm 2017). Moreover, the total budget of the three organisations currently existing in the country almost doubled over the period 2008–2017. Nevertheless, it does not necessarily demonstrate the improvement of the overall situation. In recent years, several organisations were closed down, allegedly to the lack of funds. Currently, only three NSPs operate in Slovakia.

As can be seen in the organisations' annual reports, the funding system is multisource and includes mainly regional and local governments, the Ministry of Health and the Ministry of Social Affairs (OZ Odyseus 2017; OZ Prima 2017; Združenie Storm 2017). As mentioned above, financing is based on public tenders and 1-year projects (Ministerstvo zdravotníctva Slovenskej republiky 2019), which makes the organisations write numerous elaborated applications each year. Such funding framework is uncertain and unstable, but the interviewed experts do not express concerns about the future sustainability of their organisations. However, this can be due to the fact that they are the only NSP providers remaining in the country. Relevant ministries administer available EU Structural Funds. Having control over these resources, the responsible civil servants tend to limit the amount of organisations' funds allowed initially within a project (KI–14). Informants also raised the problem of corruption in the Ministry of Health (One.org 2018), which results in favouring certain applicants, e.g. TV channel producing moralising videos about drug use. Indeed, the results of public tender from the website of the Ministry of Health show that in 2017, a media company was granted nearly 50,000 Euro for that purpose—10% of the total expenditure and only 3000 Euro less than all NPSs altogether (Ministerstvo zdravotníctva Slovenskej republiky 2019).

The donors' limitations concerning the categories of expenses and the instability of the funding over a year (due to lengthy tendering procedures) result in need of extensive planning of the entire budget year (KI–14). The rigidity of funding rules does not allow to respond to dynamically changing circumstances and evolving needs of clients (KI–16).

Experts believe that local communities are rather unaware of how harm reduction works. It is widely believed that organisations are helping their clients to use drugs and that the existence of service in central location attracts PWUD (KI–15). This can be related to the marginal role of harm reduction in Slovak drug policy and strong law enforcement and prevention focus. Some local inhabitants actively oppose HR organisations establishing in their areas through organising protests. In the past, the instances of verbal and physical violence towards outreach workers were not exceptional. Nowadays, although conflicts are still present, organisations try to mitigate them. However, the violence has not disappeared completely; it now tends to be directed exclusively towards NSPs' clients (KI–15). Certainly, this affects the work of the services, whose employees devote time to community work and protecting their clients. Such situations can also discourage PWUD from using services altogether, further hindering the effectiveness of NSPs' work.

Local politicians are not perceived, as a rule, as hostile towards organisations. They are rather seen as driven by self-interests (gaining and keeping power) and using arising opportunities (e.g., picturing oneself as the defender of the district/area) for political gain (KI–14).

4.3.4. Hungary

According to interviewed experts, in Hungary, the use of psychoactive substances is still a taboo. Drug use is considered as a weakness, sin, and addiction tends to be perceived as consciously chosen, blameful way of life. It is confirmed by the research of attitudes, which demonstrates that the vast majority of Hungarians do not want any contact with PWUD. Namely, 64% of them would not like to have a drug-dependent person as a neighbour. It is the highest result of all group included in the study (at the same time, the result for people with a criminal record was 50%). The research also show that the public opinion, full of negative stereotypes and driven by moral panic, is detrimental to various services, including harm reduction (Zsély 2009). This general attitude towards psychoactive substances and people who use drugs is very strongly reflected in the country's current drug policy. The national anti-drug strategy titled 'Clear consciousness, sobriety and fight against drug crime' and includes a message 'to those people who have tried drugs: a clear indication that they take a risk by abusing

substances, and they can harm themselves and their environment' (Hungarian Parliament 2013). It also is noticed in the attitudes of public servants in various state offices, as well as in public health care institutions, where frequently PWUD are denied services (KI–9).

Drug consumption is punishable by up to 2 years of imprisonment (Parliament of Hungary 2012), and the possibility of diversion is very limited to one every 2 years (Parliament of Hungary 2012). Such shape of criminal law favours frequent incarceration of PWUD, thus negatively affecting their relationships with harm reduction services. Besides breaking NSPs' relationships with clients, such legal environment can also be a deterring factor in services use, especially in the absence of any form of clients' protection such as, for example, a non-interference agreement between the police and Budapest NSPs which was in place in 2004–2013. The criminalisation of substance use (as opposed to the criminalisation of possession only) also changes the legal environment of the NSPs themselves. Since facilitation of committing a crime is also punishable, services' employees can also be at risk; it is only a matter of political will whether distributing needles is interpreted as an accessory in a criminal offence.

Interviewed experts are strongly convinced that drug policy is beyond the area of interest of state politicians. Recent research on the topic confirms this observation: in 2010–2018, the word 'drug' appeared in parliamentary speeches 608 times, out of which 140 took place in 2013—the year of adopting drug strategy. Furthermore, 'harm reduction', 'low-threshold' and 'needle exchange' appeared 290 times during the same period (Kaló, Felvinczi, and Sárosi 2019). Moreover, it can be argued that this indifference manifests itself in the dynamics of legislation: Hungarian drug policy lacks continuity and strategic thinking; legal regulations on psychoactive substances (de- and re-criminalisation of drug consumption) have been changed each time the ruling party has changed (Kender-Jeziorska 2018).

Politicians on the state level are seen as self-interested and reluctant to show support for harm reduction, which is clearly reflected in the country's drug strategy (see below). They are thought to be populistic, manipulative and intending to destroy

organisations they perceive as hostile or representing contradicting worldviews (KI–11), which is clearly negatively affecting the effectiveness of service delivery.

The National Anti-Drug Strategy for 2013–2020 adopts a strong criminal justice approach and abstinence paradigm. One of its long-term goals is that 'shall be drug-free until 2020, in spite of the fact that this may seem unreal, based on the trends in the world and in Hungary' (Hungarian Parliament 2013). This goal is clearly in conflict with harm reduction principles and reflects opposing views of the decision-makers. Harm reduction activities are part of the Hungarian Anti-Drug Strategy only as an auxiliary to recovery services, and PWID are pictured as a burden for the society. Such an approach, it is argued, enhances the taboo around drugs and discourages PWUD from using harm reduction services (Mizsur 2019).

As already mentioned, drug policy does not keep a high position on Hungarian politicians' agenda. There is some perceived competition for political and financial support between drug policy and other policy fields, with drug policy remaining marginalised. The most up-to-date data on public expenditure shows that in 2007, 0.04% of Hungarian GDP (39 million Euro) was spent on drug policy. Today, this number is very likely much lower. While expenditure for harm reduction constituted 4% of this amount, altogether 20% was spent on prevention and treatment and 75% on law enforcement (EMCDDA 2019c). Hence, even before the harm reduction crisis, which began in 2010, this area was not a priority in Hungary.

The demand reduction system is ineffective primarily due to low coverage of existing services (OST, treatment), and lack of other, crucial for clients' re-adaptation, e.g., housing, protected workplaces. In 2015, nearly 700 individuals were covered by OST (Bálint et al. 2018a:125)   , which is approximately 20% of the population using opioids. In the same year, there were 86 outpatient and 13 inpatient entities providing treatment, reporting to the National Focal Point (Bálint et al. 2018a).

Organisations attempt to establish some relationships, based on personal contacts, to provide their clients with holistic care (e.g., with doctors or treatment centres). Still, due to strong prejudices (e.g., in the health care system), PWUD often have difficulties in accessing various services (KI–8). NSPs' social workers assist their clients in

contacts with various institutions to facilitate them. Such activities, being rather time-consuming, decrease the capacity of organisations to work on other issues, e.g., individual social work with clients. There is also a shortage of professionals willing to work in the field, which makes organisations struggle to find suitable employees.

Donors impose extensive paperwork and reporting on every activity of clients, which is seen as counterproductive and creating an unnecessary administrative burden (KI–9). The analysis of annual reports of NGOs providing NSPs (e.g. Alternatíva Alapítvány 2016; Drogprevenciós Alapítvány 2014; Kék Pont Alapítvány 2014) shows that financial system is multisource (though virtually all donors are state actors), with every donor announcing various tenders, having different priorities and limitations regarding what the money can be spent on. This results in need of writing numerous project applications every year to ensure the continuation of the services. Importantly, it is reported that 'harm reduction' does not appear in any tenders announced. This information is corroborated by Hungary's report to the EMCDDA, which states that 'no public call for tender had been issued since 2012', yet, contracts signed earlier are renewed each year (Bálint et al. 2018a). Nevertheless, the services need to find solutions to maintain needle exchange services and try to obtain funding via other service categories. Organisations have to plan extensively and carefully, anticipating possible shifts in clients' needs, especially given the dynamic situation on the NPS market. The aforementioned structural factors cause a further decrease in organisations' already limited capacity, and thus the effectiveness of service delivery.

The funding is characterised by a high level of instability (1-year-long projects) and unpredictability—organisations can never know whether they will receive the funding or not. The difficult political situation of harm reduction and its inferior place in the drug policy system enhances this uncertainty. Organisations strive to survive; the amount of funds is meagre. The data of two organisations providing information show that the budget per client was only around 65 Euro per client in 2017. The data from the Directorate-General for Social Affairs and Child Protection, responsible for the funding of the needle exchange show that in 2017, 46 low-threshold projects were supported with 140,000 Euro altogether—approximately 3000 Euro per project per year.

The local community is primarily considered as hostile towards PWUD and ignorant, and therefore, easy to manipulate by politicians (KI–7). In general, it seems that the majority of services operate relatively smoothly, and conflicts with the local communities are not emerging. However, the information acquired from the interviewed experts suggests that 'not in my backyard' attitudes are present where services are visible (KI–8). Several years ago, serious conflicts with local communities escalated in Budapest, being fuelled by the actions of local politicians.

Although the relations of services with local inhabitants were rather neutral in the past, they had changed when the mayor of the eighth district of Budapest started a scapegoating campaign against an NSP working in the area, accusing it of attracting PWUD and making it responsible for the injecting equipment abandoned on the streets (Kék Pont Alapítvány 2014). Numerous slander articles were published on the district's official website (Józsefváros Önkormányzat 2019), and protests of local inhabitants organised (Józsefvárosi Önkormányzat 2014). In the face of the state government's refusal to provide financial help, the NSP was closed. The closure of this needle exchange was followed by another one, due to the sudden increase in client turnover after the first closure. NSP clients became visible on the streets, which triggered complaints from the local community and the district mayor withdrawing the licence for providing needle exchange soon after. Both closed programmes were responsible for providing approximately half of the country's needles (Sárosi 2018).

4.3.5. Structural barriers and NSP effectiveness: similarities and differences

As the above within-case analysis demonstrated, significant differences can be observed between examined countries. Especially salient, although not surprising, is the case of the Czech Republic. It seems that the majority of the structural factors identified work as facilitators rather than barriers in NSP service-delivery. On the contrary, in Poland, Slovakia and Hungary, the majority of factors seem to have a detrimental impact on NSPs.

The identified factors are not independent of one another. On the contrary, the ecological model assumes interrelations within and between various levels of the environment. For example, the public opinion on drugs and attitudes towards PWUD

possibly affect the legislation and drug policy, which, in turn, affects the local-level policies. Such interactions are demonstrated in the data. In Slovakia, the prevalent belief in law enforcement as the most effective tool in addressing drug use resulted in policy strongly focused on criminal justice and marginalising harm reduction. In Hungary, on the other hand, the current drug strategy arguably shifted the discourse, strengthening the taboo around substance use and deterred PWUD from using the services.

Importantly, in all countries, the interviewed experts highlighted the interplay between local politics and attitudes of local communities. Politicians (both on state and local level) are seen as opinion leaders responsible for shaping people's views. The examples of the Czech Republic and Hungary show that single factors have a significantly lower impact on the NSP service delivery than the combination of thereof. Namely, in the Czech Republic, despite generally negative attitudes of the local communities towards both PWID and NSPs in the past, intensive community work and generally neutral attitudes of local politicians allowed for achieving a situation where NSPs relations with local inhabitants are satisfactory. On the other hand, the case of Budapest shows that political action was needed to fuel people's pre-existing fears and prejudices to damage previously acceptable situation in the neighbourhood and trigger open conflict.

Similarly, the majority of the identified barriers and facilitators on the macro level are intertwined. In Poland, Slovakia and Hungary, the low interest in drug policy results in scarce resources. Public condemnation of drug use and support for law enforcement measures and abstinence-based services, in turn, result in low political support for harm reduction and, in consequence, in uneven distribution of the scarce resources within the policy subsystem, with harm reduction being on the margins. In the Czech Republic, in turn, relatively high political interest in the drug policy area and undoubted support for harm reduction interventions result in resources distribution favourable for NSPs.

However, there seems to be a similarity between the countries on the macro level. The data shows that in all analysed countries, substance dependence is considered a life choice, i.e., a result of more or less conscious actions of individuals. It is clear that its

impact on NSPs operation varies between countries, however. Research shows that Czech students disagree with cannabis decriminalisation at a similar level to Polish students (Brodziak et al. 2016). Still, the legislation on the matter varies substantially between these two countries. It seems that the fundamental difference is the apparent lack of impact of societal views on the legislation, politics, and policy. One scenario is that politicians act against the will of people and take a position of opinion leaders. Another possibility is, however, that these societal views are weaker in the Czech Republic than in other countries. If this is the case, one of the explaining factors can be religion: while the Czech Republic is the most secularised country in Europe, Poland is the most religious one, with Slovakia and Hungary ranked in between (European Values Study 2018).

Another interesting issue involves Poland, Slovakia and Hungary, and state politics. In all three countries, the indifference of politicians was observed with regard to the drug policy field. However, in Hungary, the low level of existing interest is characterised by relative hostility towards harm reduction, while in Poland and Slovakia, neglect and abandonment of the area seem to dominate. Results are similar but have different dynamics. Namely, in Poland and Slovakia, the deterioration of the needle exchange situation has been gradual, with 1–2 organisations closing services annually in Poland, and 1 organisation closing in Slovakia recently (importantly, the biggest NSPs in Slovakia are still operating). On the contrary, in Hungary, the change was unexpected and quick—two biggest NSPs in the country were closed down within several months from one another.

Shortage of professionals was reported in the Czech Republic, Poland, and Slovakia, yet again, its impact varies. The reason for that is the kind of professional missing from the labour market. In the Czech Republic, it is health professionals, i.e., nurses and addictology doctors. In Poland and Slovakia, in turn, it is social workers (due to the lack of respect for the profession and due to the features of the education market, respectively). Of course, needle exchange can operate smoothly without medical staff, but it cannot be implemented without the basic workforce, hence the difference in the impact.

In sum, in the Czech Republic, the environment of harm reduction services has been stable over the years, with rather high political support, participatory processes in policy-making and favourable legal regulations (decriminalisation of simple possession) introduced in 2010. Needle exchange programmes in the country have been steadily developing, with the number of clients increasing by 53% between 2006 and 2016, the number of services increasing 2.5 times and number of needles distributed in the country skyrocketing by 1130% in 1998–2016 (Mravčík et al. 2018).

In Poland and Slovakia, general indifference seems to be dominant: lack of political support, insufficient funds, rather moral (than evidence-based) approach to drug policy. The number of NSPs in Poland fell from 23 to 12 between 2001 and 2015 (EMCDDA 2017), the total number of needles distributed decreased by more than 3.5 times (from 668,152 to 181,180) in 2002–2013 (Malczewski et al. 2015), and the number of clients almost six times, from 7763 in 2001 (Sierosławski et al. 2002) to 1360 in 2015 (EMCDDA 2017). In Slovakia, the number of organisations running NSPs fell from six in 2005 (Kiššová and Kastelová 2006) to three in 2018 (own data). The number of clients in two out of three organisations existing today has been stable (11% increase between 2008 and 2017; own data), so has the number of needles distributed in the country: 362055 in 2005 (Kiššová and Kastelová 2006) and 357,705 in 2016 (EMCDDA 2018b). It can be thus concluded that the presence of a significant number of structural barriers, including the lack of political support and sufficient funding, is related to stagnation or deterioration of services' development over time. Further research is needed to assess the role of individual factors in explaining the dynamics of changes in Poland and Slovakia (deterioration versus stagnation).

The crucial role of structural barriers is especially visible in the case of Hungary. The environment of harm reduction was continuously improving during the 2000s, with significant political support and inclusive processes of policymaking (e.g., involving NGOs in round tables, works on national drug strategies). This trend is reflected in the performance of needle exchange programs, with the number of organisations operating NSPs rising from 10 in 2004 (Reitox National Focal Point Hungary 2015) to 29 in 2012 (Reitox National Focal Point Hungary 2015)—almost threefold increase. The number of clients increased by nearly 260% in 2004–2013 (Reitox National Focal

Point Hungary 2005, 2015) and the number of needles distributed in the country by over 680% (Reitox National Focal Point Hungary 2005, 2012).

Significant changes of critical structural factors, especially political support, drug policy paradigm (including adopting a new drug strategy), financing framework and the amount of funds available, took place during 2011–2014. First, radical cuts in public expenditures in drug policy and especially harm reduction took place in 2011. The results were visible already a year after; the number of distributed needles has fallen by 35%, while the number of clients remained stable (Reitox National Focal Point Hungary 2013). Although the situation started to recover in 2012–2013 slowly, the introduction of the new drug strategy followed by the politically motivated fight against certain services in Budapest resulted in closing down two country's largest NSPs. Ever since, the indicators show poor performance, with the number of organisations providing services decreasing from 29 in 2014 (Reitox National Focal Point Hungary 2015) to 23 in 2017 (Bálint et al. 2018a), the number of needles distributed in the country falling by 70% and the number of clients decreasing by 50%.

4.4. Discussion

This study attempted to contribute to the scholarship on drug policy and harm reduction through addressing a relatively unexplored area, i.e., the environment where needle exchange programmes operate. Contrary to the majority of researches undertaken on structural barriers to HIV prevention among people who inject drugs, which are focused on an individual, this study focused on organisations providing services, putting them in the centre of attention. It answered three major questions: what the structural barriers and facilitators to needle exchange service delivery in Visegrád countries are, how they differ between analysed countries and how they impact the NSP service delivery.

The data sources can be considered a major limitation of this study. As mentioned in the Methods section, the qualitative data were primarily collected through interviews with employees of needle exchange programmes. As such, they are characterised by a certain level of subjectivity. This limitation was addressed by use of complementary sources, primarily relevant documents, legal acts, reports, and press publications. One

of the ways to develop a fuller picture of the analysed phenomenon could be extending the data collection to relevant policymakers.

4.5. Conclusions

This study identified 24 themes (structural barriers and facilitators) across 11 categories on three levels (culture, state, local). They include issues related to the broader society (e.g., morality), politics and policy on state and local level, frameworks and amounts of funding, the situation on the education labour market, and attitudes of local communities.

Based on the analysed data, it seems that structural barriers play a significant role when it comes to the performance of service delivery. Both cross-case and within-case analysis confirmed that the numerous and severe structural barriers are related to poor NSPs performance and the other way around, the presence of numerous facilitators is related to services' development.

This study contributes to both theory and practice. First, it demonstrates that the ecological model can be successfully applied to study organisations. Second, it fills the gap in the research, identifying and classifying a set of structural factors in the environment of NSPs in the ECE region. It can thus serve as a starting point for further investigations involving other geographical or policy areas.

Regarding the practical relevance, the study demonstrated that structural factors identified are not independent; on the contrary, they are often intertwined and affect one another, creating a complex system of relationships. Therefore, in case of any desired changes, it is not sufficient to address them individually, one by one. The efforts aiming to shift the situation need to be multilevel, targeting numerous areas of barriers' presence simultaneously, to the extent possible.

5. CHAPTER 5: CONCLUSIONS

The broad topic of this dissertation is policy performance. The narrower area investigated is the factors affecting policy performance in a collaborative field. The dissertation aimed to shed some light on these factors in the context of a unique policy field of drug policy and challenging geographical context of Central-Eastern Europe. The dissertation focused on identifying circumstances contributing to the policy's poor versus high performance, focusing on different aspects of policymaking, namely, policy framing, collaborative governance regimes, and structural factors affecting effective service delivery. Together, the results of the three articles making up the dissertation provide a holistic, complex picture of the performance of harm reduction policy in the region. The work contains several theoretical contributions and has a significant practical relevance, too.

Chapter 2 of the dissertation, containing the article 'A sin or a health issue? Morality policy framing and the state of harm reduction in Central-Eastern Europe' focused on the relationship between policy standards and objectives on the one hand and policy performance on the other. Using the analytical framework of morality policy framing, it classified drug policies of Visegrád countries into one of four framing categories. Subsequently, based on the collected data of needle exchange services, it assessed the harm reduction policy performance understood as coverage and accessibility of services. Finally, it looked at the relationships between the two through within-case analysis, as well as in a comparative perspective.

The article results confirm the association between using a morality frame to shape drug policy and poor harm reduction policy performance in the case of Hungary. On the other hand, an association was also found between a strong health-social framing and high policy performance in Czechia. Another important finding of the article is related to the availability of data on harm reduction policy outputs. Namely, in some

cases (most notably, Slovakia), aggregate, country-level data are not available. In other cases (primarily Hungary and Poland), the quality of data is relatively low, with high incompleteness and fragmentation levels. The level of detail of the data is characterised by the significant variance between countries, which may be considered an indicator of the entire policy system's capacity.

Chapter 3 includes the article 'Collaborative governance regimes in illiberal democracies: A comparative case of drug harm reduction policy in Central-Eastern Europe', which investigated the differences in state-NGO relationships between Central-Eastern European countries exhibiting and not exhibiting the signs of an illiberal turn in governance. The article used the theoretical framework of collaborative governance to develop a typology of collaborative governance regimes and classify analysed countries into categories based on empirical data.

The article's main theoretical contribution lies precisely in the novel conceptualisation of collaborative governance regimes and the development of their conceptual classification (including pro-collaborative, neutral, and anti-collaborative regime categories), including operationalisation of each of categories along with a range of observable dimensions, too.

The article results suggest a relatively strong presence of a pro-collaborative regime in Czechia, a mix of pro-collaborative and neutral regimes' features in Poland and Slovakia, and a strongly anti-collaborative regime in Hungary. Based on the Hungarian case, the article inductively conceptualises and operationalises the anti-collaborative regime as follows:

The operational space of NGOs is severely limited, with open, harsh intimidation of selected (perceived by the government as hostile) NGOs, including the use of legal (administrative as well as criminal) instruments against them;

The policy system is unstable, with frequent changes characterised by unpredictability and uncontrollability;

Mechanisms for the involvement of non-governmental organisations are non-existent, and possibly previously existing mechanisms are removed;

Policy implementation (service delivery) by non-governmental organisations is hindered through semi-formal administrative measures;

The system governing the distribution of indirect resources is designed in a way that results in grave underfunding of 'hostile' NGOs on the one hand, and favouring of organisations sharing the ideology of the government, on the other; the governments consciously and outrightly attempt to restrict the possibilities of selected NGOs to acquire funding from non-governmental sources;

Direct funding is provided at the minimum possible level;

The level of trust between the government and NGOs is extremely low or completely lacking, and one can also observe government activities intentionally undermining trust.

Based on the lack of evidence for the anti-collaborative regime in the Polish drug policy field, the article argues that such regimes do not appear uniformly across various policy fields. Based on anecdotal evidence, the article also claims that anti-collaborative regimes' materialisation in different policy areas may vary in space in time. It is visible, for example, in a recent shift of interest towards migration policy in Hungary and in the area of reproductive rights in Poland. Therefore, our results suggest that the illiberal governance, and consequently, the existence of anti-collaborative regimes, are characteristic only for those policy fields, which ideologically and politically oppose the worldviews and values of the currently ruling political parties.

Chapter 4 includes the article 'Needle exchange programmes in Visegrád countries: A comparative case study of structural factors in effective service delivery' and focuses on identifying barriers and facilitators of policy performance, as well as exploring the relationship between the number and severity of these structural factors and policy outputs. It uses the ecological framework and 'risk environment' theory to reveal what

meso-, exo-, and macro-level conditions affect service delivery organisations' work and how.

The results of the article identify numerous factors affecting harm reduction policy performance across eleven categories: morality, criminal law, state politics, policy in general, drug policy, the framework of harm reduction service delivery by NGOs, resources, education/labour market, local politics, community, and the criminal underworld. Through within case and comparative analyses, the article describes service delivery NGOs' experiences concerning how the identified variables affect their work. Official data on needle exchange services' outputs are used to assess policy performance. The results confirm the relationship between the number and severity of identified barriers and poor policy performance on the one hand, and between the number and scope of identified facilitators, on the other. The study also confirms that structural factors are interrelated and affect one another, creating a complex system of relationships.

To satisfy the requirements of scientific integrity, the necessary limitations of this dissertation, going beyond what is mentioned in respective chapters, need to be mentioned. The main limitations of this work are related to the methodological issues, yet some conceptual challenges should also be addressed.

The first major limitation concerns the data sources. Namely, papers included in Chapters 3 and 4 use the interview data collected from the same key informants working in non-governmental organisations based in major cities. In both cases, the triangulation of data sources was applied. An extensive body of documents and secondary sources was analysed to inform the findings, and data saturation seemed to be achieved. Still, in this context, the validity of the research could be improved by collecting interview data from harm reduction services providers working in smaller settlements. Moreover, the complexity and objectivity of the data could be improved by including other (e.g., treatment, prevention) service providers' employees and policymakers as key informants.

Similar criticism can be raised in the case of the paper 'A sin or a health issue? Morality policy framing and the state of harm reduction in Central-Eastern Europe', concerning

the sources used to determine the dominant frames used to describe drug policy in examined countries. Indeed, the choice of the different national drug strategies parts may impact the results. The intention here was to choose all the sections of respective documents that are not purely technical but include overarching motivations, attitudes and principles guiding specific solutions. As it turned out, there were more such sections in some cases (namely, Czechia and Hungary) and fewer in some cases (Slovakia). As noted earlier, in the case of Poland, no such section could be identified. On the other hand, the very existence of the section titled 'Basic values' in Hungarian drug strategy and a lack of such sections in other countries' documents is informative. While we believe that, given the limitations, we have done the best one could do, there is no doubt that including other sources (e.g., other policy documents, parliamentary discussions, public appearances of government politicians) would increase the soundness of the framing classification results and help minimise possible bias.

The second main limitation is related to the very criticism raised in the context of quantitative research, namely, the level of objectivity of the data and the researcher. In our opinion, it is not questionable that the investigator may merely attempt objectivity in the context of qualitative inquiries. Their understanding of phenomena will always be influenced by and filtered through prior knowledge and experience and include bias. The same is true for the key informants interviewed for this research. The key informants were employees of the examined organisations; hence the information they provided was not concerned with some external phenomenon but something very close to their vocation and personal mission. It is close to impossible to maintain a neutral attitude in such a context.

The complexity of the situation concerning the investigator stems from the long-term involvement in the drug policy field as a practitioner in non-governmental organisations. On the one hand, this role could have positively influenced the interviewees, creating an atmosphere of trust and, in consequence, more open communication than it could have been in the case of an 'outsider' researcher. On the other hand, however, our professional engagement in the field and strong support of evidence- and human rights-based drug policies, including harm reduction, without a doubt played a role in the research process. Such a problem could be addressed (in a

context other than a doctoral dissertation) by involving other researchers in the process of data coding and analysis.

At this point, it is also worth getting back to the conceptual and theoretical remarks included in the Introduction of this dissertation and reflecting on them in the context of the knowledge and experience gained during the last several years of research.

First, it seems to be in place to address the apparent oxymoron in the very topic of the research included in Chapter 3. Indeed, at first sight, it may seem odd to collate collaborative governance on the one side with illiberal governance on the other. However, it needs to be noted that the results of the research showed that the manifestations of illiberal turn in collaborative governance arrangements do not appear uniformly across policy areas. In fact, in drug policy, the collaborative governance regime identified in Poland was closer to those of Slovakia or the Czech Republic, despite the country being in the midst of illiberal transformation. In other words, no anti-collaborative governance regime was identified in this case. On the other hand, the anecdotal evidence from this country suggests that in Poland, other policy fields, namely, women's reproductive rights, sexual minorities rights, and – very recently – migration policy, may exhibit (some of) the features of anti-collaborative governance regimes. Further, it seems that over the last several years, such anti-collaborative measures could affect other policy fields (e.g., migration, sexual minorities) in Hungary as well.

Second, we would like to re-address the question of why drug policy is such an exciting policy field for exploring the issues discussed in this work. In the introduction, we mentioned several unique features of drug policy. One of them was that it is one of only a few policy fields concerned with regulating individual citizens' behaviour. In this regulation, it extensively uses criminal law as a policy instrument. Furthermore, the experience acquired during the work on this dissertation suggests that it is very strongly related to the general societal consensus regarding the morally evil status of drugs and people who are engaged in their use, sales, production, etc. The situation we can see in many countries with respect to drug policy resembles the concept of moral panic, which is characterised by five essential features (Goode and Ben-Yehuda 2009):

1. Concern regarding the behaviour of a specific group and the possible consequences of this behaviour for the society or some of its parts, 'manifested or measurable in concrete ways, through public opinion polls, public commentary in the form of media attention, proposed legislation, number of arrests and imprisonments, and social movement activity' (p. 37).

2. Hostility towards the members of the group engaging in the behaviour of concern, who are portrayed as enemies and whose actions are 'seen as harmful or threatening to the values, the interests' (p. 38). A strong distinction between 'good us' and 'evil them' is visible.

3. Consensus – a widespread agreement among the society as a whole or its specific parts that 'the threat is real, serious, and caused by the wrongdoing group members and their behavior' (p. 38).

4. Disproportion of the concerned reaction compared to the actual extent, prevalence of the behaviour or the severity of the threat it involves. In other words, 'public concern is in excess of what is appropriate if concern were directly proportional to objective harm' (p. 40).

5. Volatility of the moral panic phenomenon with, however, the possibility of institutionalization understood as the continuation of the existence of the moral concern 'in the form of social movement organizations, legislation, enforcement practices, informal interpersonal norms or practices for punishing transgressors' (p. 41).

Indeed, the research included in this dissertation shows that drug policy, and especially its harm reduction element, is still a very controversial policy field where deep beliefs are strongly involved, and ideology often dominates over the evidence. Due to this nature, it can easily become a policy field used in political fights, where drugs and people who use drugs can serve as a 'suitable enemy', exhibiting four of the five features of the concept: (i) definition of drugs being decided by those in power; (ii) people using drugs being perceived as dangerous and inhuman; (iii) the 'enemy' being impossible to eliminate; (iv) the problem having symbolic value as the evil that society

can unite against (Christie 1986). Given the above, one of the interesting areas for further research can be the few similar policy fields, e.g., migration, reproductive rights, sex work.

The controversy of harm reduction policies and intervention also result from its low-threshold character and non-judgemental and non-discriminative approach. In essence, harm reduction is based on the principle of meeting people where they are and respecting their situation, autonomy and agency, as opposed to imposing socially accepted requirements and rules on them. This is in clear conflict with the picture of a person who uses drugs as immoral, inhuman, evil and threatening. We believe that this also touches upon the clash between the paradigm of need-based support and merit-based support, where harm reduction is clearly representing the former, and many other, more widely accepted services represent the former (e.g., accessibility of homeless shelters only for people not being under the influence of illicit substances).

The three features of the drug policy described above have vast implications for policy implementation. First, a large part of drug policy focuses on people who use drugs – to prevent their use, treat their dependency, minimise harms or incarcerate them. This focus is related to a range of challenges that are unheard of in most other policy fields: the subjects of the drug policy (people who use drugs) experience extreme stigma, marginalisation and discrimination both from the side of the government and different public institutions (e.g., law enforcement, health care system), and the society as a whole. Indeed, it is clear that moral panic has tangible consequences, for example, mass imprisonment resulting from panic over illicit drugs in the United States (Garland 2008). In our context, the main consequence is that harm reduction organisations have to overcome not only barriers resulting strictly from policy and politics but also those emerging, for example, in local communities. The amount of community work necessary to achieve at least minimal tolerance in neighbourhoods where services operate and the range and magnitude of activities NGO employees engage in to reduce harm resulting not from drug use but repressive drug policies are incredible.

Further, we argued that drug policy is a policy field that requires a considerable collaborative effort. This is indeed visible in the results of this dissertation, most notably, in the context of funding of harm reduction service providers. As described

earlier, organisations acquire funding for their operation from a broad range of (mostly) state actors at different levels: various ministries at the central level, regional authorities, and local authorities. Moreover, this research results show an urgent and vital need for cooperation with different public institutions, for example, health care providers, law enforcement authorities, social services, etc. At the same time, the data shows that the contradictions between different policy priorities (e.g., incarceration of people who use drugs and harm reduction) are not addressed at the system level but need to be dealt with by the frontline policy implementers, in this case, NGO employees.

The third argument is related to the great extent of outsourcing public service delivery to non-governmental organisations on the one hand, and project-based funding frameworks with a low amount of funds, on the other. Our results show that examined non-governmental organisations are funded mainly from the state and local budgets and do not operate for-profit services. All of the above creates a situation of a uniquely high level of competition between NGOs in the field. Moreover, especially when the budget for demand reduction, prevention and harm reduction is the same, a considerable amount of civil servants' discretion is involved in awarding funds. In such instances, policy goals formulated in policy documents have a very limited impact on what the policy effects will be.

Fourth, the theme that kept emerging during the research process is the lack of comprehensiveness of the drug policy field understood as a holistic approach and lack of firm embedment of harm reduction in the drug policy subsystem. Interviewed professionals often emphasised that the situation of their services in terms of funding or relations with public institutions is highly dependent on persons occupying relevant positions (e.g., Minister of Health) at the moment and their personal attitudes towards harm reduction. This creates a situation when it is not even the change of government that can fundamentally change the priorities and resulting situation of service providers, but a mere individual.

The fifth reflection is related to the two previous ones. As we discussed earlier, the complexity of drug policy and the bottom-up origins of harm reduction results in a situation where there are numerous policy sources, and policy objectives are often

general, vague, or even contradictory. Consequently, there are significant differences between the range of harm reduction services operating in countries with otherwise similar legal frameworks in terms of the criminalisation of drug use and/or possession for personal use (with but a few exceptions). For example, while in Central-Eastern Europe only 'traditional' harm reduction interventions, like needle exchange programmes, are available, in other countries, NGOs implement more innovative interventions like drug-checking (e.g., in Austria, Spain) or drug consumption rooms (e.g., Germany, France). The reasons behind the availability of specific interventions in some countries and not in others cannot be placed within the legislation or general policy frameworks – other policy aspects need to be explored to shed some light on this phenomenon.

Finally, one observation relates directly to organisations providing needle exchange services. While writing this dissertation, we learnt that the most deficit 'good' in harm reduction organisations is time, or, to look at it from another perspective, capacity. It seems that the limited capacity is a result of a cumulation of all barriers and unfavourable conditions the NGO employees have to fight against: from socio-cultural considerations to hostile or indifferent political environment to underfunding and lack of professionals, to local communities protesting against services operation in their neighbourhood. This limited capacity could be observed during our last several years of collecting data for this dissertation and other research projects. Namely, the responsiveness (understood as answering emails) of organisations in all countries is very low, not to mention the ability to compile and provide data on their operation (identical to those they report to their donors). Indeed, the picture that emerges from the results of this research is a picture of groups of highly concerned, empathetic and motivated dreamers, whose personal missions and sacrifices are the main reasons why harm reduction exists at all on the ground.

We can identify several exciting areas for further research based on the above reflections. First, a further area of study can be drug policy performance in Poland, which in this dissertation turned out to be a compelling case with no policy framing identifiable based on the analysed documents, no anti-collaborative regime identified, yet clearly poor performance of harm reduction services. Second, given the relatively high level of discretion of public administration and high dependence of policy

implementing NGOs on individuals in relevant positions, it would be interesting to see some inquiries into the world of civil servants working in the drug policy field, which could provide exciting insights into another level of the policy implementation process. Third, given the considerable differences in the availability of different types of harm reduction services in countries with similar legal frameworks, an exciting area of inquiry involves exploring the causal mechanisms behind this phenomenon, perhaps with a particular focus on advocacy coalitions in affecting policies. Finally, given the emerging picture of harm reduction services' employees, it would be worth it to gain more insights into these street-level implementers' behaviours, motives, values, and attitudes.

Overall, the dissertation contributes to the understanding of policy performance in essentially collaborative settings. The results show the vital role of policy standards and objectives in determining the policy effects. However, perhaps even more notably, our study confirms, in line with the third-generation implementation researchers' observations (and especially scholars focused on network governance), the remarkable role of relationships between actors and level of conflict in affecting policy performance. It shows that in a complex policy field like drugs, collaboration is essential for achieving satisfactory policy effects (O'Toole 1988). Further, the dissertation clearly demonstrates that 'policy implementation is far from being a trivial activity' (Knill and Tosun 2012:151) and highlights the importance of specific policy programmes' institutional context (McLaughlin 1987).

From our results, a picture that emerges in the context of street-level implementing agencies seems to be close to that drawn by Lipsky, a picture of actors 'fac[ing] great pressures of inadequate time in relation to limitless needs', 'mak[ing] choices about the use of scarce resources' and being 'caught in situations that are fundamentally tragic' yet 'still try[ing] to make the best of it' (Hill and Hupe 2002:53). The dissertation shows that this challenging situation of implementing agencies is often a result of ideological considerations, suggesting that policy implementation is an essentially political process (Barrett and Fudge 1981b; Ripley and Franklin 1982).

The principal value of this dissertation lies in its aim of exploring the policymaking process and explaining policy performance in case of a highly contested policy field,

where conflicts around policy formulation and implementation include not only more technical considerations of choice of policy instruments, etc. but, first and foremost, disagreements on deep beliefs and values. By focusing on such a context, we were able to reveal challenges in the policy process that are clearly different from factors we can find in most implementation studies, which often focus on much less contested policy fields. Our analytical approach, especially the development of the typology of collaborative governance regimes and adoption of the ecological framework for studying organisations, may serve as an inspiration and be applied by other researchers to investigate other, similar policy fields and policy issues, e.g., reproductive rights, migration, assisted suicide, homelessness, etc. Given the above, we believe this work contributes to the research on policy implementation and policy performance through 'develop[ing] and test[ing] explanatory and predictive implementation theories of the middle range' (Goggin et al. 1990:15).

The results of the dissertation also have considerable practical application. First, they can serve as guidance for decisionmakers regarding how to design and implement controversial policies to minimise the influence of factors undermining policy performance. Second, they may contribute to the advocacy efforts of drug-related non-governmental organisations in negotiating policy solutions. Third, they can serve as an important source of information for international organisations like, for example, the European Union, in mapping the challenging policy environments and addressing them in their own policy strategies.

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