Iga Jeziorska*

# A Sin or a Health Issue? Morality Policy Framing and the State of Harm Reduction in East-Central Europe

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* [iga.jeziorska@uni-corvinus.hu] (Department of Public Policy and Management, Corvinus University of Budapest)

**Abstract**

*Aims.* There are significant differences in harm reduction services availability and performance in various countries. The paper examines the state of one of the harm reduction interventions – needle exchange services – through the lenses of morality policy, attempting to establish potential relationships between policy framing and policy outcomes. *Method.* The research uses an explorative design with cross-country comparison. The unit of analysis is drug policy in a country, and the geographical scope includes Czechia, Hungary, Poland, and Slovakia, following the maximum variation case selection procedure. Countries' drug strategies are analysed to identify the policy frames, and data on needle exchange programmes are used to assess the state of harm reduction. *Results.* The analysis identified health and social drug policy framing in Czechia and Slovakia, the morality frame in Hungary, and no frame in Poland. The availability and coverage of needle exchange programmes is the highest in Czechia, followed by Slovakia, Hungary and Poland. Conclusions. The Hungarian case confirms the relationship between morality framing and poor policy outcomes, while the Czech case between health framing and effective policy. Further research is needed to establish the function of morality framing as a necessary and/or sufficient condition for unsatisfactory policy performance.

**Keywords**: morality policy, policy framing, harm reduction, East-Central Europe (ECE), needle exchange, drug policy

## 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, para. 1). 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 use altogether (Single, 1995). Initially controversial and contested by many as potentially promoting drug use, the harm reduction approach has slowly made its way into 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 and Kaldor, 1997; MacDonald, Law, Kaldor, Hales, and Dore, 2003; Vlahov and Junge, 1998; Wodak and Cooney, 2006). Moreover, such interventions have proved to be cost-effective as well (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 organizations. The United Nations, in the Resolution adopted by its General Assembly in April 2016, highlights the need for a balanced approach to drug policy and '[i]nvite[s] relevant national authorities to consider [...] effective measures aimed at minimizing the adverse public health and social consequences of drug abuse [...], as well as consider ensuring access to such interventions, including in treatment and outreach services, prisons and other custodial settings [...]' (United Nations, 2016: 6). The European Union even goes a step further, calling in its Action Plan on Drugs 2017–2020 for '[s]cal[ing] up where applicable, availability, coverage and access to risk and harm reduction services, e.g. needle and syringe exchange programmes, opioid substitution treatment [and] opioid overdose management programmes' (Council of the European Union, 2017: 7).

Notwithstanding this international agreement about 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, 2019).

There are also clear between-country differences in the level of accessibility of services. According to civil society experts, while the accessibility of prevention and treatment responses in East-Central Europe countries is similar to Western European one, the accessibility of harm reduction programmes is significantly lower (Kender-Jeziorska and Sarosi, 2018: 43).

One of the explanations for this phenomenon may be the role of values and social norms – drug policy that addresses addictive-behaviour-related matters is one of the typical examples of morality policies (Euchner, 2019). It is possible that while in mainstream Western literature and policy practice the controversy around illicit drugs has become negligible (which seems plausible, among other factors due to the recent normalisation of drug use – Parker et al., 2002; Ravn, 2012; Wilson et al., 2010), it is still contestable in Central and Eastern Europe.

In order to shed some light on the potential reasons for the above-mentioned 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 the Czech Republic, 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 (more detailed case selection logic can be found in the Methods section). In other words, the goal is to establish whether a relationship exists between the morality framing of drug policy and the state of harm reduction in selected countries. To that end, the following section presents the theoretical framework. Subsequently, data and methods 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 counties in implementing and monitoring HIV prevention interventions as points of reference. The analysis will focus on needle and syringe exchange programs (NSPs) for people who inject drugs.

## 2 Morality policy

The theoretical framework of this inquiry derives from studies of morality policy. Since the proliferation of research on morality policy 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. The primary definitional criterion of morality policies that differentiates them from other kinds of policies is that they essentially include conflicts of fundamental values, as opposed to instrumental conflicts about wealth redistribution (Knill, 2013; Meier, 1999; Mooney, 2001).

There is no agreement, however, regarding the specific criteria for classifying policies as morality ones, nor whether certain policies should be defined as morality policies *a priori,* or whether they *become* morality issues due to policy actors' behaviour. A policy-based analytical approach represents the former orientation. It highlights the policy content and differentiates between four main categories of moral policies: (i) 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).

The latter view, on the other hand, includes two main approaches. The politics-focused one considers morality policy to be 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 the politics surrounding them, i.e. technical simplicity, saliency to the general public, and high citizen participation (Mooney, 2001: 7–8).

Finally, the last approach argues that policies become morality policies due to their being framed as such by policy actors. In other words, in cases of morality policies 'those who frame the issues place adherence to [sic] moral principles above alternative considerations' (Mucciaroni, 2011: 191). This paper adopts the framing approach, this being an important and explicit element of two of the most influential approaches to analysing policy change: namely, Advocacy Coalition Framework, and Punctuated Equilibrium Theory. While various policy actors can use different frames, and specific frames are liable to be differently received and supported among various social groups, this paper focuses on the government as the actor that frames policies. Adopting the framing approach, this paper assumes that morality policies can vary in space and time.

## 3 Methods and data

The above discussion implies that (i) the framing of drug (and within it, harm reduction) issues may vary between countries, and (ii) morality policies (the framing policy field as such) tend to have poor results. Therefore, we ask: What, if any, is the relationship between drug policy framing and the state of harm reduction? In order to answer the above research question, this paper adopts an exploratory study design with a cross-country comparison.

The geographical scope includes the Visegrad Group states: the Czech Republic, Hungary, Poland, and Slovakia, following maximum variation sampling, and taking the expert-assessed availability of needle exchange services as the criterion. According to this assessment, the level of NSP availability in the Czech Republic is very high, in Hungary very low, in Poland medium, and in Slovakia low.

The inquiry involves three main steps: (i) determining the dominant frame used to describe drug policy in a country, (ii) assessing the state of harm reduction in a country, and (iii) identifying potential relationships between the two.

The identification of the policy frames was conducted using a framework borrowed from Euchner and colleagues (2013). An analysis of relevant and corresponding parts of national drug strategies (Table 1) was performed.[1] Words and phrases (i) referring directly to the types of frames (see the analytical framework) and (ii) used in the context of describing drug policy goals and functions were counted to determine the dominant policy frames.

| 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 |

*Table 1: List of documents analysed to identify the policy frame*

The state of harm reduction assessed in the second step is understood as the immediate outcome of policies. 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 other things, for data collection about the drug policy field. The following sources were used:

For the Czech Republic, 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 (Balint et al., 2018b).

[1] Using the qualitative data analysis software MaxQDA. The analysis focused on identifying segments that refer to predefined themes.

For Poland, 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. Therefore, organisation-level data was 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 involving data requests sent to organisations' directors or managers.

## 4 Analytical framework

In the attempt to identify the framing of drug policy, this paper borrows a typology from Euchner and colleagues, who – in their study of drug and gambling policies – identified four policy frames, as summarised in Table 2 (Euchner et 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 (b) values, and 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 threat 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 | Trade in illegal drugs and drug-related crime are serious disturbances 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 (health-care costs, missing workforce caused by addicts) or benefits (revenues through licensing, taxation) to the national economy | Drug abuse and addiction cause significant economic damage. | Moderate level of availability and coverage of needle exchange services. |

*Table 2: Summary of analytical framework*
Sources: Euchner et al. (2013), Meier (2014)

Further, this paper follows the conclusion of Meier, who argues that one-sided policy issues (drug abuse among them) are often poorly designed and do not work due to the unanimous opposition against them, resulting in both a lack of informed discussion on the matter and the involvement of professional expertise (Meier, 1994). It would follow, therefore, that where drug policy is framed as a moral issue, policy outcomes in the area

of harm reduction will be poor. Similarly, security and public order framing, due to its focus on criminal justice and law enforcement, is likely to be related to the low level of performance of harm reduction programmes. Further, it can be assumed that health and social framing will result in a high level of positive outcomes, as the main goal of harm reduction is to improve or prevent the deterioration of the health status of people who inject drugs. Finally, for economic and fiscal framing, it is plausible to predict a high level of service performance, given that NSPs are 'one of the most cost-effective public health interventions ever founded' ( Wilson et al., 2015: 6) and help save significant public resources on HIV and Hepatitis C treatment (Kwon et al., 2012).

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* (2012) – a document developed in the aftermath of the adoption of the 2006 Political Declaration on HIV/AIDS by the UN General Assembly (Political Declaration on HIV/AIDS, 2006). The guide introduces a comprehensive package of interventions for addressing HIV among people who inject drugs, including, among other elements, needle exchange programs, opioid substitution treatment, HIV testing and counselling, and antiretroviral therapy. It also provides a range of indicators to monitor the level of implementation of specific services. Following the Guide, this study focuses on two main aspects of needle exchange service-delivery:

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

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

An auxiliary variable – the estimated number of people who inject drugs – is used to enable the estimation of the services' coverage.[3] Variables are measured across a range of indicators chosen based on the availability of the data and feasibility of their study. The table below presents the conceptualisation and operationalisation of the variables. (A summary of specific indicators and, where applicable, benchmarks for each variable can be found in Appendix 1.)

| Variable | Conceptualisation | Operationalisation |
|---|---|---|
| Population size | The magnitude of the phenomenon of injecting drug use 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 service occasions (total client contacts) |

*Table 3: Conceptualisation and operationalisation of main variables*

[2] The performance of services is a policy outcome. However, from the perspective of concrete services, values for specific indicators are service outputs.

[3] Slovakia is an exception, as only data on the prevalence of problematic drug use is available. The number of people who inject drugs within this population is very likely to be lower. On the other hand, Slovakia is characterized by the widespread injection of methamphetamine (Pervitin). Based on the available data, it is not possible to even roughly estimate the number of people who inject drugs in Slovakia.

## 5 Identification of policy frames

In the Czech national drug strategy, the health and social frame is strongly dominant. It appears 30 times in the analysed parts of the document, in forms such as 'well-being,' 'loss of people's lives,' 'public health,' 'protection from harm,' and 'healthy development of [...] individuals.' The second strongest frame is a security and public order one, with 14 keywords (primarily 'safety' and 'security,' but also 'political stability' or 'rule of law').

In Hungary, the morality framework seems to appear the most – 37 times. However, the interpretation of the language used in the Hungarian national drug strategy is not straightforward. At first glance, it seems that references to health and social issues are the dominant ones and – if looked at without much context – this is true. However, it appears that in Hungary it is the health and well-being of society at large that is being protected, while people who use drugs appear as a threat. They are a 'burden' who 'by abusing substances' 'can harm themselves and their environment,' and 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 promoting the 'spread [...] of lifestyles representing clear consciousness' in order to 'popularize 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 rather strong although implicit critique of drug use as not conforming to decisionmakers' vision of society and supported norms and values. The health and social frame is the second most dominant one in Hungarian drug strategy, with 22 references of a neutral character.

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

In the Slovak drug strategy, similar to that of the Czech Republic, 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 the Slovak document is a security and public order one, with two references in the text.

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

This section presents the results of the data analysis. First, within-case analysis is performed for each country, focusing on the current situation. Subsequently, a comparative perspective is adopted, briefly discussing the current (2017) situation, and focusing on the similarities and differences in NSPs development dynamics in four countries.

| 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 | Morality |
| Poland | National Programme for Drug Prevention 2011–2016 | None[4] |
| Slovakia | National Anti-Drug Strategy of the Slovak Republic for the period 2013–2020 | Health and social |

*Table 4: Dominant drug policy frames*

## 6 Needle exchange programmes

### *6.1 The Czech Republic*

In 2017, altogether 108 needle exchange programmes were operating in the Czech Republic in 138 cities and villages. This accounts for one-third of all cities and towns in the country. Needle exchange is provided 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 big cities, several services operate in different areas. Services, to a more modest extent, also operate in smaller towns and villages, which indicates the high level of the programs' geographical coverage.

More than 32,000 PWID used services on a country level in 2017, which accounts for the high coverage of the PWID population (approximately 74 per cent). In 2017, clients received 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 number.

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

Overall, the current availability and coverage of NSPs in the Czech Republic is high, with room for improvement in case of the number of needle-syringes distributed per client.

### *6.2 Hungary*

In 2017, 40 NSP sites were operating in 20 Hungarian cities and towns (Balint et al., 2018a: 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 is low and somewhat uneven – i.e. needle exchange is not available in more than one 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.[5] In 2017, clients came into contact with NSPs on nearly 14,000 occasions. A high number of service units were provided (234 per 100 PWID).

[4] The Polish National Programme for Drug Prevention 2011–2016 is a very technical legal document and does not include any contextual, normative, or value statements.

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

The number of injecting paraphernalia that were provided was 66 per service client in 2017, which translates into only 23 needles-syringes per PWID – extremely low coverage.

In sum, the geographical coverage of NSPs in Hungary is low and uneven. The coverage of the target population is moderate concerning the number of PWID in contact with services and high concerning service occasions per 100 PWID. Coverage in terms of distributed equipment is extremely low.

### *6.3 Poland*

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

Over 1700 clients used needle exchange services in 2017; i.e. approximately one-quarter of the estimated target population.[6]

Data on client contacts are not available from 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, however, be taken with a grain of salt, since the performance of two services (out of 12) is hardly representative of 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. With respect to the entire PWID population, this translates to eight needles-syringes per person annually, an extremely low number.

Overall, the availability of NSPs in Poland is extremely low and concentrated in the biggest cities only. Even there, however, the geographical coverage of NSPs is inadequate and limited to only a few settlements. Polish services reach out to nearly a quarter of the target population, client contacts are rare, and very little injecting equipment is provided.

### *6.4 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 are available in five cities and towns, which accounts for the 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 (exactly one-quarter of the estimated PWID population[7]), which indicates a medium level of coverage.

Clients contacted all NSPs on over 16,000 occasions, which translates to 184 contacts

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

[7] The most up-to-date estimation of the population size is from 2008 at 10,500 (Reitox National Focal Point Slovakia, 2009: 67). Importantly, this estimation does not include people who inject drugs but a broader category of 'problematic drug users'. The number of PWID is very likely somewhat smaller.

per 100 PWID – a high result for this indicator of coverage. All three organisations gave away over 400,000 needles-syringes in 2017. The number of needles-syringes distributed per client per year was 184; however, due to generally low level of target population coverage, the amount of injecting equipment distributed among PWID was small, at only 39 units per person. Given the highly imperfect and outdated data on the target population, however, the real coverage concerning paraphernalia distributed is likely somewhat higher.

Overall, the availability of NSPs in Slovakia seems to be 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. Service coverage is medium with respect to the proportion of PWID reached. While the number of distributed paraphernalia is medium-high for PWID in contact with services, it is low if we take into consideration the entire target population.

### *6.5 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) are analysed, and benchmark levels are used next to absolute numbers.

#### *6.5.1 Availability of needle exchange programmes*

An important comment regarding the denominator used for NSP availability levels is required. While the level thresholds are adopted directly from the WHO, UNODC, UNAIDS Technical Guide (WHO et al., 2012), the denominator differs. Due to the lack of data on the number of cities in which PWID are present, the availability rate was calculated using the total number of cities of a specific population in each country.

| Indicator | CZ | HU | PL | SK |
|---|---|---|---|---|
| Percentage of cities where NSPs are present, including: Cities of 100,000+ inhabitants | High (100 %) | Low (46 %) | Low (18 %) | Low (50 %) |
| 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 %) |

*Table 5: Availability of needle exchange programs*

Clearly, in big and mid-sized cities the geographical coverage of needle exchange programs is by far the highest in the Czech Republic, where services exist in all five biggest cities and the vast majority of smaller ones. In three other countries, the overall availability of services is low. Within this group, Hungary performs best with almost half of its 13 biggest cities operating NSPs. In Slovakia, needle exchange is available in one of the two largest settlements, and one-fifth of smaller ones. In Poland, only one-fifth of the biggest cities have NSP, while programmes are hardly available in smaller towns.

### 6.5.2 *Coverage of needle exchange programmes*

As shown in the table below, most needles-syringes are distributed in the Czech Republic, where almost 150 units of equipment per PWID were provided in 2017. Further, taking into consideration only PWID in contact with services, the result is very close to high in terms of the effectiveness of HIV prevention. In Slovakia, paraphernalia coverage is moderate but leaning towards high among service clients. It remains low for the entire target population. The situation in the remaining two countries is significantly worse, with exceptionally low needle coverage in Poland.

| Indicator | CZ | HU | PL | SK |
|---|---|---|---|---|
| Number of needles-syringes distributed per PWID per year | Mid (146) | Low (21) | Low (8) | Low (39) |
| Number of needles-syringes distributed per NSP client per year | Mid (198) | Low (66) | Low (35) | Low (184) |

*Table 6: Injecting paraphernalia distributed*

In the case of reaching out to the target population, again, the Czech Republic performs best, ensuring coverage at the level of 74 per cent (Table 7). In contrast, Slovak needle exchange programmes are in contact with only one in five people who inject drugs. Polish services perform slightly better, covering almost one-quarter of the PWID population, while in Hungary close to one in every third person who was injecting drugs contacted NSPs at least once in 2017.

| Indicator | CZ | HU | PL | SK |
|---|---|---|---|---|
| Percentage of all PWID who were reached by an NSP in the last 12 months[8] | 74 % | 31 % | 24 % | 21 % |

*Table 7: Outreach to population of people who use drugs*

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

| Indicator | CZ | HU | SK |
|---|---|---|---|
| The number of NSP occasions of service in the last 12 months per 100 PWID | High (1055) | High (234) | High (184) |
| The number of NSP occasions of service in the last 12 months per 1 NSP client | 14 | 7 | 7 |

*Table 8: Occasions of service*

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

The data shows that Czech NSPs provide 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 appears that each client visited a service once a month on average. In Hungary and Slovakia, the number is half of this, which means that each person injecting drugs who was in contact with services visited them roughly once every two months. Concerning the occasions of service (contacts) per 100 PWID, the numbers in Slovakia and Hungary are also relatively similar. Notwithstanding the differences, however, in the context of the UN guidelines on HIV prevention services, all countries perform well, achieving high scores in the category of client contact.

In sum, it is clear that in the area of harm reduction the Czech Republic is leading, and is performing well in terms of both service availability and coverage. In Hungary, the availability of NSP is low. Although one in every three persons who was injecting drugs was in contact with services in 2017, and the number of service occasions 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 is deficient. Coverage in Poland is the lowest of all the examined countries. Meanwhile, in Slovakia, the situation is somewhat mixed – while outreach to PWID is low, the injecting paraphernalia coverage of organisations' clients is close to high. None of the three countries, however, would qualify as having an effective HIV prevention system concerning needle exchange programmes.

## 7 Conclusions

This paper has attempted to identify the relationships between the framing of drug policy as a health, morality, security, or economic issue, and the outcomes of harm reduction policies in the Czech Republic, Hungary, Poland, and Slovakia. It examined relevant parts of the countries' national drug strategies, borrowing the typology of policy frames from Euchner and colleagues (Euchner et al., 2013). Further, it analysed official data about the availability and coverage of needle exchange programmes using a guide developed by United Nations agencies as the source of the majority of indicators.

The analysis of countries' drug strategies revealed the strong health and social orientation of Czech drug policy and a somewhat weaker such orientation in the case of Slovakia. In Hungary, the morality frame is dominant in the country's drug policy, while in Poland no frame was identified due to the highly technical character of the document.

The examined policy outcomes of needle exchange programmes are definitely poor in Hungary and Poland. In the case of Slovakia, the picture is more complex, with generally meagre performance at the country level and in the context of the entire population of people who use drugs. On the other hand, at the organisational level, the performance of Slovak needle exchange programs seems to be much better, primarily in terms of the number of distributed injecting paraphernalia per NSP client.

Going back to our research question, therefore, have we managed to identify any relationship between drug policy framing and the state of harm reduction? It seems that the Hungarian case confirms the central hypothesis – that the morality framing of drug policy is related to weak policy outcomes. Further, it seems that the strong health orientation of the Czech drug strategy is somehow related to the excellent (compared to the other countries') performance of needle exchange services.

On the other hand, in Slovakia, there is a health-focused drug strategy and noticeably inferior harm reduction outcomes. The complex picture of the situation in this country (see above), however, triggers some questions. Is it plausible that Slovakia's harm reduction policy could have performed much better had there been more organisations providing the services in question? Recently, several NSPs in Slovakia ceased to exist (supposedly, due to a lack of funding), leaving one part of the country abandoned. Is the reason for rather insufficient country-level NSP outcomes indeed the lack of funding, or does the analysed document by itself not capture the actual framing of drug policy? Indeed, Slovak drug strategy is significantly less well elaborated than the Czech or Hungarian one – perhaps there is a need to include more sources to increase the validity of this finding.

Finally, there is Poland, with very low availability and coverage of needle exchange services and unknown framing. Is it justified to presume that Polish drug policy is framed as morality policy? Or are other policy frames related to its severe underperformance as well?

This paper, with its empirical scope and theoretical orientation regarding topics which are highly understudied in the region, contributes to the understanding of morality policies and drug-related policies. Two statements can be made. First, the case of Hungary confirms that morality framing is related to poor policy outcomes. Second, the case of the Czech Republic confirms that a strong health-social orientation is related to excellent policy outcomes in the area of harm reduction policy. Even more importantly, however, it opens interesting avenues for further research, perhaps most interestingly regarding the status of morality framing as a necessary and/or sufficient condition for ineffective policies.

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## Appendix

### *Appendix 1: Variable indicators and benchmarks*

| Variable | Indicators | Benchmarks |
|---|---|---|
| Population size | Estimated number of people who inject drugs (PWID) | – |
| Availability | Number of NSP sites | – |
| | Number of cities where NSPs are present | – |
| | Percentage of cities where NSPs are present[9] | Low ← 60% ← Mid → 80% → High |
| Coverage | Total number of needles-syringes distributed by NSPs in the last 12 months | – |
| | Number of needles-syringes distributed per PWID accessing services per year | Low ← 100 ← Mid → 200 → High |
| | Number of PWID who accessed an NSP over the last 12 months | – |
| | Percentage of all PWID who were reached by an NSP over the last 12 months | Low ← 20% ← Mid → 60% → High |
| | Number of NSP occasions of service (total contacts) in the last 12 months | – |
| | The ratio of the number of NSP occasions of service in the last 12 months per 100 PWID | Low ← 30 ← Mid → 70 → High |

[9] The original indicator refers to the 'percentage of cities/ states/ provinces/oblasts where PWID are located, and NPSs are present'. In this study, the percentage of all cities are calculated (for all country cases) due to the lack of data on the presence of PWID.

### *Appendix 2: Outputs of needle exchange programmes in the Czech Republic*

| **Availability** | | |
|---|---|---|
| **Indicator** | **Value** | **Level** |
| Number of NSP sites | 108 | X |
| Number of cities where NSPs are present | 138 | X |
| Percentage of cities where NSPs are present, including: | 65% | Mid |
| Cities of 100,000+ inhabitants (N=5) | 100% | High |
| Cities of 50,000–99,999 inhabitants (N=17) | 88% | High |
| Cities of 20,000–49,999 inhabitants (N=46) | 76% | Mid |
| Cities of 10,000–19,999 inhabitants (N=78) | 37% | Low |
| Cities of 5,000–9,999 inhabitants (N=133) | 23% | Low |
| **Coverage** | | |
| **Indicator** | **Value** | **Level** |
| Total number of needles-syringes distributed by NSPs in 2017 | 6 401 662 | X |
| Number of needles-syringes distributed per PWID per year | 146 | Mid |
| Number of needles-syringes distributed per NSP client per year | 198 | Mid |
| Number of PWID who accessed an NSP in 2017 | 32 300 | X |
| Percentage of all PWID who were reached by an NSP in 2017 | 74 % | High |
| Number of NSP occasions of service (total contacts) in 2017 | 460 900 | X |
| The ratio of the number of NSP occasions of service in 2017 per 100 PWID | 1 055 | High |

### *Appendix 3: Outputs of needle exchange programmes in Hungary*

| **Availability** | | |
|---|---|---|
| **Indicator** | **Value** | **Level** |
| Number of NSP sites | 40 | X |
| Number of cities where NSPs are present | 20 | X |
| Percentage of cities where NSPs are present, including: | 21% | Low |
| Cities of 100,000+ inhabitants (N=13) | 46% | Low |
| Cities of 50,000–99,999 inhabitants (N=15) | 40% | Low |
| Cities of 20,000–49,999 inhabitants (N=41) | 20% | Low |
| Cities of 10,000–19,999 inhabitants (N=82) | 0% | None |
| Cities of 5,000–9,999 inhabitants (N=130) | 0% | None |
| **Coverage** | | |
| **Indicator** | **Value** | **Level** |
| Total number of needles-syringes distributed by NSPs in 2017 | 137 580 | X |
| Number of needles-syringes distributed per PWID per year | 11 | Low |
| Number of needles-syringes distributed per NSP client per year | 66 | Low |
| Number of PWID who accessed an NSP in 2017 | 2 093 | X |
| Percentage of all PWID who were reached by an NSP in 2017 | 31 % | Low |
| Number of NSP occasions of service (total contacts) in 2017 | 13 883 | X |
| The ratio of the number of NSP occasions of service in 2017 per 100 PWID | 207 | High |

### *Appendix 4: Outputs of needle exchange programmes in Poland*

| **Availability** | | |
|---|---|---|
| **Indicator** | **Value** | **Level** |
| Number of NSP sites | 12 | X |
| Number of cities where NSPs are present | 10 | X |
| Percentage of cities where NSPs are present, including: | 7% | Low |
| Cities of 100,000+ inhabitants (N=39) | 18% | Low |
| Cities of 50,000–99,999 inhabitants (N=48) | 2% | Low |
| Cities of 20,000–49,999 inhabitants (N=136) | 1% | Low |
| Cities of 10,000–19,999 inhabitants (N=160) | 0% | None |
| Cities of 5,000–9,999 inhabitants (N=N/A) | None | None |
| **Coverage** | | |
| **Indicator** | **Value** | **Level** |
| Total number of needles-syringes distributed by NSPs in 2017 | 60 000 | X |
| Number of needles-syringes distributed per PWID per year | 8 | Low |
| Number of needles-syringes distributed per NSP client per year | 35 | Low |
| Number of PWID who accessed an NSP in 2017 | 1 726 | X |
| Percentage of all PWID who were reached by an NSP in 2017 | 24 % | Mid |
| Number of NSP occasions of service (total contacts) in 2017 | 3 646[10] | X |
| The ratio of the number of NSP occasions of service in 2017 per 100 PWID | 50 | Mid |

### *Appendix 5: Outputs of needle exchange programmes in Slovakia*

| **Availability** | | |
|---|---|---|
| **Indicator** | **Value** | **Level** |
| Number of NSP sites | 9 | X |
| Number of cities where NSPs are present | 5 | X |
| Percentage of cities where NSPs are present, including: | 17% | Low |
| Cities of 100,000+ inhabitants (N=2) | 50% | Low |
| Cities of 50,000–99,999 inhabitants (N=9) | 22% | Low |
| Cities of 20,000–49,999 inhabitants (N=28) | 0% | None |
| Cities of 10,000–19,999 inhabitants (N=31) | 6% | Low |
| Cities of 5,000–9,999 inhabitants (N=40) | 0% | None |
| **Coverage** | | |
| **Indicator** | **Value** | **Level** |
| Total number of needles-syringes distributed by NSPs in 2017 | 404 886 | X |
| Number of needles-syringes distributed per PWID per year | 39 | Low |
| Number of needles-syringes distributed per NSP client per year | 184 | Mid |
| Number of PWID who accessed an NSP in 2017 | 2 199 | X |
| Percentage of all PWID who were reached by an NSP in 2017 | 21 % | Mid |
| Number of NSP occasions of service (total contacts) in 2017 | 16 271 | X |
| The ratio of the number of NSP occasions of service in 2017 per 100 PWID | 155 | High |

[10] The number of contacts is based on data acquired directly from (only) two organizations since official, country-level data is not available.