



# THE DRUG SITUATION IN GEORGIA

Annual Report  
**2013**

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ANNUAL REPORT

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## EXECUTIVE SUMMARY

There are positive developments in the field of drug policies and coordination in the country in 2013-2014. Inter-agency Coordinating Council for Combating Drug Abuse, founded in 2011, finalised the National Anti-drug Strategy and Action Plan. A National Focal Point on Drug Information is to be founded as an inter-ministerial institutional tool to monitor drug strategic action plan implementation, optimise policies and assure that they are based on evidence. At the same time, punitive drug policies based on criminalization of drug use are still in place and street drug testing practices are again on the rise, as was in 2007.

No reliable data is available on the extent and patterns of illegal drug use in the country as no general population survey has been carried out so far. Data are only available from ESPAD-like school surveys; the last survey was carried out in Tbilisi in 2009 (735 students from the 13 secondary schools of Tbilisi, with a mean age of 16.1 at the time of data collection). Results suggest the lifetime prevalence for any illegal drug as high as 20% (33% for males; 8% for females). Marijuana was identified as the most widespread drug as 17% of the surveyed adolescents reported having used marijuana at least once in their lifetime. After cannabis, ecstasy was the most available illicit drug for the respondents, as 7.5% reported its use at least once in their lifetime. According to the *Youth Behavioural Surveillance Survey* conducted in 2012 in the frame of the USAID funded *Georgian HIV/AIDS Prevention Program*, and studying HIV/AIDS knowledge, attitudes and practices among high school and university students in Tbilisi (1,879 students in the age range 15-24) use of marijuana and ecstasy in a lifetime was reported only by 10.4% and 3.4% of the respondents, respectively. However, the results of these two studies are not comparable due to substantial differences in methodology and target population.

Drug use trends reveal that the most widespread drugs among people who inject drugs (PWID) are again “traditional” heroin, homemade opioid desomorphine (“Krokodil”, “Krok”) and homemade stimulants (“Jeff” and “Vint”). According to the information provided by the police and the addiction treatment clinics, new psychoactive drugs were widespread among youngsters in Georgia during the reported period. To respond to this problem, a number of measures were implemented by the Ministry of Internal Affairs: complex analytical work; adoption of a new law regulating the use of new psychoactive substances; enhanced control over drug trafficking; establishment of inter-agency state commission to suppress spread of new psychoactive substances, and implementation of a nationwide anti-drug campaign (“No to New Psychoactive Substances”). According to the Ministry of Internal Affairs, as a result of these complex measures, the consumption of new psychoactive drugs decreased by 90%.

Institutional mechanisms of drug demand reduction still need to be developed in the country. There are no sustainable institutional mechanisms supporting evidence based drug universal prevention programmes in schools and prevention activities are still limited to campaigns, which are not planned and evaluated according to the European standards of prevention science.

Infrastructure of treatment (both detoxification and substitution) has been developing in the country but still does not correspond to the scale of the problem. Financial accessibility of treatment is poor, as price for two weeks detoxification treatment varies from GEL 1,200 (approx.€ 543) to GEL 2,500 (approx.€

1,130<sup>1)</sup> in case of governmental funding, and up to GEL 2,500 (approx. € 1,130) in case of out of pocket payment by the patient, while according to the research approximately one third of the injecting drug users have monthly income less than GEL 100 (nearly € 45), and rate of unemployment is three-fold as high as in the general population. In contrary, financial and geographical accessibility of the harm reduction services has been significantly developed during the last few years but most of them are funded by international donors without contribution from the national budget which hinders their sustainability. The psychosocial component is missing in the chain of continuous care for individuals with substance use disorders due to which treatment results within the existed treatment modus are not sustainable.

Drug seizures significantly increased in 2013 and 2014 (i.e. 117 kg of heroin in 2013 vs 16.2 kg in 2007, or 0.09 kg in 2011). Following the peak in 2008 there was a steady reduction of drug crime convictions by the first instance court until 2012. However, in 2013 there was more than a twofold increase of convictions (6,456 individuals, overwhelming majority of them convicted with the article no. 260 and no. 273 of the Penal Code of Georgia (see Table 1). A total of 60,196 individuals were tested for presence of drugs and metabolites in 2013, of them 22,711 with positive results which represent the highest scale of drug testing since it was launched in 2007. Drug strategy still needs to find the right balance between law enforcement, prevention, treatment and psychosocial care focused measures.

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1. Exchange rate (2.21) is calculated based on the National Bank of Georgia official daily exchange rate for 2013  
<https://www.nbg.gov.ge/index.php?m=582&lng=eng>

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# 1. DRUG POLICY: LEGISLATION, STRATEGIES AND ECONOMIC ANALYSIS

## 1.1. INTRODUCTION

Drug Policy in Georgia can be described as a more “punishment-oriented” where basic principles of public health are not sufficiently observed. The balance between law enforcement responses and the strategies focusing on health and social care is still inadequate in the country.

From 2011, number of successful steps was implemented focused on the improvement of drug policies in the country. The *Coordinating Council for Combating Drug Abuse* (an inter-agency coordinating body) was created and became functional under facilitation of the *Ministry of Justice of Georgia*. The national drug strategy and corresponding action plan (“State Strategy to Combat Drug Abuse”) was elaborated and adopted by the Interagency Council. The *National Drug Monitoring Centre* is to be founded to assure proper institutional mechanisms for collection, processing and circulation of drug information.

## 1.2. LEGAL FRAMEWORK

### 1.2.1. Laws and Bylaws in the Field of Drug Issues

Drug legislation counts the number of laws and regulations governing illegal as well as legal turnover of narcotic drugs and/or psychotropic substances. Drug use *per se* is an offence under both administrative and criminal legislations of Georgia. *Code of Administrative Offences* (CAO) provide several articles governing drug related offences; namely Article 45<sup>1</sup> and 116 (as of 2014 amendments of the Code, Article 117 was abolished and its disposition moved to Article 116). Illegal consumption of drugs without medical prescription for the first time during a year or possession of small amount of drugs without an intent to sell stipulates a fine of GEL 500 (approx. € 226) or in exceptional cases, administrative detention up to 15 days under Article 45 while the same act committed again during the same year will result in criminal liability (article 273 Penal Code of Georgia, see Table 1 ). Article 116 of the CAO regulates offences of driving under the influence of narcotic and/or psychotropic substances or abstaining from drug testing, resulting in suspension of driving license for 3 years.

In 2006 Ministers of Internal Affairs and Labour, Health and Social Affairs of Georgia issued *Joint Decree No. 1244–278/n* which regulates procedure for drug testing. The newly adopted *Law on Police* (04.10.2013) introduced a new concept of previously used “reasonable doubt” for a police officer to present a person for drug testing, namely “sufficient ground for suspicion”<sup>2</sup>, that authorizes a police officer to deliver a person to a drug testing facility where the fact of drug consumption is established by laboratory (rapid strip tests) and/or clinical examination, and is not necessarily properly confirmed (see Chapter 9.2.3).

1. Article 45 – Illegal acquisition or possession of small amount of drugs without an intent to sell or illegal consumption of drugs without doctor’s prescription, stipulates fine of 500 GEL (€ 226), in exceptional cases, when deemed insufficient, based on the circumstances of the case and personality of an offender – administrative detention up to 30 days (Code of Administrative Offences of Georgia).
2. “Fact or/and information, which would satisfy objective observer to make a conclusion”

As mentioned above, apart from administrative liability, Georgian legislation also stipulates criminal liability for illegal trafficking of narcotic drugs and/or psychotropic substances. Offences other than illegal consumption punishable under criminal legislation include illicit production, possession, cultivation, sale, import or export of narcotic drugs as well as psychotropic substances. Chapter XXXIII of the *Penal code of Georgia* stipulates all drug related offences, listed in the Table 1 below.

**Table 1: Chapter XXXIII of the Penal Code of Georgia: Drug-related offences**

Article No.	Drug-related offence	Range of sanction
<b>Article 260</b>	Illegal manufacturing, production, purchase, storage, transportation, dispatch or sale of narcotic drugs, its analogue, precursor or new psychoactive substance	Imprisonment from 6 months till lifetime imprisonment
<b>Article 261</b>	Illegal manufacturing, production, purchase, storage, transportation, dispatch or sale of psychotropic substances, its analogue or especially dangerous narcotic substances <sup>1</sup>	From fine to imprisonment up to 12 years
<b>Article 262</b>	Illegal import, export or international transit of narcotic drugs, its analogue, precursor or new psychotropic substances	Imprisonment from 5 years till lifetime imprisonment
<b>Article 263</b>	Illegal import, export or international transit in a large quantity of psychotropic substances, its analogue or especially dangerous narcotic substances	Imprisonment from 2 to 12 years
<b>Article 264</b>	Misappropriation or extortion of narcotic drugs, its analogue, precursor, new psychoactive substances, psychotropic substances, its analogue or especially dangerous narcotic substances	From fine to imprisonment up to 12 years
<b>Article 265</b>	Illegal planting, growing or cultivating of plants containing narcotics	From fine to imprisonment up to 12 years
<b>Article 266</b>	Establishment or maintenance of a covert laboratory for illegal production of narcotic drugs, its analogue, precursor, new psychoactive substances, psychotropic substances or its analogue	From 4 to 12 years of imprisonment
<b>Article 267</b>	Issuing a false prescription or other documents for the purchase of narcotic drugs, with the purpose of sale or its actual sale	From fine to imprisonment up to 13 years
<b>Article 268</b>	Issuing a false prescription or other documents for the purchase of psychotropic or especially dangerous narcotic substances, with the purpose of sale or its actual sale	From fine to imprisonment up to 12 years
<b>Article 269</b>	Violation of regulations for manufacturing, production, use, registration, storage, transportation, dispatch or import of narcotic drugs or its precursors	From fine to imprisonment up to 5 years
<b>Article 270</b>	Violation of regulations for manufacturing, production, use, registration, storage, transportation, dispatch or import of psychotropic and especially dangerous narcotic substances	From fine to imprisonment up to 2 years
<b>Article 271</b>	Provision of a residence or other premises for illegal use of narcotic drugs, its analogue, new psychoactive substances, psychotropic substances, its analogue	From fine to imprisonment up to 9 years
<b>Article 272</b>	Inducing someone in abusing narcotic drugs, its analogue, new psychoactive substances, psychotropic substances, its analogue	From fine to imprisonment up to 6 years
<b>Article 273</b>	Illegal preparation, purchase, storage of a small quantity of narcotic drugs, its analogue or precursor for personal use or its illegal use without medical prescription	From fine to imprisonment up to 1 year
<b>Article 274</b>	Evasion from compulsory medical treatment	Imprisonment up to 1 year

1. Narcotic drugs whose medical usage is restricted by Georgian legislation ([http://police.ge/files/pdf/sakanonmdeblo%20baza/9.Law\\_on\\_Narcotic\\_Assistance.pdf](http://police.ge/files/pdf/sakanonmdeblo%20baza/9.Law_on_Narcotic_Assistance.pdf))

Severity of sanction depends on the aggravating circumstances of the offences, including the amount of substances seized (without complementary substance). Prior to 2012, quantities of controlled substances seized from unauthorised handling were established by the Decree of Parliament #2557, now regulated by newly adopted law on “*Narcotic drugs, Psychotropic substances, Precursors and Narcological Aid*” (May 22, 2012). *Law on “Narcotic Drugs, Psychotropic substances, Precursors and Narcological Aid”*, (often called the “frame law”) provides the overall framework for control of narcotic drugs, defines general rules for authorised handling of narcotic drugs, psychotropic substances and precursors as well as principles of narcological aid.

Appendix 2 of the law defines small, large and extremely large quantities for over two hundred narcotic drugs and sixty-seven psychotropic substances. For a number of currently widespread substances (see chapter 2) as are amphetamine, methamphetamine, desomorphine, small amounts are not defined and any amount of the substance is considered a large, leading to a stricter sentence.

On 16.04.2014 *Law on “New Psychoactive Substances”* was adopted given the increased tendencies in consumption of new psychoactive substances in Georgia as well as special provisions added to the “*Penal Code of Georgia*” criminalizing illegal production, purchase, storage and other illegal activities (see the list above in Table 1). The aim of the law is to prevent potential damage caused by new psychoactive substances to the health of the population, and combat unauthorised handling of these substances, also to ensure the coordinated work of the respective state agencies. The law defines nine classes of chemical compounds for new psychoactive substances and lists twenty distinct new psychoactive substances.

The *Law on Combating drug related crime* was adopted in 2007 and allows deprivation of certain rights (among others, right to drive a vehicle, right to practice medicine, right to practice law, right to work at national and/or local governmental bodies, etc.) based on the court judgment for 3 years for “drug user” (defined by the law as a person who has committed crime under Article 273 of the Penal Code of Georgia) and for longer periods for the facilitation of drug related activities or sale of drugs. The law was amended several times, the last time being in March of 2014. Important amendments include a) addition of deprivation of the right to engage in pharmaceutical activities or ability to establish a pharmacy; b) possibility to restore rights or reduce the period of deprivation of rights after passage of 1/3 of the time based on “good behaviour”. In cases of plea bargain, deprivation of rights can also be diminished or cancelled.

### **1.2.2. Implementation of Law**

Implementation of the laws has a significant impact on the development of legal regulations governing drug related issues. In this respect, Georgian judicial practice is straightforward in implementing the law, following the legal framework and recommendations of the Supreme Court of Georgia in judging drug related cases. For example, see Table 2 – the recommendations of the Supreme Court of Georgia (July 25, 2007) with respect to Article 273 of the Penal Code of Georgia (Illegal preparation, purchase, storage of a small quantity of narcotic drugs, its analogue or precursor for personal use or its illegal use without medical prescription).

**Table 2: Recommendations of the Supreme Court of Georgia (July 25, 2007) with respect to article 273 of the Penal Code of Georgia**

Circumstances	Sentence
<b>Convict cooperated with the investigation</b>	Fine no less than GEL 1,000 (€ 452)
<b>Convict has been convicted before</b>	Imprisonment for 1 year and fine no less than GEL 3,000 (€ 1,357)
<b>1. Convict cooperated with the investigation 2. Has been convicted before</b>	Imprisonment for 9 months
<b>Without any aforementioned circumstances</b>	Imprisonment for 6 months or fine no less than GEL 3,000 (€ 1,357)

### 1.3. NATIONAL ACTION PLAN, STRATEGY, EVALUATION AND COORDINATION

#### 1.3.1. National action plan and strategy and their evaluation

In 2013, the Inter-agency Coordination Council for Combating Drug Abuse approved a National Drug Strategy and Action Plan, which, for the first time in the country, covers all the relevant areas of drug policy and is in line with the existing international principles and contemporary trends. The document was elaborated with active participation of all relevant stakeholders including international and local organizations and was positively assessed by Pompidou Group of Council of Europe in June of 2013. The final version of the Strategy and Action Plan was approved by the Inter-Agency Council on December 4, 2013.

Main thematic directions of the Strategy are: Supply Reduction, Demand Reduction, Harm Reduction, Overcoming Stigma and Discrimination, Coordination & International Cooperation, and Research & Analyses.

The Action Plan for 2014-2015 specifies and provides details of the planned activities, responsible and involved institutions, costs, timelines and measurable indicators for assessment of the results of implementation.

#### 1.3.2. Coordination mechanisms

In 2011 the President of Georgia established an Inter-Agency Coordinating Council for Combating Drug Abuse composed of representatives of the following state institutions: *Ministry of Justice of Georgia* (MoJ), *Ministry of Labour, Health and Social Affairs of Georgia* (MoLHSA), *Ministry of Education and Science of Georgia* (MES), *Ministry of Finance of Georgia* (MoF), *Chief Prosecutors' Office of Georgia*, *Ministry of Internal Affairs of Georgia* (MIA), *Ministry of Sports and Youth Affairs* (MoSYA), Parliament of Georgia and Supreme Court of Georgia.

The main objectives of the *Coordination Council* are: (a) Elaboration of drug abuse prevention policy based on human rights protection principles (b) Development, periodical revision and monitoring of implementation of a national strategy on combating drug abuse (national drug strategy) and corresponding

action plans; (c) Development of proposals and recommendations for elaborating the national drug strategy; (d) Coordination of interagency activities in the process of implementation of the national drug strategy for the purpose of promoting the application of corresponding measures.

In the document, there are no specific procedures described in relation to the Council's coordination function.

The Council is coordinated by the Ministry of Justice of Georgia. It holds periodic meetings, usually on a quarterly basis to discuss relevant ongoing drug-related issues.

The functioning of the Council is based on participation principle in contrast to the above mentioned key agencies. Representatives of so called "invited (non-voting) member" organizations participate in its work, namely, international agencies - *Delegation of EU in Georgia*, *Delegation of Council of Europe in Georgia*, *US Agency for International Development (USAID)*, *United Nations Children's Fund (UNICEF)*, *United Nations Office on Drugs and Crime (UNODC)*, the biggest treatment institution in the country – *The Centre for Mental Health and Prevention of Addiction* and the only non-governmental organization - *Addiction Research Centre Alternative Georgia*.

The following non-governmental organizations are usually invited to provide thematic contributions to the working process: *Global Initiative in Psychiatry*, *Kamara*, *Bemoni*, *Uranti*, *Georgian Harm Reduction Network*, *Human Rights Education and Monitoring Centre* and others.

### 1.3.3. Other Drug Policy Developments

In 2013-2014, new legal regulations and other initiatives targeting the spread of new psychoactive substances and/or newly emerged home-made substances were introduced.

As a response to the widespread abuse of home-made opioid desomorphine ("Krokodil" or "Krok", produced from pills containing codeine), according to the information received from the MIA, the ministry conducted complex analytical work and corresponding legislative changes were initiated; MIA and MoLHSA jointly initiated and in March 2014 the Parliament approved an amendment to the "Law on Narcotic Drugs, Psychotropic substances, Precursors and Narcological Aid" stipulating the criminal liability for unauthorised handling of codeine-, ephedrine-, norephedrine- and pseudoephedrine-containing medicines, especially arraignment of employers and employees of pharmacies. In addition, in 2013 at the institutional level, MIA and MoLHSA signed a joint memorandum, and established a working group to control pharmaceutical market (MIA, 2014c).

In response to the challenges posed by abuse of new psychoactive substances *The State Commission Supporting Suppression of Distributing New Psychoactive Substances* was set up on the bases of Article 6 of the Law of Georgia *On New Psychoactive Substances*, and Paragraph 1 of Article 1 of the Joint Order №344/№01-30/n/№147 *On Establishing State Commission Supporting Suppression of Distributing New Psychoactive Substances and Approving its Regulation* issued on May 13, 2014 by the Minister of Internal Affairs of Georgia, Minister of Labour, Health and Social Affairs of Georgia and Minister of Finance of Georgia (MIA, 2014c). State Commission is composed of:

- Director of Central Criminal Police Department of the Ministry of Internal Affairs (chairman of the State Commission)



- Head of Department of Pharmaceutical Activities of Legal Entity Public Legal Body (LEPL) State Regulation Agency for Medical Activities of the Ministry of Labour, Health and Social Affairs of Georgia (vice-Chairman of the State Commission)
- Head of Customs Department of LEPL Revenue Service of the Ministry of Finance of Georgia (vice-Chairman of the State Commission)
- Head of Forensic Main Division of the Ministry of Internal Affairs of Georgia
- Head of Legal Circulation of Drugs Division of the Department of Pharmaceutical Activities of LEPL State Regulation Agency for Medical Activities of the Ministry of Labour, health and Social Affairs of Georgia
- Deputy head of Customs Department of LEPL Revenue Service of the Ministry of Finance of Georgia
- Pro-rector of the Academy of the Ministry of Internal Affairs of Georgia (secretary of the State Commission)

Furthermore, in case of necessity and upon request of the chairman, relevant specialists could be invited to participate in meetings of the State Commission.

As stated in the Joint Ministerial Order and in the Law on New Psychoactive Substances, “*Commission conducts monitoring over the situation related to new psychoactive substances in the country and over the challenges existing in this regard, as well as ensures implementation of the relevant legislation. More precisely, the Commission’s powers are the following: the State Commission monitors the circulation of various chemical compounds entailing potential risks, on the market; conducts risk assessment and analysis related to new psychoactive substances, considering international experience; publishes quarterly and annual reports concerning the existing situation in Georgia related to new psychoactive substances. Furthermore, beyond the functions of monitoring and analysing which are very important per se, the State Commission is actively involved in the law-making process; more precisely: the State Commission prepares legislative proposals for the Government of Georgia in order to initiate the introduction of new psychoactive substances and classes of chemical compounds of new psychoactive substances to the annexes of the Law of Georgia On New Psychoactive Substances. In terms of powers of legislative initiative, the following conditions should be met: in order to initiate the introduction of new psychoactive substances to the Law annexes, the State Commission is authorized to prepare proposals if: a) there are reasonable grounds to believe that certain chemical compounds have been abused among some circles of the society to have narcotic intoxication; and/or b) their consumption, as proven by scientists as well as by the experience of respective state agencies and international organizations, endangers the life or health of a user or it is impossible to exclude such a danger. As for initiating the introduction of classes of chemical compounds of new psychoactive substances to the Law annexes, the State Commission is authorized to prepare proposals if conducting similar measures in regard to certain new psychoactive substances is less effective, in order to suppress their distribution and therefore, to avoid possible danger to the life or health of a user*”.

In August 2014, in response to the long-lasting advocacy efforts of professional community, drug policy activists and civil society organizations, the MoLHSA presented changes in 5/12/2000 239/n decree and removed an obligation for health care providers to report cases of suspected drug overdose to the police. It is expected that this change will result in a significant increase of emergency admissions (and reduction in mortality) related to drug overdose.

#### 1.4. ECONOMIC ANALYSIS

In recent years, drug responses in Georgia have been financed by international donors and a number of ministries such as MoLHSA, MES and MIA. *The Global Fund to Fight AIDS, Tuberculosis and Malaria* has

remained the single major donor to cover HIV treatment and prevention, including low threshold harm reduction services and opiate agonist maintenance treatment. MoLHSA has been a major public funder of drug dependence treatment.

There is no single comprehensive source of information on drug-related budgets and/or expenses. In fact, only health-related expenditures are relatively traceable via labelled targeted allocations for substance use prevention and treatment, and HIV prevention and treatment programs. Any other drug-related expenditures (law enforcement, education, others) are not labelled and it is almost impossible to identify the share of drug-related expenses in bulk budgets of MIA and MES or other ministries, because of the budgets and the specifics of the activities performed by the above mentioned state agencies .

#### 1.4.1. Health care expenditures

Information on drug-related health expenditures was obtained from two publicly available major sources – budget and expenditures of the MoLHSA and Global AIDS Response Progress Reporting (GARP), a standardized reporting template on national HIV/AIDS expenditures submitted to UNAIDS by countries on an annual basis. Identifiable expenditures earmarked for the funding of drug-related health programmes amounted to a total GEL 10,4 million (approx. € 4,7 million) in 2013. This sum included GEL 4,2 million (€ 1,9 million) provided from the national budget, GEL 3,5 million (€ 1,6 million) made available from international donors, and GEL 2,7 million (€ 1,2 million) paid by individual patients. Compared to the previous year, this was a remarkable increase; see Table 3, with public expenditures increased by 28%.

**Table 3: Drug-related health care expenditures in 2012-2013 (€ million<sup>1</sup>) (MoLHSA, 2013, 2014)**

Type of service/function	National public budgets		International sources		Private sources	
	2012	2013	2012	2013	2012	2013
<b>Harm reduction, including agonist maintenance treatment</b>	1,3*	1,2*	1,3	1,2	0,6	1,2**
<b>Voluntary Counselling and Testing (VCT)***</b>	0,1	0,1	0,6	0,4	0	0
<b>Inpatient and outpatient drug-free treatment and primary (post-detox) rehabilitation</b>	n.a.	0,6	0	0	n.a.	n.a.
<b>TOTAL</b>	<b>1,4</b>	<b>1,9</b>	<b>1,9</b>	<b>1,6</b>	<b>0,6</b>	<b>1,2</b>

\* covers agonist maintenance treatment; no public funding is allocated for needle/syringe programs

\*\* out of pocket co-payment for agonist maintenance treatment

\*\*\* includes funding for VCT targeting commercial sex workers and men having sex with men

Figures presented in the Table 3 should be regarded as indicative. For example, it is not clear what portion of VCT funding goes specifically to IDUs.

HIV/AIDS care and treatment is covered by both GFATM and the national budget. Georgia has been successful in maintaining universal access to highly effective antiretroviral treatment (ARV), with every individual who needs treatment having the possibility to receive it. In 2013 GEL 10,2 million (€ 4,6 million) were spent on HIV/AIDS care and treatment, with GEL 3,6 million (€ 1,6 million) provided by

1. 2013 GEL/€ ~ 2.21; 2012 GEL/€ ~ 2.12

national budget and GEL 6,5 million (€ 3,9 million) provided through GFATM funding. Given the 40% share of injection drug users in ARV treatment in 2013 (872/2,179) (Chkhartishvili, 2015), estimated GEL 4,0 million (€ 1,8 million) was spent on care and treatment for IDUs.

Funding of substance-use-related services has remained a major issue affecting the availability and accessibility of treatment for substance-use-related disorders. The significant part of services provision, in particular low-threshold harm reduction services, relies solely on international funding. Out of the wide range of harm reduction responses needed in the country, the State funds only substitution treatment. Given the recent restructuring of the GFATM funding model (AIDSPAN, 2011) and Georgia's improving economic indicators (lower-middle income economy with low burden of disease), the country faces the challenge of termination of this single major mechanism of funding for HIV prevention and treatment within the near future. Although national health expenditures have been increasing since 2001 in monetary terms access to healthcare (Chkhartishvili, 2015), substance use treatment has been limited to a large extent by an individual's ability to pay rather than an entitlement program that allows access to different pre-paid services. Importantly, neither state-funded insurance nor private insurance programs cover screening, assessment or treatment for substance-use-related problems.

Although funding for treatment of substance use disorders in Georgia has been increasing in recent years and introduction of a specific funding model (about 50/50 co-payment by state and individual patient) allowed for rapid expansion of opiate agonist treatment, it still remains highly inadequate for the needs identified. Public expenditure on demand reduction was approximately GEL 98 (€ 44) per adult with drug use problems in 2013. Given this lack of funding, it is not surprising that substance use treatment is able to deliver services to only 5-10% of adults with substance use problems in Georgia.

Since 2012, MES budget allocates funds for a variety of security measures, including prevention of spread of drugs at the educational institutions. In 2013, the Ministry allocated GEL 9,6 million (€ 4,3 million) for indicated measures, though not for drug specific activities: significant part of this budget is allocated for salaries of so called "Mandatory" or resource officers responsible for safety in the schools (see chapter 3.4).

The budgets of law enforcement agencies do not provide specific indications for drug-related allocations. The only study that provides indirect estimates on the expenses of law enforcement agencies, including that of the MIA, and concerns arrest and testing of drug users, was based on the data from 2008. The study found that total expenditures of law enforcement and criminal justice systems (police, prosecutors office, court, prison system), related to drug testing and following prosecution, was GEL 18,0 million (€ 7,4 million) (Otiashvili, 2012).



## 2. DRUG USE IN THE GENERAL POPULATION AND SPECIFIC TARGETED GROUPS

### 2.1. INTRODUCTION

A general population survey on drug use in adult population (GPS) has never been conducted in Georgia, and for the moment, no reliable data is available on attitudes or the prevalence and patterns of illegal drug use in the country. The first-ever GPS will be conducted by the Addiction Research Centre - Alternative Georgia in 2015 through the financial support of USAID. Survey results will become available by the end of 2015.

Similarly, a nationwide youth survey has never been conducted in the country. Since 1990s, based on the ESPAD questionnaire, several studies were implemented, covering only the capital city, Tbilisi (Todadze, 2003). The last one implemented in 2009 in the framework of SCAD programme thoroughly followed ESPAD standards (Baramidze, 2009). The study results are reflected in the Annual Drug Report for 2009 (Javakhishvili, 2009).

In 2015, the NCDC (*National Centre for Disease Control*) plans to conduct a full scale ESPAD survey of national coverage with the methodological and financial support of EMCDDA (*European Monitoring Centre for Drugs and Drug Addiction*). Study results will be available at the end of 2015.

In 2012, in the framework of USAID funded GHPP (Georgian HIV/AIDS Prevention Program), the Youth Behavioural Surveillance survey was implemented. The chapter below reflects the results of the study concerning drug issue.

In addition to the above mentioned, a small scale study was conducted in the framework of the *Iliia State University Institute of Psychology* project, funded by MES and focused on piloting of Comprehensive Social Influence Program in the three private secondary schools of Georgia. The results of this study are reflected in chapter 2.3.

### 2.2. DRUG USE IN THE GENERAL POPULATION

No data are available so far. The first GPS in Georgia is being carried out in 2015 and results will be available by the end of 2015.

### 2.3. DRUG USE IN THE SCHOOL AND YOUTH POPULATION

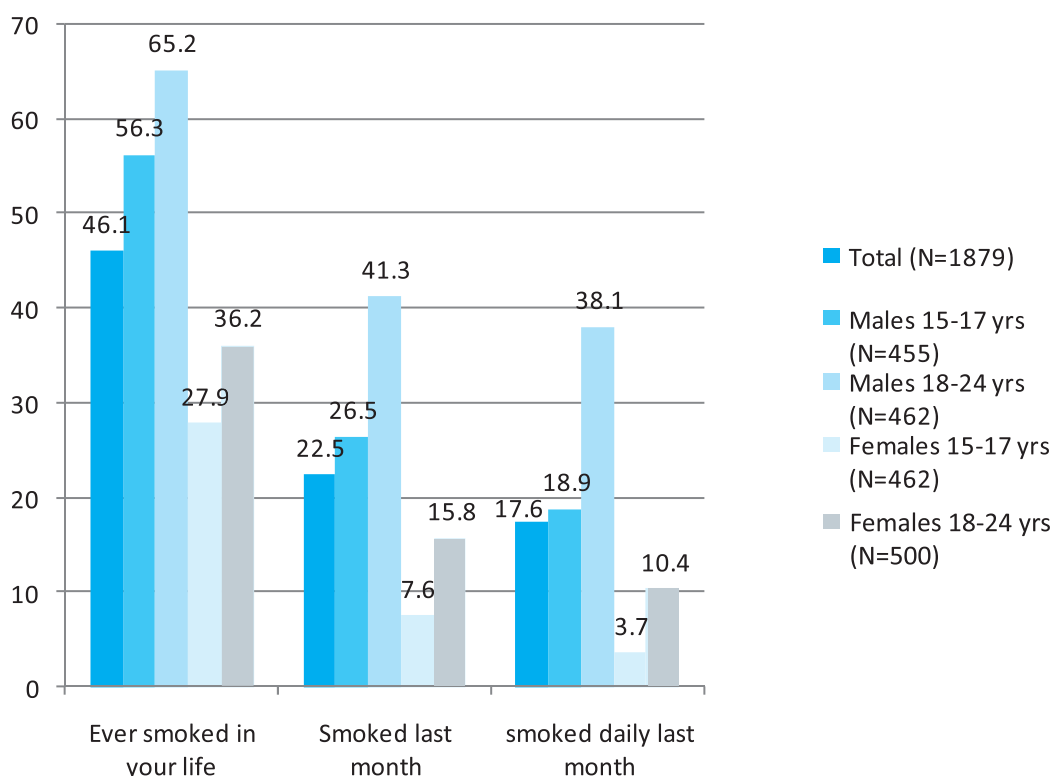
In 2012, a Youth Behavioural Surveillance Survey was conducted studying HIV/AIDS knowledge, attitudes and practices among high school and university students in Tbilisi, half of which were residents of the different regions of Georgia. The total number of the respondents was 1,879 of 15-24 year-old

youths (schoolchildren and university students). Participants were selected randomly from the official list of schools, universities and vocational centres provided by MES.

A combination of three different instruments was used in the study as a research tool: (1) A Behavioural Surveillance Survey (BSS) among Most at Risk Populations (MARPs) questionnaire, (2) An ESPAD questionnaire, (3) A set of questions related to the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) indicators (UNGASS, 2010).

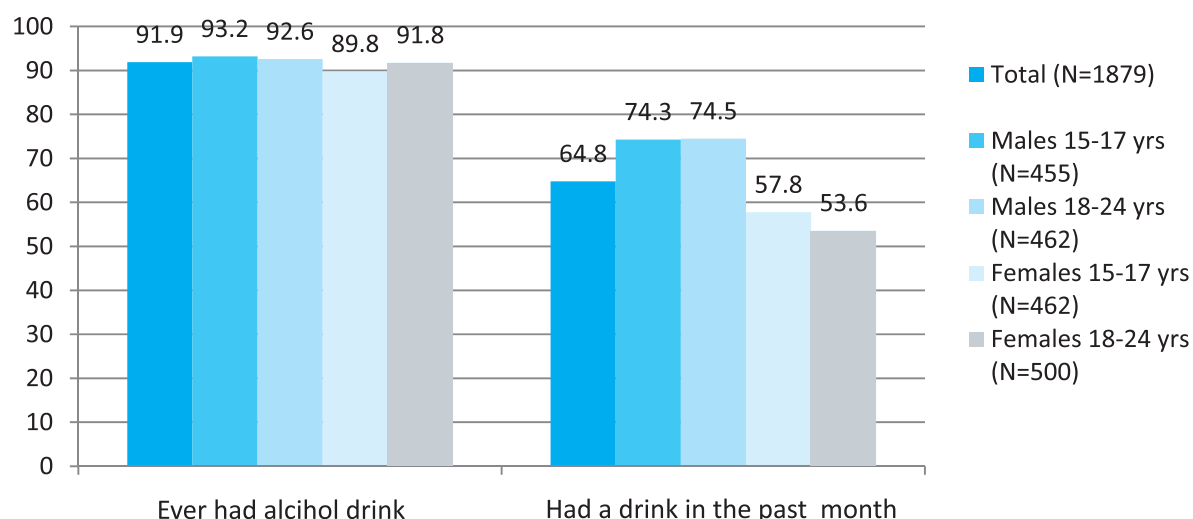
Questions were asked about tobacco, alcohol, marijuana, ecstasy and other drug consumption about the last month, year and lifetime experience. About half of the respondents (46.1%) had ever smoked tobacco, and there were significant gender differences (60.7% for male respondents and 32.2% female). Also, differences can be seen in comparison of school pupils and university students (41.9% vs 50.1%). See Figure 1 for detailed information.

**Figure 1: Lifetime and last month prevalence of tobacco smoking and prevalence of daily smoking among Tbilisi secondary schools and university students, in % (Dershem, 2012)**



As for alcohol consumption, the vast majority of respondents ranging from 89.8% to 93.2% for all four respondent groups have consumed alcohol (i.e., wine, beer, vodka, martini, champagne, or other drinks containing alcohol) at some time in their life, regardless of gender or age group (see Figure 2).

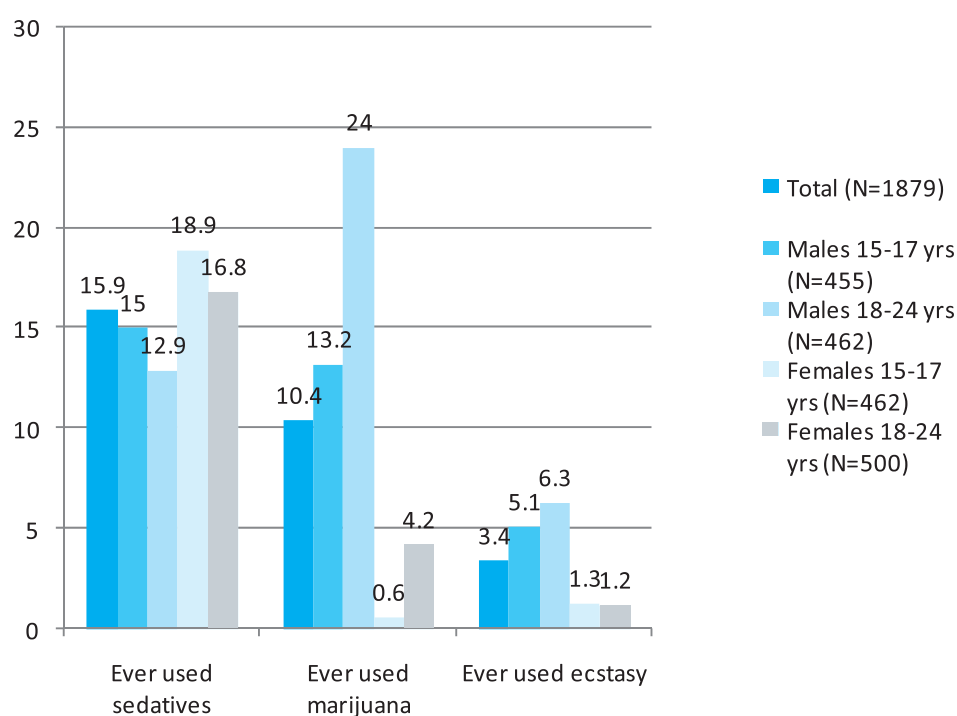
**Figure 2: Lifetime and last 30 days prevalence of alcohol drinking among Tbilisi secondary school and university students, in % (Dershem, 2012)**



No statistically significant gender differences were detected (in terms of consumption of other drugs) either among the university students or school children (correspondingly, 18.0% and 19.7%).

As for use of sedative drugs, there was no difference between age groups. On the contrary, there was a slight but significant difference between male and female respondent groups - on average, 17.6% of females reported ever using sedatives compared to 13.9% of males, which was significantly different ( $\chi^2=4.85$ ,  $df=1$ ,  $p<0.00$ ). The study revealed significant differences in marijuana use by both age and gender as well as gender difference in ecstasy use (see Figure 3):

**Figure 3: Lifetime prevalence of sedatives, marijuana and ecstasy among Tbilisi secondary school and university students, in % (Dershem, 2012)**



Besides lifetime prevalence, the BSS study offers data on the last 12 months and last 30 days use of marijuana (or hashish) and ecstasy among surveyed youth. The Table 4 shows study results for all the three timeframes:

**Table 4: Lifetime, last 12 months and last 30 days use of marijuana (or hashish) and ecstasy among school pupils and university students (Dershem, 2012)**

Prevalence	Total (N=1,879)	Males 15-17 (N=455)	Males 18-24 (N=462)	Females 15-17 (N=462)	Females 18-24 (N=500)
<b>Marijuana or hashish</b>					
<b>Lifetime</b>	10.4% (195/1,879)	13.2% (60/455)	24.0% (111/462)	0.6% (3/462)	4.2% (21/500)
<b>Last 12 months</b>	4.0% (76/1,879)	6.6% (30/455)	7.6% (35/462)	0.6% (3/462)	1.6% (8/500)
<b>Last 30 days</b>	1.0% (18/1879)	1.1% (5/455)	1.5% (7/462)	0.4% (2/462)	0.8% (4/500)
<b>Ecstasy</b>					
<b>Lifetime</b>	3.4% (66/1,879)	5.1% (23/455)	6.3% (29/462)	1.3% (6/462)	1.6% (8/500)
<b>Last 12 months</b>	2.0% (37/1,879)	2.6% (12/455)	3.5% (16/462)	0.2% (1/462)	1.6% (8/500)
<b>Last 30 days</b>	1.1% (20/1,879)	2.0% (9/455)	1.7% (8/462)	0.0% (0/462)	0.6% (3/500)

Only 0.6% of the study respondents reported injected drug use (12 persons out of 1,879). The highest rate was among male students aged 18–24 (2.2% or 10 of 462). As for last 12 months, 2 out of 1,879 respondents (0.1%) reported that they had injected; both of them were males, aged 18–24.

In the framework of the project focused on piloting of the Comprehensive Social Influence (“Unplugged”) Program, in 2012, a sample of 200 pupils in the age range from 11 to 15 from the 5 private schools (2 control and 3 experimental) in Tbilisi were surveyed by means of the ESPAD questionnaire. The prevalence rates of use of different drugs among the respondents are given in Table 5:

**Table 5: Drug use within sample of school children aged 11–15 in Tbilisi in 2012, in % (Javakhishvili, 2012)**

Prevalence of drug use	Smoking	Alcohol use	Being drunk	Marijuana use	Non-medical use of sedatives
<b>Lifetime use</b>	24.4	81.0	41.7	0.5	6.4
<b>Last 12 months</b>	No data	72.4	30.7	1.6	1.1
<b>Last 30 days</b>	4.6	42.4	14.9	1.0	1.1

According to the evidence from the treatment facilities (Sikharulidze, 2015) (Vadachkoria, 2015), use of new psychoactive substances among youth was higher than the use of other drugs. To address this issue, Ministry of Internal Affairs adopted legislative changes (see chapter 1.2.1), established a state commission to prevent spread of new psychoactive substances; intensified its efforts to enhance the control of illicit drug trafficking in the country; and implemented The nationwide anti-drug campaign. Based on the data provided by MIA, due to these multifaceted measures, the consumption of new psychoactive drugs in the last 6 months of 2014 decreased by more than 90% compared with the same time period of 2013 year (see chapter 3.6).

National Statistics Office of Georgia with close cooperation with Ministry of Sports and Youth Affairs conducted “National Youth Survey” in accordance with the Grant Agreement signed with UNICEF in July 2013. The aim of the study was to identify the basic needs and problems that are faced by young people in Georgia and promote knowledge and evidence-based youth policy development. The study covered 2,500 households across all regions in Georgia, with the exception of Abkhazia and South Ossetia. In each household, one 15- to 29-year-old member was interviewed by means of a personal questionnaire.

According to the study results, there is a significant difference in alcohol and tobacco consumption in gender groups – 21.6% of respondents stated that they smoke regularly (e.g., daily), and only 4.1% of these are female respondents.

Overall, consuming alcohol in the last 12 months was reported by 63.4% of the surveyed respondents – 81.3% of male and 45.9% of female respondents. The majority reported consuming alcohol once in a month or less frequently (66.8%). The proportion of young people who consumed alcohol 1-3 days a month is 19.4%. A relatively small proportion of respondents consumed alcohol 1-2 days a week (11%), and a very low proportion consumed alcohol 3-7 days a week (2.8%).

## 2.4. DRUG USE AMONG TARGETED GROUPS / SETTINGS AT NATIONAL AND LOCAL LEVEL

### 2.4.1. Drug Use among Commercial Sex Workers

*The Curatio International Foundation and Association Tanadgoma* conducted a Bio-behavioural Surveillance survey in 2014 using the Time-Location Sampling technique and recruited (N=280) female sex workers (FSWs) in 2 cities of Georgia (160 in Tbilisi and 120 – in Batumi). The median age of FSWs is 40 years in Tbilisi and 38 years in Batumi. This half is older than 25 years and represents the age group “40+” (50.6% in Tbilisi and 42.5% in Batumi); the majority of them are ethnic Georgians (83.8% in Tbilisi and 92.5% in Batumi) who have secondary / vocational education (79.4% in Tbilisi and 82.5% in Batumi).

Rates of daily alcohol use are 9.4% in Tbilisi and 21.7% in Batumi. The survey did not investigate lifetime injection practices among FSWs. The percentage of FSWs who used non-injected drugs during the last 12 months is 6.3% in Tbilisi and 5.8% in Batumi. The most frequently used non-injected drugs are sedatives/ sleeping pills. As for injecting drugs, 1.9% (3 respondents) of FSWs in Tbilisi and 0.8% (1 respondent) - in Batumi, all of them over 25 years of age, reported having used them during the last 12 months. Subutex® and heroin were listed as drugs that had been injected (see Table 6).

**Table 6: Prevalence of Alcohol and Illicit Drug use among female sex workers in 2014, in % (Tsereteli, 2014)**

Alcohol and drug use	Tbilisi (%)	Tbilisi (n/N)	Batumi (%)	Batumi (n/N)
Daily alcohol consumption	9.4	15/160	21.7	26/120
Non-injected drug use in last 12 months	6.3	10/160	5.8	7/120
Sedatives/ Sleeping pills	5.6	9	2.5	3
Injected drugs use in the last 12 months	1.9	3/160	0.8	1/120
Buprenorphine (Subutex®)	1.9	3	0.8	1
Heroin	1.25	2	--	0

### 2.4.2. Drug use among men having sex with men

The study by the Curatio International Foundation sheds some light on the scale of drug and alcohol use among MSM (Men Having Sex with Men) in Tbilisi. In the years 2010 and 2012, HIV risk behaviour was studied among MSM using a respondent driven sampling method. Table 7 summarizes the information on the use of psychoactive substances among MSM in 2010 and 2012.

**Table 7: Prevalence of Alcohol and Illicit Drug use among MSM, in Tbilisi (%)**  
(Tsereteli, 2010, (Tsereteli, 2013)

Indicator	2010 (N=278)	2012 (N=218)
Drink alcohol every day	8.6	9.2
Non-injecting drug use during the last 12 months	21.6	17.9
Injecting drug use during the last 12 months	4.3	2.8

Among those who used non-injecting drugs, marijuana was the most frequently consumed substance. Four out of the 6 respondents who reported injecting drug use in 2012, injected buprenorphine.

## 3. PREVENTION

### 3.1. INTRODUCTION

According to the EMCDDA definition, “*Prevention is evidence-based socialisation where the primary focus is individual decision making with respect to socially appropriate behaviours. Its aim is not solely to prevent substance use, but also to delay initiation, reduce its intensification or prevent escalation into problem use...Prevention has more to do with child and adolescent development rather than with talking adolescents out of drugs*”<sup>1</sup> (EMCDDA, 2015). There are three forms of prevention which. Altogether if they are put in place, create a comprehensive approach:

- Universal prevention (prevention for all) targets the whole population, mainly school and/or community, regardless of the vulnerability of its members;
- Selective prevention is focused at groups, communities, families at risk (i.e. war affected traumatised populations, poor, etc.);
- Indicated prevention deals with the particular individuals who are considered either as under high risk (i.e. due to behavioural problems) or due to identified cases of drug use (i.e. experimenting).

In addition to these three forms, there are environmental strategies of prevention targeting societal and cultural norms, legal regulations of psychoactive substances and other contextual variables trying to reduce risk factors and intensify protective factors.

Prevention is the least developed direction amongst responses to the drug problem in Georgia. There are no institutional mechanisms developed for any of the described above forms of prevention in the country and nowadays prevention is limited to fragmentary interventions (campaigns) by NGOs, Church, schools and other stakeholders which most often are not based on evidence, are not evaluated and no quality assurance mechanisms are employed.

In 2012 *Ilia State University Institute of Psychology* piloted the Comprehensive Social Influence (“Unplugged”<sup>2</sup>) Program (EU-DAP, 2015) in the three private schools in Tbilisi (Javakhishvili, 2014) and, based on this, formatted the program for the Georgian culture and context. This is an evidence based universal prevention program focused at incorporation of drug education into the school curricula. As a result of the project, there is a ready to use package of the “Unplugged” program elaborated for Georgia. Implementation of the program is incorporated in The National Anti-drug Action Plan but no state budget has yet been allocated for its realization.

### 3.2. PREVENTION SYSTEM, STRATEGY, POLICY

The Georgian National Anti-Drug Strategy and Action Plan was elaborated in the years 2012-2013 and adopted in December 2013. The Action Plan involves the following activities: incorporation of drug related risks issues into general curricula of public schools, conduction of healthy life style and anti-drug

1. <http://www.emcdda.europa.eu/topics/prevention>

2. <http://www.eudap.net/>



campaigns for the public schools students, organization of corresponding local and national conferences and competitions (i.e. on the best anti-drug essay) for and with participation of school children, and awarding winners. In addition, a number of activities are focused on building public schools capacity to address drug problem: i.e. elaboration of a special handbook on risk behaviours for school teachers, also supporting development of the institutional mechanisms for lifelong learning for school administrators and pedagogues in Addictology.

The Action Plan involves two evidence based school based prevention programs - Comprehensive Social Influence (“Unplugged”) Program, and School Drug Policy Program, but at the moment there is no budget allocated for their implementation, which hinders introduction of evidence based drug prevention education into school curricula in the country.

*The Ministry of Sports and Youth Affairs* elaborated the State Youth Policy of Georgia (August 17, 2012; Decree N1608), where the importance of healthy lifestyle and carrying out active campaigns for preventing the abuse of psychoactive substances among the youth is stressed.

To conclude, campaigns implemented by the different actors which are not based on evidence and have questionable effect remain the most popular modus of action in the field of drug prevention in Georgia.

### 3.3. ENVIRONMENTAL PREVENTION

The Code on Administrative Offences sets the rules for alcohol and tobacco consumption and distribution. In particular, Article no 155\*3 prohibits consuming tobacco products in public and medical institutions, as well as at schools. It is also prohibited to sell tobacco products to the persons under age of 18 and engage them in the tobacco business (i.e. distribution). It is also illegal to sell tobacco near schools and in the children’s sections of trade centres and to sell single (not packed) cigarettes. The law also regulates the warnings that have to be printed on tobacco products and bans demonstration of tobacco consumption via mass media.

The Code on Administrative Offences bans consumption of alcohol at public places, prohibits selling of alcohol to the people under age of 18. Article 116 prohibits driving a motor vehicle under the influence of psychoactive substances. The leaders of public agencies can request employees/future employees to present drug testing certificate, if it is foreseen by the Georgian law (Law of Georgia on Civil Service).

### 3.4. UNIVERSAL PREVENTION

*The Ministry of Education and Science* is involved in implementation of the 2014-2015 Action Plan of the National Anti-Drug Strategy of Georgia. In 2014-2015 schooling year the Ministry focused on elaboration of the guidebook on how to respond to substance use (alcohol, nicotine, drug use) and promote healthy eating in the school setting for teachers, head teachers, school administration and parents.

Another initiative of the Ministry is a nation-wide contest on the anti-drug blogs and posters among school-children. In 2014 the National Curriculum Department has already accomplished the preparatory work which will allow implementing the contest in 2015. The winning anti-drug posters will be disseminated at public schools in Georgian, Armenian and Azerbaijani languages.



The funding priority stated by the Ministry for the years 2013-2015 is healthy lifestyle initiatives offered by educational institutions, NGOs and private organizations. For example, with the technical support within the framework of the Georgian HIV Prevention Project (GHPP), in 2013-2014 the Ministry of Education and Science of Georgia has successfully introduced the healthy lifestyle curriculum within the educational system. A special handbook for biology teachers was published (GHPP, 2012) and children aged 15-18 get necessary information about HIV and drug abuse in biology classes. They also become familiar with harmful consequences of tobacco, alcohol and the risks of early pregnancy.

On March 29, 2014, *The National Centre for Teachers Professional Development* arranged a students' conference 'Healthy lifestyle, physical and mental health', where one of the subjects was potential factors influencing drug abuse and elimination strategies. The participants (students from the different schools) presented various research projects focused on maintenance of healthy lifestyle.

Within the framework of the safe school concept, the special public legal body – so called “Mandatory” Service (Office of Resource Officers/school supervisors) was founded by the Ministry of Education and Science in 2010. It is focused on maintaining public order and security within the territory of educational institutions via ensuring elimination of carrying weapons such as knives and other sharp objects and firearms and the spread of alcohol and drugs among schoolchildren/students. The resource officers went through a series of the special training which included primary identification of drugs and drug users. Since 2010, the Resource Officers institute is functional within public (and some of the private) schools.

### 3.5. SELECTIVE AND INDICATED PREVENTION

As for indicated prevention, the *Childcare and Psychological Support Centre* was founded within the “Mandatory” Services of the MES in April of 2013. The Centre addresses children and adolescents with behavioural problems referred by the Resource Officers as well as schools teachers and administrations. The non-governmental Foundation *Global Initiative on Psychiatry* developed a special model utilising psychosocial intervention by a multidisciplinary team (psychologist, social worker and child psychiatrist) for early detection and intervention of juvenile delinquency, and trained the Centre staff in the implementation of this approach for children and adolescents with behavioural problems. This could be considered an institutional mechanism for indicated prevention within the Ministry of Education and Science of Georgia. In 2014, the multidisciplinary team approach was introduced to the regional offices of the Childcare and Psychological Support Centre in Batumi, Kutaisi, Poti, Telavi and Gori.

Technical assistance was provided to the *Ministry of Corrections and Legal Assistance* (MCLA) and MES in introducing the targeted psychosocial educational preventive intervention which covers juvenile prisoners, probationers and high-risk adolescents. The program also aims at promoting healthy lifestyle and prevention of HIV and abuse of psychoactive substances (USAID, 2014; Georgia HIV Prevention Project, 2010–2014).

### 3.6. NATIONAL AND LOCAL CAMPAIGNS

Anti-drug campaigns are the most widespread mode of action in the field of prevention in the country, though campaigns usually are not accompanied by surveys measuring the scale and patterns of drug use before and after campaigns, giving evidence of their effectiveness.

In 2014, MIA began, inter alia, a broad anti-drug campaign “No to New Psychoactive Drugs – Lets Change Attitude Together”. The aim of the campaign is to increase awareness among general population, especially among youth, about the negative aspects of illicit drug use and trafficking, with specific focus placed on new psychoactive drugs. A number of activities took place within the framework of the campaign, such as producing and broadcasting anti-drug social videos, organising educatory meetings of the MIA representatives with the school and university students and a special contest on the best anti-drug media products with the participation of the Tbilisi State University Journalism School, etc. According to the information by MIA, “*the main messages of the campaign have reached all segments of society and especially the most vulnerable groups in this regard – the youth, which indeed has resulted in reducing drug consumption and prevention of drug use in the country*”<sup>1</sup> (MIA, 2014b).

MSY (*The Ministry of Sport and Youth Affairs*) implemented the Anti-Drug campaign<sup>2</sup> in March-October of 2013 in the framework of the youth festival “Students Days 2013 against Drugs”, involving 1000 students from 43 universities of Georgia (MSY, 2014). It implied sport competitions, educational contests and cultural events to promote healthy lifestyle as well as debates amongst the students on the topic: “Drug abuse – crime or disease?”. In 2014, MSY implemented a series of sport activities among youth with the slogan “Choose the healthy lifestyle”.

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1. <http://police.ge/en/projects/narkotikebi/antinarkotikuli-kampania>

2. [http://msy.gov.ge/index.php?lang\\_id=ENG&sec\\_id=321&info\\_id=8502](http://msy.gov.ge/index.php?lang_id=ENG&sec_id=321&info_id=8502)

## 4. HIGH-RISK DRUG USE

### 4.1. INTRODUCTION

Considering the frequently changing drug situation and recent developments, the term “problem drug use” was revised and has been replaced since 2014 with the term “high-risk drug use (HRDU)<sup>1</sup>”, focusing on recurring drug use, which can potentially or actually result in the development of drug addiction, other health problems, psychological and social harm (negative consequences). In the text we still stick to the old term *Problem drug use* as it is currently widely used in Georgia and is basically defined as regular injected use of illicit psychoactive substances. Prevalence estimates of injected drug use are available since 2009, based on the studies using the multiplier method utilising data from harm reduction services and detoxification. Harm reduction services and behavioural surveillance surveys are also sources of information about characteristics of problem drug users.

### 4.2. PREVALENCE OF PROBLEM USE

There has not been any survey for determining the prevalence and incidence of problem drug use in Georgia before 2009, resulting in vague definitions and exaggerated data. There was a survey held in 2009 by the Bemoni Public Union on the prevalence of problem drug use within the framework of the South Caucasus Anti-Drug Program, using the multiplier/benchmark method (Sirbiladze, 2010). Results of this survey were reviewed at the experts meeting where consensus was reached and, consequently, the approximate number of problem drug users was determined to be 40,000 (95%; CI: 39,000-41,000) in the country. The prevalence of problem drug use was 1.5% (1.48-1.52%) among the population aged 15-64.

Within the framework of the funding received from the GFTAM, *Bemoni Public Union* and *Curatio Foundation* conducted the survey on the prevalence of drug use again in 2012, followed by the experts’ consensus on the approximate number of problem drug users in the country (Sirbiladze, 2013). The number agreed on was 45,000. Correspondingly, the prevalence of problem drug use amounted 1.65% (1.63%-1.67%) among the population aged 15-64. These results exceeded those of the previous (2010) survey by five thousand (95% CI: 44,434-45,524), although in a 2012 survey, different methodology was used (Sirbiladze, 2013) which does not allow for valid comparison. There is an opinion that the observed growth is the result of applying different methods of research rather than having actual growth.

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1. <http://www.emcdda.europa.eu/activities/hrdu>

### 4.3. CHARACTERISTICS OF HIGH-RISK DRUG USERS

#### 4.3.1. Data from Georgian harm reduction network

*The Georgian Harm Reduction Network* conducted two surveys in 2012 which studied the prevalence of psychoactive drug use and injection risk behaviour among injecting drug users. These two surveys provide data on the two different groups of drug users: (1) the beneficiaries of the HIV/AIDS prevention program involved in the needles and syringe program (NSP) for 6 or more months (Gogia, 2013a), and (2) the participants of the Peer Driven Intervention (PDI) who have never been involved in the AIDS prevention program (Gogia, 2013b).

The first survey covered 1,154 beneficiaries participating in the NSP in eight cities of the country (Tbilisi, Telavi, Gori, Kutaisi, Samtredia, Zugdidi, Poti and Batumi). The non-probability consecutive sampling method was used for selection of the study participants. The majority of participants were men 96.45% (1,113 out of 1,154); median age was 37.7 (SD=8.5); 62.9% of them were married; 93.7% had incomplete secondary or higher education; 70.0% were unemployed.

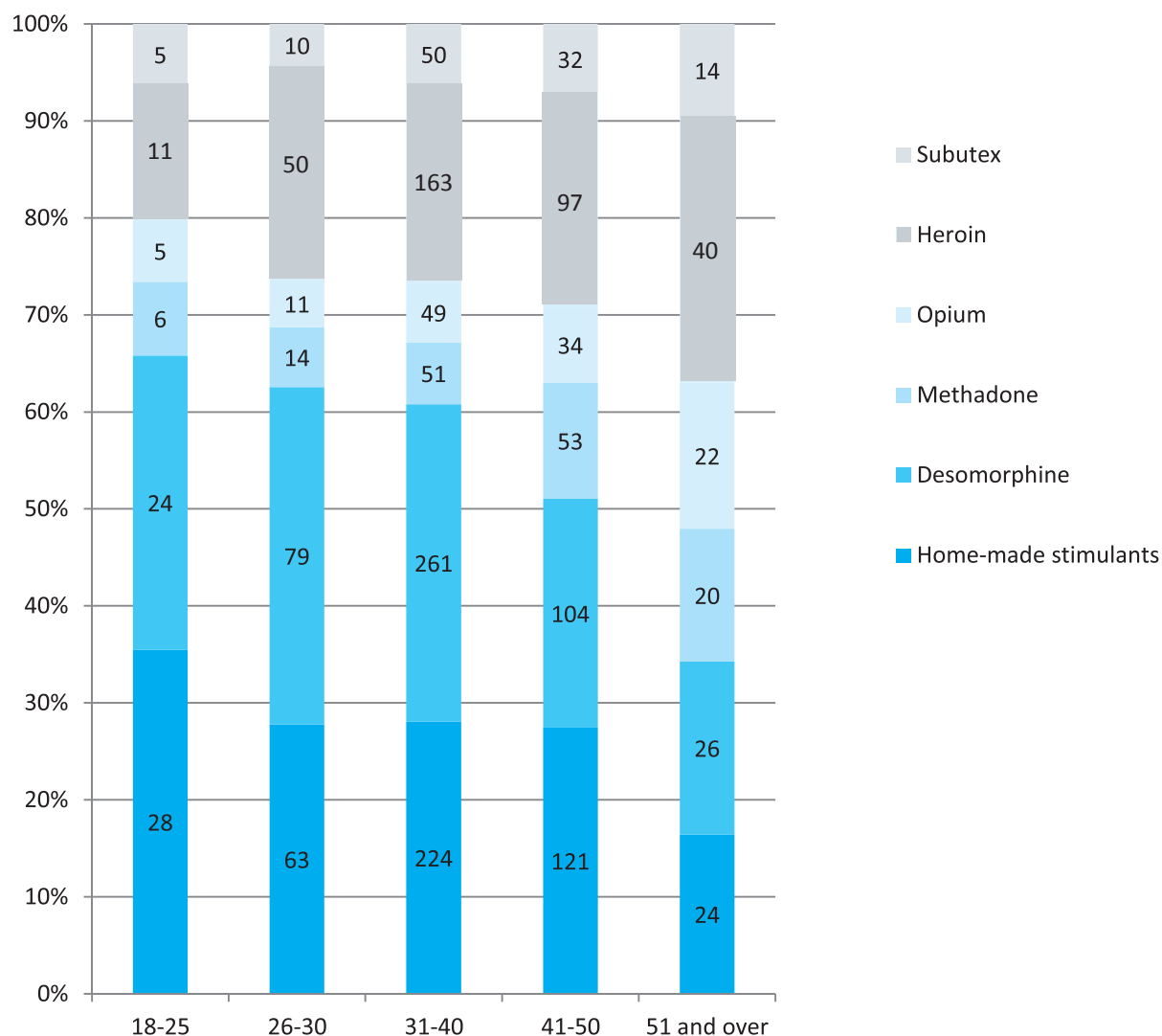
The second survey reached 2,342 injecting drug users involved in the PDI, which is implemented at nine service centres providing harm reduction services in the same eight cities of the country as listed above. The survey utilized respondent driven sampling methodology. The majority (96.63%) of participants were men (2,263 out of 2,342); median age of the respondents was 32 (SD=8.5); 44.5% were married; 94.3% had incomplete secondary or higher education; unemployment rate reached 73.7%.

Similar trends were observed of using specific drugs among the two different groups of the study subjects. The most prevalent injecting drugs were homemade opioid desomorphine (so-called “Krokodil” or “Krok”) reported by 45% (PDI) and 43% (NSP) and homemade stimulants “Vint” and “Jeff” reported by 34% (PDI) and 40% (NSP) of the respondents. Use of heroin was reported by 30% (NSP) and 33% (PDI) of the respondents.

Based on the comparative analyses of drug use trends among NSP and PDI beneficiaries in the same cities during the last 30 days, significant differences were revealed, i.e., in Kutaisi desomorphine use was reported by 72% (PDI) and 11% (NSP); in Poti, heroin use was reported by 48% (PDI) and 13% (NSP).

In both (NSP and PDI) groups of drugs users, opiates use was higher than use of stimulants, though there were some age-specific differences – namely, the share of stimulants use was higher among the younger drug users as is reflected in the Figure 4:

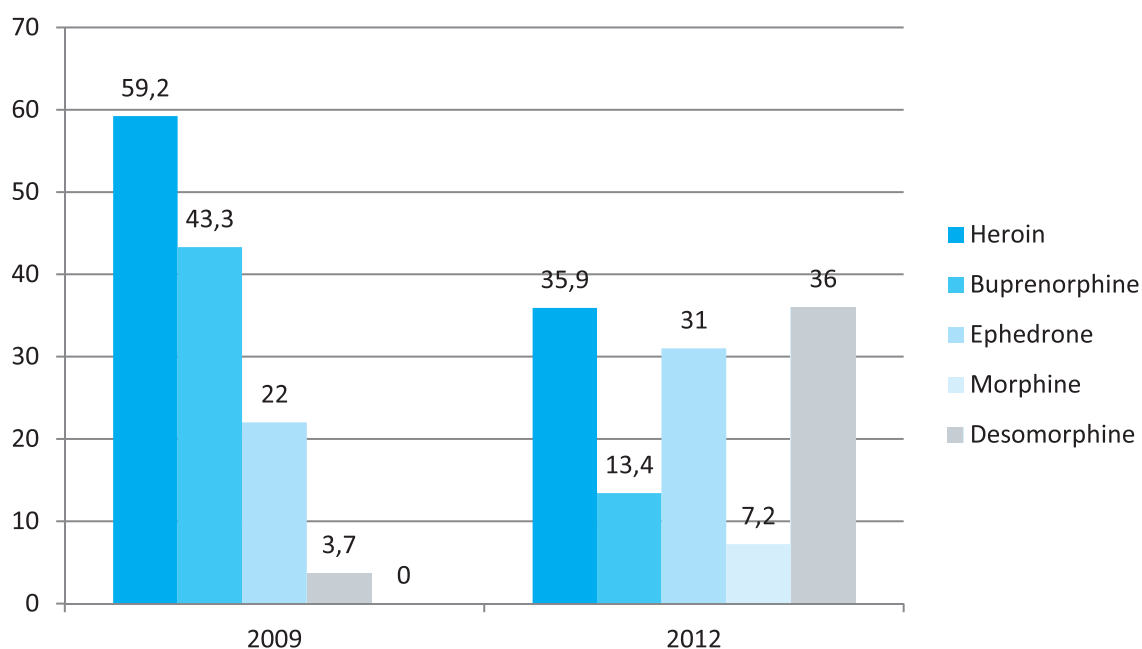
**Figure 4: The psychoactive substances used by PWIDs (NSP study) during the last 30 days with respect to the age groups (Gogia, 2013a)**



#### 4.3.2. Data from behavioural surveillance survey

The behavioural surveillance survey was conducted by the research consortium led by *Curatio International Foundation* in six cities of Georgia in 2012 (Tbilisi, Batumi, Zugdidi, Kutaisi, Gori, Telavi) to study HIV-related risk and protective behaviours among injecting drug users (Chikovani, 2012). The respondent driven sampling method was employed. Overall, 1,791 respondents were surveyed. According to the study results, the most widespread injected drug amongst the studied PWIDs is “Krokodil” - homemade desomorphine (36%), followed by heroin (35.9%), then – “Vint” and Jeff” - homemade stimulants (31%), buprenorphine (13.4%) and morphine (7.4%). The same research consortium conducted the behavioural surveillance survey in the same six cities employing similar methodology in 2009 (Curatio, 2009) which gave the opportunity to observe the emerging trends in drug use across the cities. The results of the comparison show a decrease in buprenorphine use and an increase in use of the homemade opioids and stimulants (see Figure 5):

**Figure 5: Comparison of primary drugs reported by PWID in the 6 main cities of Georgia in 2009 and 2012 (Chikovani, 2012)**



As for socio-demographic characteristics of the studied PWIDs, the following picture was revealed: more than 95% of the respondents were male, mean age of the overall sample was 36.8; the majority had completed secondary and higher education (out of the 1,791 respondents just 3 reported only primary education, and one – no education at all). At the time of the study, the majority of the respondents were unemployed varying from 57.4% in Zugdidi to 91.9% in Tbilisi. Throughout the cities on average, every third IDU had monthly income in the range from GEL 100 to 300 (approx. € 47 - 142<sup>1</sup>) while in a combined sample about one fourth of studied IDUs had income less than GEL 100 (€ 47).

Both surveys conducted by the *Georgian Harm Reduction Network* as well as the Behavioural Surveillance Survey conducted by the research consortium led by *Curatio International Foundation* reveal a very similar picture in terms of preferred injecting drugs and socio-demographic characteristics of the studied drug users. All three studies show almost identical results regarding last month drug use patterns: homemade desomorphine and stimulants, as well as “traditional” opioid heroin were reported as drugs of preference in all the three studies. As for socio-demographic characteristics – the majority of the respondents in all the three studies were males in their mid-thirties, literate and educated, mostly unemployed and suffering from low income.

1. 2012 GEL/€ ~ 2.12

## 5. DRUG TREATMENT

### 5.1. INTRODUCTION

The drug treatment system in Georgia is in the process of development and still is influenced by the Soviet inertia. In the last decade opioid substitution treatment has been started and nowadays it competes with the abstinence oriented treatment both in terms of the capacity and the number of the patients involved. There is no infrastructure for psychosocial rehabilitation of individuals with substance use disorders – absence of community based rehabilitation centres and therapeutic communities create a gap in the development of the chain of continuous care.

Reliable and valid national data on patients treated for substance use disorders does not exist in the country. There are no regulatory mechanisms that define the notification of the Treatment Demand Indicator (TDI). The aggregated data collected over the past decade was provided by several clinical centres and medical facilities without harmonization, implying a lack of standards for data collection and processing. Starting from 2013, NCDC designed a special standard data collection form which includes aggregated information by gender, age-groups, number of first time and repeated visits, route of administration, type of primary and secondary drugs, poly drug use, and HIV testing/result. As the standardised procedure of data collection started only in 2013, it is not possible to compare TDI data for 2013 to the data of the previous years.

### 5.2. TREATMENT STRATEGY AND POLICY

A significant part of the National Strategy on Combating Drug Abuse document is focused on treatment. The specific objectives of the strategy related to treatment are as follows:

- To ensure that drug dependent persons are provided with evidence-based treatment which meets their medical, psychological and social needs.
- To secure the availability of harm reduction programs.
- To provide treatment, rehabilitation and harm reduction opportunities for psychoactive substance users in the penitentiary facilities.

In the Strategy document is stated that *“In order to accomplish the aforementioned objectives, it is essential to create an adequate infrastructure and institutional mechanisms for treatment quality control; implement modern evidence-based methods. Additionally, treatment should be promoted as an alternative to punishment for drug users”* (Strategy, 2014).

### 5.3. TREATMENT SYSTEM AND ACCESS TO TREATMENT

In Georgia there are public and private treatment services. The types of treatment are outpatient and inpatient abstinence oriented treatment (detoxification), substitution treatment, short term primary rehabilitation and psychosocial rehabilitation.



### 5.3.1. Abstinence Oriented Treatment

There are six clinics specialising in abstinence oriented treatment (AOT) in Georgia, providing inpatient and outpatient detoxification followed by short-term primary rehabilitation. Five of them (*Centre for Mental Health and Prevention of Addiction*, *Centre for addiction and psycho-correction*, *Medical Centre “Uranti”*, *Medical Centre “Bemoni”* and *Medical centre named after Jobny Chanturia*) are located in Tbilisi, the capital city of Georgia, one (“*Narcological Centre*”) in Batumi. Out of listed six clinics, two (*Centre for Mental Health, and Prevention of addiction* and “*Narcological Centre*”) are governmental, four are private.

*The State Program on Addiction Treatment* is functional in the country and all of the treatment institutions listed above receives governmental funding for the limited number of patients – approximately three hundred persons a year. A bigger part of the patients pay out of pocket. According to the governmental resolution No. 279 (January 31<sup>st</sup>, 2013), the cost of in-patient detoxification should not exceed GEL 1,250 (€ 580) and the cost of primary rehabilitation should not exceed GEL 1,000 (€ 460). Risk-groups, such as those with HIV/AIDS, socially vulnerable family’ members, patients between 18-25 years of age and those who have not yet been enrolled in the state program are being prioritized. In 2013, the cost of in-patient detoxification treatment together with the primary short term rehabilitation in the listed above clinics varied in the range from GEL 1,500 (€ 678) to GEL 2,250 (€ 1,018). As for out-patient treatment – from GEL 1,200 (€ 543) to GEL 1,500 (€ 678).

Out of the existing six, only five clinics provided data on the patients treated in 2013 to NCDC. The cumulated number of patients who received AOT during the year in those clinics is 835. Relatively detailed information on the treated patients including sex and age distribution, number of admissions, primary drug of use and route of administration was collected only by four of those five clinics, covering 531 persons. According to this data, the majority of the patients were males (525 persons – 99.8%), in the age range from 21 to 51 (See Table 8):

**Table 8: Age distribution of the patients treated in 2013 (NCDC, 2014)**

Age group	Absolute numbers and %	
	Males (n = 525)	Females (n = 6 <sup>1</sup> )
≤20	5 (0.9%)	0
21-30	123 (23.4%)	3
31-40	234 (44.6%)	2
41-50	115 (21.9%)	1
51-60	44 (8.4%)	0
60<	4 (0.8%)	0

Out of 531 persons, more than half were admitted to treatment for the first time (57%), the rest - repeatedly. As for the primary drug of use, opioids have the biggest share (see Table 9):

**Table 9: Primary drug of use of the AOT patients in 2013 in % (NCDC, 2014)**

Primary drug of use	% (n = 531)
Heroin	49.7%
Opium	0.3%
Desomorphine	16.2%

1. Due to the small number, we do not use percentages in this column.



<b>Buprenorphine</b>	0.7%
<b>Methadone (injection / non-injection)</b>	14.9% (5.6% / 9.0%)
<b>Other opiates</b>	0.7%
<b>Cocaine</b>	0.5%
<b>Home-made stimulants</b>	6.1%
<b>Sedatives</b>	4.8%
<b>Hallucinogen</b>	0.2%
<b>Cannabis</b>	0.2%
<b>Other substances</b>	0.5%
<b>Poly-drug use</b>	5.2%

### 5.3.2. Opioid Substitution Treatment

Opioid substitution therapy (OST) started in the country in 2005. In 2009, MoLHSA issued a Ministerial Decree No. 37/n on substitution therapy in opioid drug users where the following was defined: methodology, patient inclusion criteria and regulations, regulations on the control of narcotic drugs/psychiatric substance use without doctor's prescription, treatment completion procedures, patient's exclusion criteria, the rules of use, storage and distribution of substitution narcotic drugs and rules on the processing of medical documentation of the program. On July 3, 2014 MoLHSA released an amendment (order #01-41/n) to the above mentioned order that provides special rules for implementation of OST in particular situations (such as hospitalization of OST client, take-home dose), the list of opioids and medications for opioid substitution treatment.

Nowadays OST is functional through three different stakeholders in the country: Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM), The State Treatment Program and the private sector. Two different types of OST are available in the country: (1) methadone maintenance program and (2) the program using buprenorphine preparations – buprenorphine alone and combined preparation with buprenorphine and naloxone (Suboxone®).

According to governmental resolution No. 279 (January 31, 2013), the cost of treatment vouchers in the state treatment program on substitution therapy is regulated. Namely, the state program is based on the co-payment principle: the cost of the methadone is covered by the state (from The *State Program on Addiction Treatment* budget) while services are self-paid (out-of-pocket) by patients at GEL 110 (€ 45) a month. Co-payment does not apply to HIV-positive individuals as well as to those who are under the poverty line. Monthly, up to 1,800 beneficiaries are financed by the State, out of whom 110 are taking combined medication. There are 12 OST sites operated by the state in the different regions of Georgia: 6 sites in Tbilisi and one in each of the following towns: Poti, Kutaisi, Batumi, Zugdidi, Ozurgeti, and Telavi.

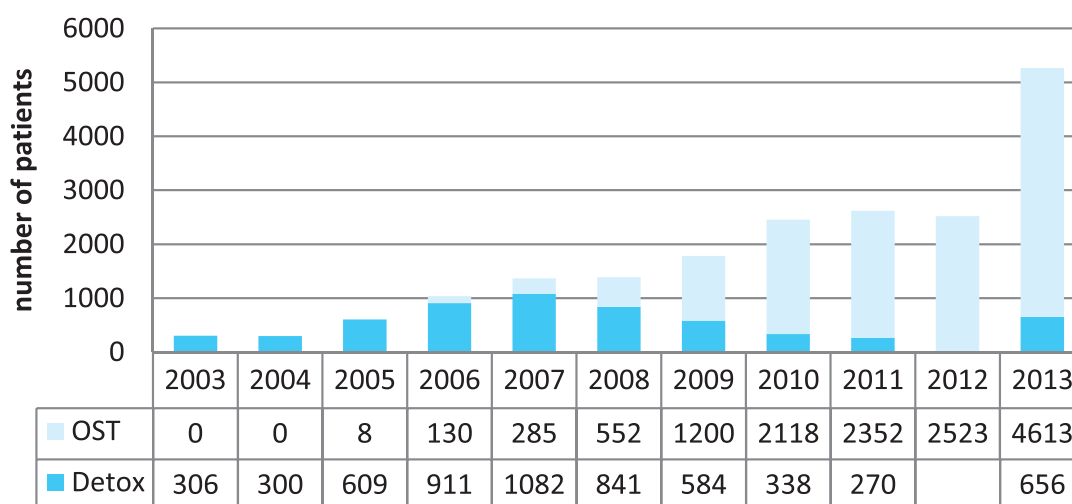
There is one private Suboxone® substitution treatment program in Tbilisi which was launched in 2012. In 2013, 342 males and 6 females were admitted there. The cost of one visit is GEL 28 (€ 13).

GFATM provides treatment via four OST sites, free of charge – two in Tbilisi, one in Gori and one in Batumi. Additionally, two GFATM sites are running in the penitentiary institutions – one in Tbilisi and another one in Kutaisi, providing short-term detoxification with methadone. In 2013, 352 prisoners received opioid detoxification services, 2 females among them.

In 2013 a total of 3,658 patients were enrolled in OST programs (excluding private Subuxone® substitution treatment and penitentiary institutions programs). Out of these patients, only 38 (1%) were female.

Below you can see the number of patients treated in OST and detoxification therapy.

**Figure 6: Number of patients treated for substance use disorders in 2003-2013 (NCDC; MoLHSA)**



### 5.3.3. Psycho-social rehabilitation

There are three out-patient psycho-social rehabilitation centres, funded by GFATM – “Kamara”, *Patriarchy of Georgia Psychosocial Rehabilitation Centre*, and the rehab unit of the *Mental Health and Addiction Prevention Centre*. These units serve clients of OST and AOT as well as ex-drug users, and employ individual, group and family therapies, ergo- and art therapy, computer classes, religious activities, peer support, etc. Voluntary testing and counselling services are provided in the rehab centres as well. In total, all three centres have the capacity to serve up to 50-60 individuals at once.

## 6. HEALTH CORRELATES AND CONSEQUENCES

### 6.1. INTRODUCTION

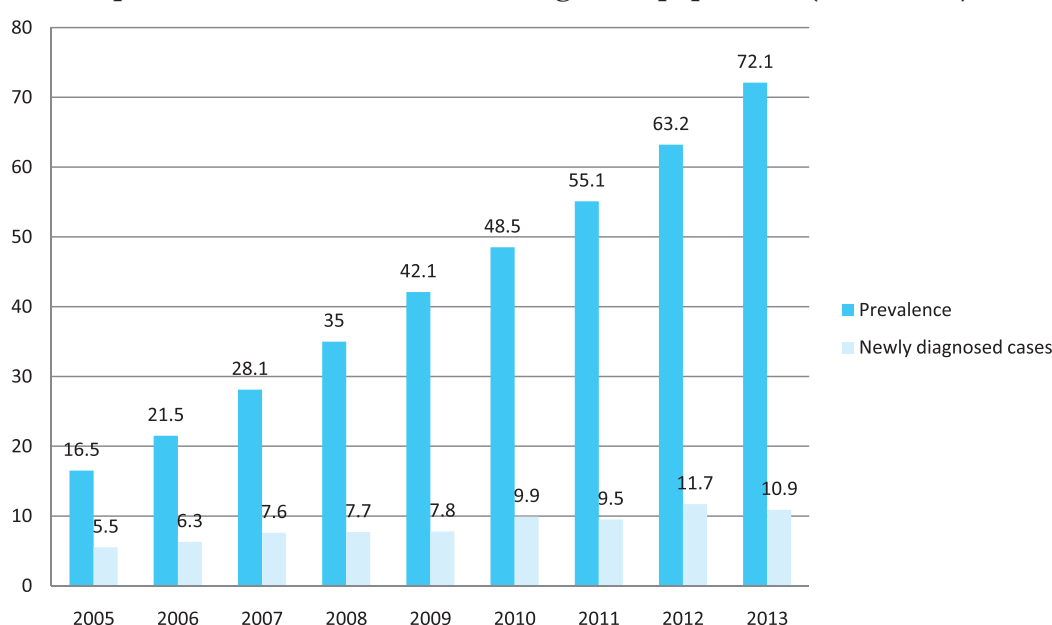
The mechanisms of collection of the information on drug related health correlates and consequences differ in the country. Institutional mechanisms of collection and processing HIV/AIDS related data are well developed due to the fact that immediately after the epidemics started in the 1980s, the Infectious Diseases, *AIDS and Clinical Immunology Research Centre (AIDS Centre)* special governmental institution was established and started to monitor HIV/AIDS situation in the country. As drug use was a leading route of transmission for previous decades, HIV/AIDS prevalence among drug users was under focus of attention of the *AIDS Centre*. The less developed are institutional mechanisms of data collection on newly diagnosed cases of drug-related viral hepatitis and even less tuberculosis. The most underdeveloped is information on drug-related death (DRD) as after the fall of Soviet Union there were no institutional mechanisms to collect corresponding data. The data collection on DRD indicators restarted recently.

### 6.2. DRUG RELATED INFECTIOUS DISEASES

#### 6.2.1. Newly registered cases of HIV/AIDS

Georgia is among low HIV prevalence (0.07% in general population) countries being at high risk for an expanding epidemic due to widespread injecting drug use. The officially registered number of PLWH in the country was 4,131 by the end of 2013. The number of newly registered annual cases has been increasing steadily and reached 490 in 2013, of them 173 (35.3%) were IDUs (see Figure 7).

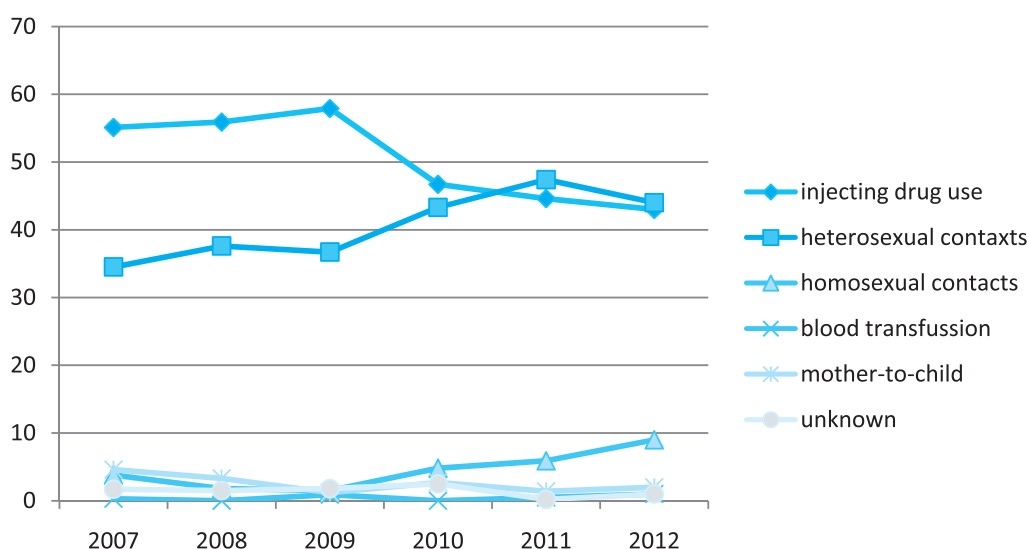
**Figure 7: HIV/AIDS reported incidence (newly diagnosed cases) and prevalence<sup>1</sup> rates 2005-2013, per 100,000 inhabitants within the general population (AIDS, 2015)**



1. Prevalence here means cumulated number of People living with HIV/AIDS minus cumulative number of those who died.

In previous years, the proportions of male and female HIV-positive cases were 75% and 25% respectively. In 2011, the proportion was changed, with males accounting for 70% of cases and females for 30%. This shift can be explained by the spread of HIV among female sexual partners of IDUs. The trend has been maintained for the last two years. Similar to the most Eastern European countries, injecting drug use was the major transmission mode in the early years of the HIV epidemic in Georgia. Since 2010, transmission has shifted towards the heterosexual mode, which became dominant by 2011. The share of drug use as a transmission mode among newly registered HIV cases decreased to 43.2 % in 2012, and 35.0% in 2013 while heterosexual transmission increased up to 44.8% in 2012 and 49.0% in 2013 (see Figure 8).

**Figure 8: Modes of HIV transmission by year, in % (GARP, 2013)**

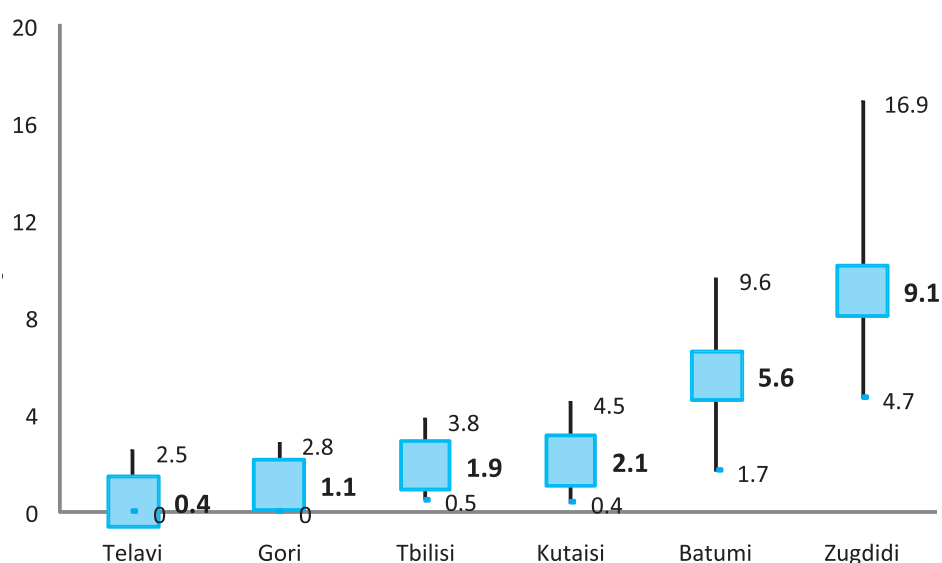


According to *the Infectious Diseases, AIDS and Clinical Immunology Research Centre* in 2013, the total number of newly registered HBV/HIV co-infections was 30, out of whom 19 (63.3%) were PWIDs. The total number of newly registered HCV/HIV co-infections was 153, out of whom 108 (70.5%) were PWIDs. Dual HBV/HCV infection in HIV positive patients was registered in 19 patients, out of whom 16 (84.2%) were PWIDs (AIDS, 2015).

### 6.2.2. HIV sero-prevalence

Several rounds of bio-behavioural surveillance surveys (BSS) have been conducted since 2002 to provide prevalence estimates of HIV among PWIDs and key indicators of HIV risk behaviour. According to the last BSS conducted in 2012 (Chikovani, 2012) among PWIDs in six major cities of Georgia, (Tbilisi, Gori, Telavi, Zugdidi, Batumi and Kutaisi) HIV prevalence among PWID was 3.0% (95% CI 2.20 – 4.04), ranging from the lowest 0.4% in Telavi to the highest 9.1% in Zugdidi (see Figure 9):

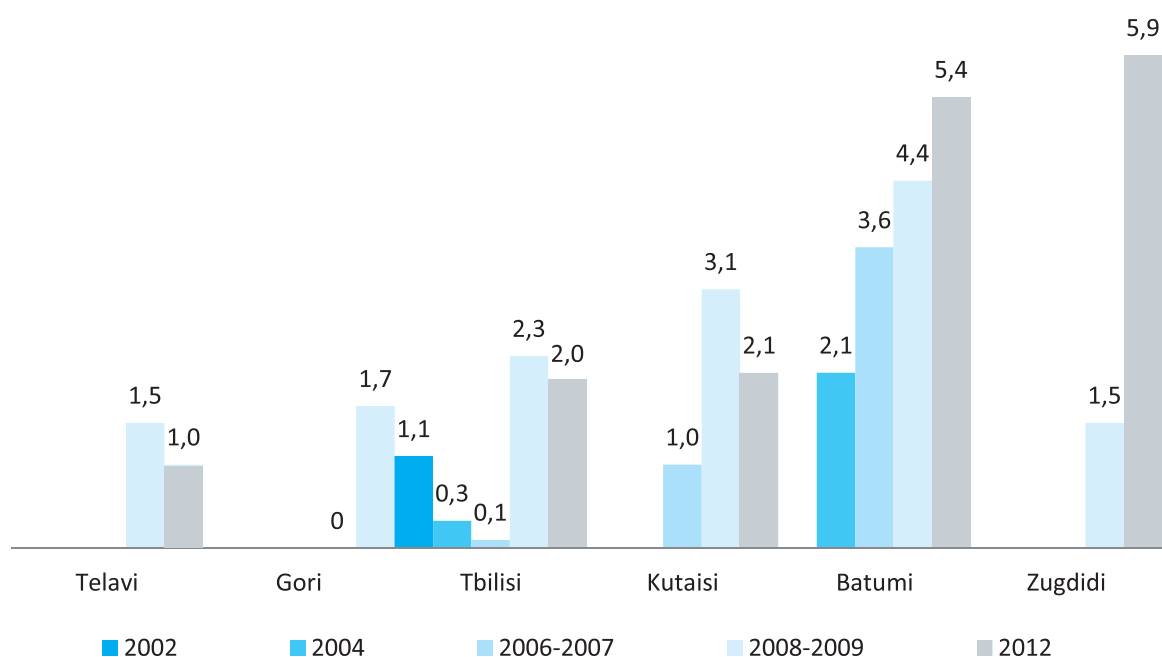
**Figure 9: HIV prevalence among PWID by towns (Chikovani, 2012)**



There is an increase, although not statistically significant, from 2009 where the same six cities' combined prevalence rate was 2.4% (95% CI 1.56 – 3.46).

Comparison of data from the early studies shows that there is an increasing trend across the cities. The statistically significant change is observed in Batumi and Zugdidi from the first to the latest BSS data. Prevalence rates from Batumi and Zugdidi show that the HIV epidemic reached a concentrated epidemic level in 2012 (see Figure 10):

**Figure 10: Prevalence of HIV among IDUs, 2002-2012, in % (SPSS, unweighted) (Chikovani, 2013)**



### 6.2.3. Other drug-related infections

#### *Viral hepatitis*

The data on prevalence of hepatitis among PWID in Georgia is limited. NCDC collects the corresponding data from the different treatment institutions though for the moment there is no mechanism to identify prevalence of viral hepatitis among PWID.

According to the previous studies conducted in the country approximately 70% of PWID have HCV antibodies. However, countrywide surveys on HCV in general population and PWID have not been conducted for several years.

The study was conducted in 2012 by *Médecins du Monde* (Mdm) among the beneficiaries of the program which offered to PWIDs free medical services related to hepatitis. According to the results, 92.1% of the studied had HCV antibodies and 83.3% an active chronic infection. Prevalence according to duration of injecting drug use suggested an annual incidence rate of 20% among drug users. As the study attracted an especially vulnerable sub-group of drug users, the sero-prevalence data on hepatitis C cannot be generalized to PWIDs in Georgia.

According to the *Georgian Harm Reduction Network* (GHRN), which is the key actor to deliver low threshold harm reduction services to PWIDs, in 2013 there were 5,139 tests performed on Hepatitis B (HBsAG) among PWIDs and 514 HBV positive cases (10%) were identified (see Table 10).

**Table 10: Hepatitis B among PWIDs – number of tests and positive cases (GHRN, 2014b)**

	2006	2007	2008	2009	2010	2011	2012	2013
<b>Number of tests performed on Hepatitis B</b>	1,871	1,338	1,946	2,077	1,783	1,224	2,324	5,139
<b>Number of positive Hepatitis B cases</b>	136	76	143	201	94	66	171	514
<b>% of positive cases</b>	7.3	5.7	7.3	9.7	5.3	5.4	7.4	10.0

Altogether 5,998 tests were performed on HCV among PWIDs and 3,182 HCV positive cases (53%) were identified (see Table 11):

**Table 11: Hepatitis C among PWIDs – number of tests and positive cases (GHRN, 2014c)**

	2006	2007	2008	2009	2010	2011	2012	2013
<b>Number of tests performed on Hepatitis C</b>	1,343	1,455	1,938	2,077	1,788	1,232	2,497	5,998
<b>Number of positive Hepatitis C cases</b>	663	827	969	999	915	666	1,276	3,182
<b>% of positive cases</b>	49.3	56.8	50.0	48.1	51.2	54.0	51.1	53.0

#### *Syphilis*

There were 1,105 new cases of syphilis registered in 2013; incidence per 100,000 inhabitants of all ages was 24.6 which is increased in comparison with the previous year (13.8%). No data are available on

how many PWIDs were among the revealed cases. Neither BSS conducted in 2012 implied testing on syphilis. Some information on the problem can be concluded using the data provided by the *Georgian Harm Reduction Network* (GHRN, 2014a). GHRN have been implementing Rapid Plasma Reagin (RPR) testing on syphilis among IDUs since 2010. In 2013 there were 4,759 RPR tests performed and 210 RPR positive cases were revealed (4%) (see Table 12):

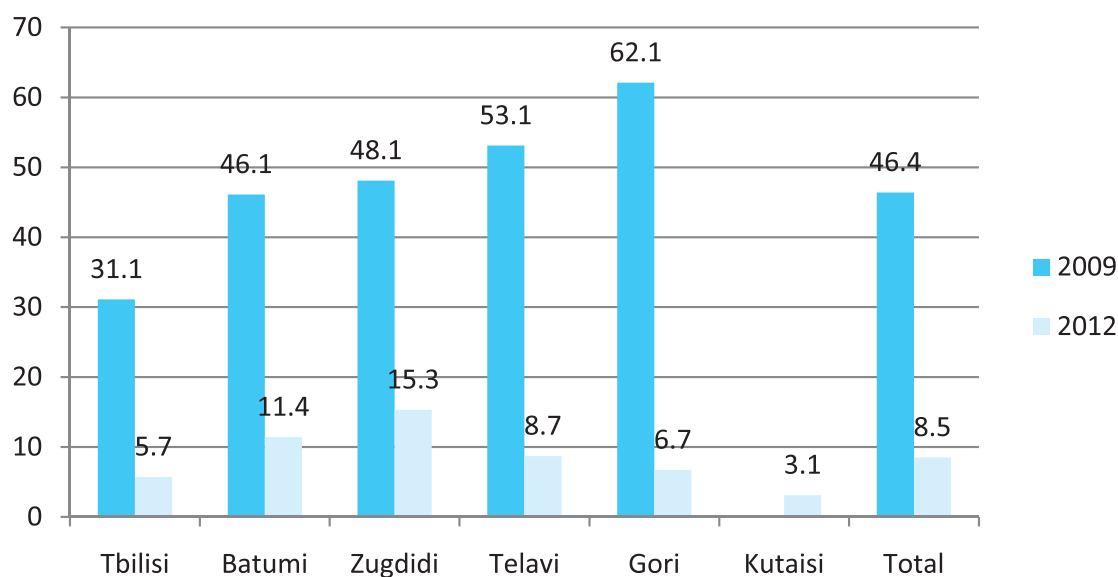
**Table 12: Dynamics of infectious diseases testing by years (GHRN, 2014a)**

Years	2006	2007	2008	2009	2010	2011	2012	2013
<b>Number of clients reached by harm reduction programs, IDUs</b>	919	1,126	1,402	3,768	4,680	3,434	7,592	22,830
<b>Number of HIV tests</b>	2,070	1,643	2,113	2,077	1,830	1,222	2,846	8,228
<b>HIV prevalence (%)</b>	1.6%	2.7%	.4%	1.1%	1.2%	2%	1%	0.3%
<b>Number of HCV tests conducted</b>	1,343	1,455	1,938	2,077	1,788	1,232	2,497	5,998
<b>HCV prevalence %</b>	49%	57%	50%	48%	51%	54%	51%	53%
<b>Number of HBV tests conducted</b>	1,871	1,338	1,946	2,077	1,783	1,224	2,324	5,139
<b>HBV prevalence %</b>	7.3%	5.7%	7.3%	9.7%	5.3%	5.0%	7.0%	10%
<b>Number of syphilis tests conducted (RPR)</b>	RPR was implemented from August 2010				523	344	1622	4,759
<b>RPR prevalence %</b>					0	0	3%	4%

#### 6.2.4. Risk behaviour

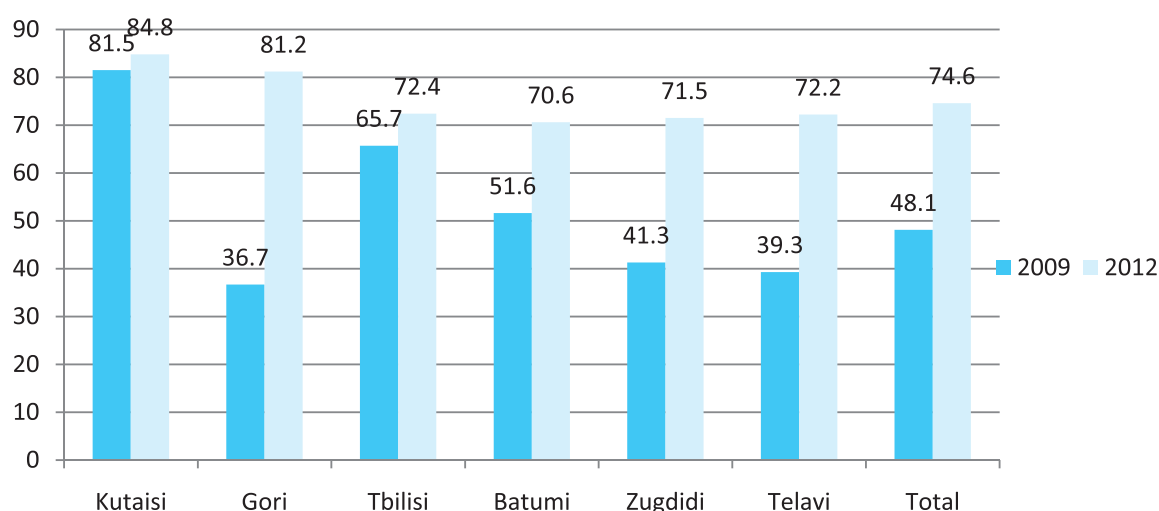
The above mentioned rounds of BSSs conducted in several cities of Georgia (Chikovani, 2012) provide valuable data regarding risk behaviour among PWIDs. Comparative analyses of the findings of those surveys across the years allow measuring changes. According to BSS (Chikovani, 2012), sharing of paraphernalia decreased significantly in all cities since 2009 (see Figure 11). It may indicate that PWIDs correctly identify risk of HIV transmission through paraphernalia. A notable association is found between this risky behaviour and types of drug and injection abroad. Those who had primary/secondary education, injected heroin and “Jeff” last month, and injected abroad were more likely to share injecting equipment. Paraphernalia sharing in case of injecting “Jeff” is explained by the drug preparation technique.

**Figure 11: Sharing paraphernalia at last injection by in 6 cities in 2009 and 2012, in %**  
(Chikovani, 2012)



As a result of improved practice towards injecting equipment and other paraphernalia use, overall safer injection behaviour improved in all the studied cities (see Figure 12). Safe injection at last injection is defined as the combination of following indicators: no usage of previously used injecting equipment by somebody else or him/herself, no usage of injecting equipment left at a place of gathering by somebody else, no usage of prefilled syringe by somebody else without his/her presence, no usage of shared equipment, no usage of drug solution from shared container.

**Figure 12: Safer injection at last injection in 6 cities in 2009 and 2012, in %**  
(Chikovani, 2012)



Injection abroad increased in all cities since 2009. A particularly significant increase is observed in Zugdidi and Batumi. In 2012, every fifth user among Batumi and Zugdidi PWIDs who injected abroad shared

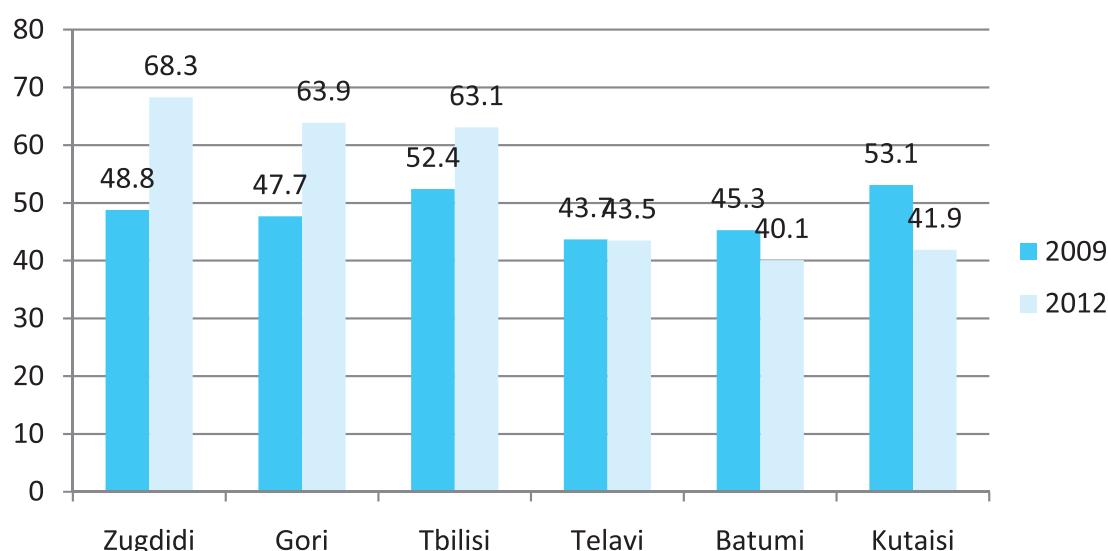


injecting equipment there. Thus, the study indicates that those who practice safer injecting at home cities shift to risky behaviour when injecting takes place outside their regular environment (other country, city).

Knowledge concerning HIV transmission is relatively good among the studied individuals. The majority are aware that the main transmission risks are unsafe injection practices as well as unprotected sex with an infected person. On the other hand, misconceptions about HIV transmission still exist that may contribute to the stigmatization and discrimination of people living with HIV. This might be reflective of the level of stigma among the general population.

The study found high risk sexual behaviour among PWIDs (see Figure 13). More than 40% in all cities reported having occasional partners and on average every third married IDU also had occasional partner. In comparison with the previous BSS study findings indicates that overall there is slight increase in condom use with occasional partners. Two cities (Zugdidi and Gori) demonstrated statistically significant positive change ( $p < 0.05$ ), however the other four cities showed no improvement or worsening of condom use behaviour. This may indicate that occasional partners are still not perceived to be a source for HIV transmission by a big proportion of PWIDs.

**Figure 13: Condom use with occasional partners during the last intercourse in 6 cities in 2009 and 2012, in % (Chikovani, 2012)**



Despite the high accessibility of confidential HIV testing, every second PWID is still not tested for HIV during their lifetime. When compared to the 2009 data, every testing proportion increased from 29.2% to 45.2% in the combined sample. Insufficient uptake of HIV Counselling and Treatment (HCT) services indicates that a large proportion of PWIDs is unaware of their HIV status, which increases risks for HIV transmission. The worst HIV testing experience was observed among young PWIDs with primary/secondary education, with poor HIV knowledge and injecting equipment sharing practices during the last month. This calls for targeting (high risk) young PWIDs with specific interventions.

### 6.3. OTHER DRUG-RELATED MORBIDITY

#### 6.3.1. Non-fatal overdoses

Until 2014, no data was available in the country on non-fatal overdoses. In 2013 the statistical form (form IV-11) changed in a way to collect information (including non-fatal overdoses) from the addiction treatment medical institutions/facilities existing in the country according to the ICD codes (F10-F19). Though, as the form does not contain information from emergency services, no data on drug related fatal overdoses appeared in the form filled in for 2014.

The knowledge of the respondents (NSP and PDI programs beneficiaries) on prevention of overdose and administration of naloxone was examined in the framework of the two surveys implemented by the *Georgian Harm Reduction Network* (see chapter 4.3.1). According to the study results, 52% of PDI program beneficiaries (1,225 respondents) and 50% (582 respondents) of NSP program beneficiaries reported never having overdosed. In PDI study, 165 (7%) respondents indicated that they have experienced overdose during the last 6 months. Out of them, 52.5% (85 respondents) reported overdose due to heroin use and 31% (51 respondents) identified overdose due to desomorphine use. An NSP study showed similar results where 8.4% (97 respondents) indicated overdose case during last 6 months, out of which 37.2% (35 respondents) was caused by heroin and 49% (46 respondents) by desomorphine (Gogia, 2013a).

According to the information provided by the police, 5,510 road traffic accidents were registered in 2013; in 228 of those (4%) alcohol use was detected; due to those accidents 27 persons died. No data is available on drug use related road accidents.

### 6.4. DRUG-RELATED DEATHS AND MORTALITY OF DRUG USERS

Till 2007 no data was available in the country on Drug Related Death (DRD) due to the absence of institutional mechanisms for data collection. Starting from 2007, registered numbers of fatal overdoses are as follows: 39 in 2007, 28 in 2008, 19 in 2009, 15 in 2011, 43 in 2012, 28 in 2013 and 38 in 2014 (2010 – no data).

The special order of the Minister of Labour, Health and Social Affairs No.239/n dated by 2000 obliging medical doctors witnessing (helping during) overdose to report to the police was an obstacle for data collection as drug users were reluctant to call an ambulance to avoid legal consequences. After adopting changes to the above mentioned order in 2014, medical personnel no longer have the obligation to report every case of overdose to the police (excluding cases where there are signs of other law offence), which should facilitate seeking help and preventing DRD as well as registration of both fatal and non-fatal drug related overdose cases. This gives hope that the number of revealed DRD cases will be closer to the actual numbers starting from 2015.

## 7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

### 7.1. INTRODUCTION

The most developed responses in the country are harm reduction measures related in context of HIV prevention policy. Institutional mechanisms to respond to the problem related to the viral hepatitis (especially C) are just developing both for in civil sector and in the penitentiary system. The institutional mechanisms for social integration/reintegration and corresponding psychosocial care and rehabilitation still need to be developed in the country.

### 7.2. PREVENTION OF DRUG RELATED EMERGENCIES AND REDUCTION OF DRUG-RELATED DEATH

Since 2009, GHRN has been implementing the “Take Home Naloxone” project within the framework of the GFATM funded HIV prevention program. The aim of the project is to raise awareness of overdose prevention among PWIDs and to build corresponding capacity via provision of the first medical aid trainings, distribution of relevant informational material and naloxone ampoules. Table 13 below reflects the distribution of naloxone ampoules among PWIDs.

**Table 13: Trends in distribution of naloxone ampoules to PWID (GHRN, 2014a)**

Years	2009	2010	2011	2012	2013
<b>Naloxone ampoules distributed among PWIDs</b>	2,400	1,848	288*	1,396	1,628

\* Decline in the number of the distributed ampoules was caused by a gap in funding of GHRN

### 7.3. PREVENTION AND TREATMENT OF DRUG-RELATED INFECTIOUS DISEASES

Prevention and treatment of drug-related infectious diseases is delivered both by state and non-state actors and is supported also by the international community.

Due to the recognition of the increased health burden associated with HIV/AIDS, the Government of Georgia has utilized various mechanisms and resources to mitigate the impact of the epidemic. Several state programs are being implemented. The main purpose of the *HIV/AIDS State Program* is early detection of HIV/AIDS new cases in order to reduce the spread of HIV/AIDS and provide access to treatment for HIV/AIDS patients. This program covers voluntary counselling and testing for high risk groups, including PWIDs. The treatment component of the program covers outpatient and inpatient services, as well as antiretroviral treatment (ART). However, the costs for ARV drugs are fully covered by TGF.

HIV counselling and testing services supported by GFATM are available in all prisons. The number of inmates tested on HIV in 2013 was up to 2,000. Short-term OST (only detoxification) courses are available for inmates with substance use disorders only in two prisons (prisons No. 2 and 8) within the framework of the Global Fund HIV grant (GFATM, 2014).

In 2013, as a result of rigorous advocacy initiatives carried out by the *Ministry of Corrections and Legal Assistance* in close partnership with civil society organizations and human rights advocates, the Government of Georgia initiated a hepatitis B vaccination and hepatitis C testing and treatment program in the penitentiary system. The program ensures that all incarcerated persons infected with hepatitis have equal access to hepatitis treatment.

In December 2013, Georgia completed adaption of 2013 WHO guidelines for earlier treatment initiation, and now ART is recommended for all patients with CD4 count  $\leq 500$  cells/mm<sup>3</sup>. Implementation of new guidelines combined with sustained high patient engagement allows Georgia to aim for greater impact on the epidemic in terms of saving lives and preventing new infections.

At the end of 2013, a total 2,092 persons living with HIV were on ART (927 of which were PWIDs). Compared to previous years, 2012-2013 showed improvement in survival/retention among patients initiating ART. For example, 12-month retention indicators increased from 79% in 2011 to 86% and 85% in 2012 and 2013, respectively. Retention rates are also high among persons with history of IDU, reaching 80% at 12 months and 79% at 24 months. This data indicates that Georgia has been successful in providing ART to IDUs, challenging prevalent misconceptions that IDUs may not fully benefit from ART.

One of the recent positive developments is free of charge hepatitis C treatment State program for all eligible HIV/HCV co-infected patients was initiated. This is the first case in the country wherein the specific population sub-group gained access to treatment free of charge. Over 300 HIV/HCV co-infected patients started treatment since the initiation of this program. Preliminary analysis of outcomes shows promising results suggesting that program will decrease liver related morbidity and mortality among people living with HIV in Georgia.

One especially active non-governmental actor in the field is the *Georgian Harm Reduction Network* (GHRN) uniting 26 organizations. GHRN runs fourteen harm reduction service sites in eleven cities across Georgia. Its main goal is to develop cooperation for implementing effective drug policy and expanding medical, social and legal services for drug users in Georgia. GHRN is the key actor to deliver low threshold harm reduction services to PWIDs. The services accessible in service sites include but are not limited to needle/syringe, safe injection devices, safe sex devices and information material distribution among IDUs. GHRN service sites offer medical counselling and other supplementary services. The Network reaches out to approximately 9,500-11,000 PWIDs per month and plays a crucial role in HIV prevention among them. Numbers of tests for infectious diseases performed by programs of GHRN are given in Table 12. Numbers of distributed needles and syringes are given in the Table 14 below:

**Table 14: Numbers of distributed needles and syringes by years (GHRN, 2014)**

Year	2006	2007	2008	2009	2010	2011	2012	2013	2014
Number of syringes & needles	350,340	376,480	462,883	474,785	1,064,372	775,222	1,021,870	2,038,740	3,573,405

The USAID-funded Georgia HIV Prevention Project (GHPP) developed and implemented HIV prevention activities for key populations (including PWIDs) and at-risk youth. Activities in 2012-2013 were implemented in four major cities of Georgia - Tbilisi, Kutaisi, Batumi and Rustavi. GHPP provided voluntary counselling and testing services to the target populations on HIV, hepatitis B and C at service centres and through two mobile laboratories.

#### **7.4. RESPONSES TO OTHER HEALTH CORRELATES AMONG DRUG USERS**

Information on the responses to other health correlates among drug users is scarce in the country. The voluntary counselling & testing services within the GHRN service centres and NGO *Tanadgoma* provide mental health (MH) counselling to the drug addicts in cases of MH co-morbidity (GHRN, 2014a). NGO New Vector with the support of *Medecins Du Monde* provided free of charge dental services to 733 beneficiaries and performed liver fibro-scanning for 650 HCV infected PWIDs in 2013 (Labartskava, 2014).

## 8. SOCIAL CORRELATES AND SOCIAL REINTEGRATION

### 8.1. INTRODUCTION

There is a lack of reliable data on social exclusion of PWIDs in Georgia. Some statistics presented in this section are derived from BSS surveys as well as studies conducted by the Georgian Harm Reduction Network. Information about social rehabilitation services is obtained through individual interviews with key informants from service providing organizations.

Psychological support and social reintegration of individuals with substance abuse disorders has never been on the list of the government's priorities. Georgian Health Care National Strategy for 2011-2015 years does not properly acknowledge the magnitude of substance abuse related problems in the country and sets no targets for drug addiction services, psycho-social support or rehabilitation services. Over the last decade, there have been no outpatient or in-patient rehabilitation services for substance users funded by some national fund that would aim towards psycho-social rehabilitation and reintegration of persons with substance abuse related problems.

The first attempt to introduce residential treatment and psycho-social rehabilitation services in Georgia was made in 2012 when the Government of Georgia established a new entity under the Public Law – the *Drug Addiction and Psycho-social Rehabilitation Centre*. A total of GEL 2 million (€ 921,658) was budgeted to build a residential type treatment centre in Bazaleti<sup>1</sup>. In 2012, an architectural project of the centre was developed and small scale of construction work was completed. Actual spending under the above-mentioned budget line amounted to GEL 138,714 (€ 63,923) in 2012. Subsequently, a technical proposal about the mission of the centre and service modalities was developed. Based on the proposal, the centre should have the capacity of providing residential type services to 60-64 patients during 3-6 month period. The proposal was submitted to MoLHSA for approval. However, since 2013, no formal review has taken place. Apparently, due to very high unit cost per beneficiary, the service was deemed financially non-viable and the topic of establishing a residential type service was dropped from the political agenda. The designated funds for this activity remained in the state budget for 2012 and 2013, but were excluded from the 2014 budget. The public legal body *Drug Addiction and Psycho-social Rehabilitation Centre* was annulled in 2015.

### 8.2. SOCIAL EXCLUSION AND DRUG USE

Data on social characteristics of PWIDs are derived from BSS (Chikovani, 2012) and GHRN studies (Gogia, 2013a), (Gogia, 2013b). Almost half of BSS respondents (44.2%) reported being married; 36% have never been married. Survey findings have proven how fragile the marriages can be for IDU communities: almost one-fifth of respondents reported being either divorced or separated. The highest rate of divorce was observed in the capital city, Tbilisi – 26.5%. The proportion of respondents who

1. Bazaleti – a small city situated within a 40-minute drive from the capital city. A territory of 4,979 m<sup>2</sup> owned by the *National Centre for Disease Control* was designated for building the centre

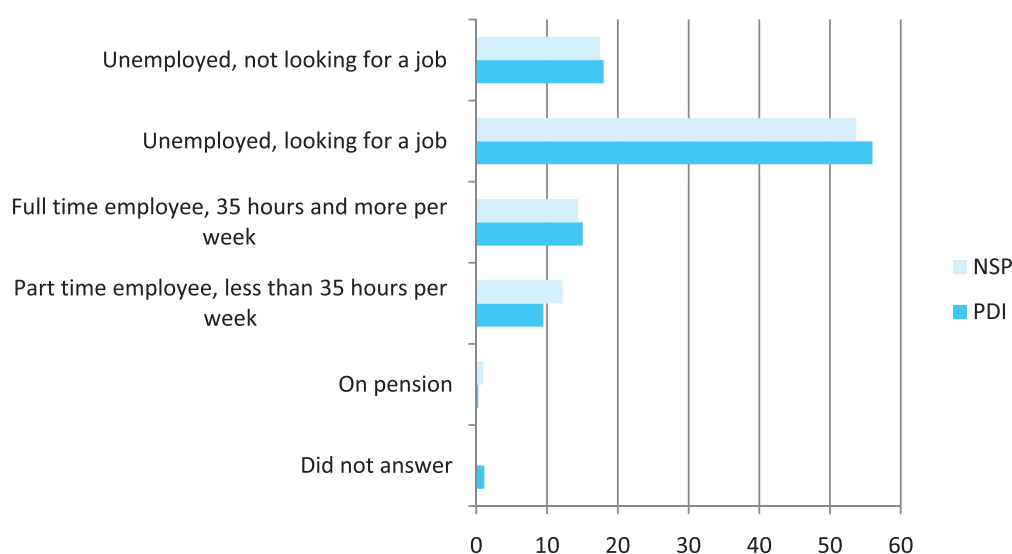
live with a spouse varies from 37.9% (Telavi) to 49.3% (Gori), while proportion of those who live with relatives/parents vary from 42.6% (Tbilisi) to 51.5% (Telavi); a very limited number of BSS respondents were living with a partner other than spouse (no more than 3.7% in Kutaisi).

The education level among PWIDs was assessed during the BSS as well as GHRN studies. All study findings have shown that the majority of the participants have completed secondary education. The BSS has shown that the highest proportion of Tbilisi respondents has higher education. In other locations, the majority of PWIDs have secondary education. A very limited number of PWIDs (3 out of 1,791) reported having only primary education and one person reported no education at the time of the survey (Chikovani, 2012).

The BSS conducted in 6 major cities of Georgia enrolled a total of 1,792 PWIDs in the survey (see subchapter 4.3.1). The majority of them were unemployed and unemployment rates varied by city from 57.4% in Zugdidi to 91.9% in Tbilisi. Only a small share of survey respondents reported having a permanent job ranging from 3.4% in Tbilisi to 13.6% in Zugdidi. The highest rate of university students was found in Telavi (8.9%).

Two studies conducted by GHRN in 2013, analysed data for two data sets: (1) drug users who were recruited to harm reduction services through the peer-driven interventions (2,342 PWIDs); and (2) drug users receiving services at needle-syringe programs (1,154 PWIDs) – see subchapter 4.3.1. Both studies were carried out at 9 service centres (Telavi, Gori, Kutaisi, Samtredia, Zugdidi, Batumi, Poti and 2 service centres of Tbilisi) offering free-of-charge harm reduction services to PWIDs. More than half of respondents in both studies were unemployed looking for a job. More than 15% of surveyed drug users reported not seeking for job opportunities – see Figure 14:

**Figure 14: Number of PWIDs by employment status (Gogia, 2013a, Gogia, 2013b)<sup>1</sup>**

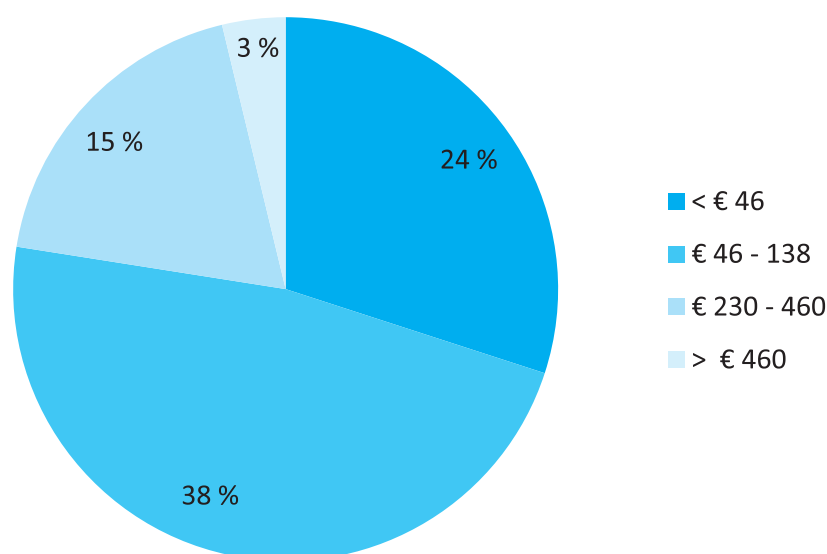


Studies conducted among PWIDs in Georgia also looked at the income level among drug users. According to the BSS findings in all six cities participating in the survey, on average, every third IDU has a monthly income in the range of GEL 100-300 (approx. € 46 – 138); about one fourth of IDU population has income less than GEL 100 (€ 46), and only 15% of all respondents reported having monthly income from GEL 500 – 1,000 (€ 230 – 460); and only few (3%) have more than GEL 1,000 (€ 460) per month (see Figure 15):

1. NPS – needle and syringe program; PDI – peer driven intervention.



**Figure 15: Monthly income of PWID, in €, in %, N = 1,791 (Chikovani, 2012)**



This information proves that PWIDs in Georgia are socially and financially vulnerable groups as they have problems related to labour status. The unemployment rate among drug users is higher as compared with the general population – according to the National Statistics Office of Georgia, the unemployment rate among general population is 14.6% vs. more than 50% rate among PWIDs. It is obvious that precarious labour status can lead to significant financial problems for PWIDs as well as their family members.

No data on drug use among ethnic minorities are available. The vast majority of drug users participating in BSS studies (more than 95%) are ethnic Georgian which corresponds to the ethnic composition of the general population of the country.

### 8.3. SOCIAL REINTEGRATION

Historically, the first psychosocial rehabilitation program for drug users in Georgia was initiated within the penitentiary system in early 2000. At different times, the program was funded by various donor organizations, including EC, *Poland Stefan Batory Foundation*, Polish Embassy to Georgia, and *Open Society Georgia Foundation* (OSGF). Through the financial support of the listed donors, the 12 Steps approach based program “ATLANTIS” for drug and alcohol was functional in the penitentiary system of Georgia until 2012.

In 2006, an *Anti-drug Centre at the Patriarchy of Georgia* was established that provided psychosocial rehabilitation services to dependent and co-dependent persons in civil sector. The programme became most popular in 2007-2012 when two monasteries at the Tabori Mountain started offering to individuals with substance use related problems residential type of psychosocial services. Every year, around 80-100 alcohol and drug dependent persons were residing at the monasteries to receive psychological and mental health rehabilitation services and to stay sober and drug free. However, since 2012, due to unavailability of funds, services have become unable to serve many people, and as of 2013-2014, only a few people sought these services.

At present, a small number of ex-beneficiaries of the “ATLANTIS” centre still continue providing psychosocial support to their peers through the peer-support groups. In total, eleven peer-support groups

are active in Georgia. They mostly gather on weekends at the *Caritas Georgia* which offers free office space to them. These services are based on volunteering and no reliable statistics on the number of beneficiaries are available.

Another psycho-social rehabilitation centre – *Kamara*, a local NGO, specifically targeting drug users and their micro-social environment, was established in 2010. *Kamara*'s operations in Tbilisi provide various services to alcohol and drug users after they complete detoxification course. Services available at *Kamara* include cognitive-behavioural therapy, yoga, psycho-diagnostics, group psychotherapy sessions, art-therapy, and music-therapy. *Kamara*'s operation is mostly supported by private contributions and it also receives funds from GFTAM. *Kamara*'s services share many similarities with outpatient treatment programs but in a very informal, “home-like” environment. The centre serves around 60 patients per year (around 6 month treatment period for each patient). *Kamara* annually organizes exhibitions of drawings and art pieces created by its beneficiaries to increase patients' self-esteem and to contribute to their social reintegration. In addition, such public events aim at reducing stigma and challenging negative stereotypes surrounding drug users in the country.

Similar types of services are also provided by the Psycho-Social and VCT Centre, a local NGO which is operational within the government institution – the Centre of Mental Health and Drug Prevention. Services offered by the Centre are funded by the GFATM. However, due to limited funds, the number of beneficiaries is limited. Program data of the Centre states that in 2013 a total of 62 drug users or recovering patients received various types of services (art-therapy – 56 beneficiaries; individual and group psycho-therapy sessions – 62 persons; recovery breathing exercises using oriental methods – 52 persons). The NGO also offers training sessions, case-based medical counselling on mental health, TB, HIV and viral hepatitis. Free of charge testing for HIV is also offered to its beneficiaries.

According to the information provided by *Bemoni* Public Union, the first social bureau for drug users was opened by *Bemoni* in 2012 in Telavi, Georgia with the support of *AIDS Foundation East-West*, within the frames of the project funded by the government of the Netherlands. The bureau is still functioning and is very successful.

In 2014, EC funded a project “Promotion of Social Reintegration: establishment of social bureaus for former prisoners and probationers and improving pre-release programs in prisons”. The project is being implemented by the Centre for Information and Counselling *Tanadgoma* in partnership with *Mainline Foundation*, *AIDS Foundation East-West*. Under the EU funded project, vulnerable populations receive counselling on HIV, HBV and HCV, psychological and medical counselling, overdose prevention, psychological rehabilitation based on the 12-step approach and providing training in communication skills for job seekers. The project is operational in four major cities of Georgia: Tbilisi, Kutaisi, Batumi and Zugdidi. Since the project inception (January 1, 2014), 392 persons benefited from its activities (193 ex-prisoners, 143 probationers and 56 prisoners); out of them, 148 were either current or former drug users.

There are no psycho-social rehabilitation services targeting female drug users. No investments have been made to establish women-friendly services that would provide social assistance to females who are under the pressure of the double social stigma triggered by their gender and drug behaviour. In addition to drug-related vulnerabilities, female drug users oftentimes become victims of domestic and gender-based violence. Therefore, neglecting the severity of the problem of drug use among women may have serious negative consequences at the national and societal level.

## 9. DRUG-RELATED CRIME, PREVENTION OF DRUG RELATED CRIME AND, PRISON

### 9.1. INTRODUCTION

In the Georgian context, primary drug-related crime is defined as drug offenses that fall under the articles 260-274 included in the Chapter XXXIII of the penal code of Georgia (see sub-chapter 1.2). There is no established definition of secondary drug related crime in the country and, therefore, no relevant data are available in crime statistics. For the purposes of the current report, the term drug-related crime refers to primary drug crime; under term convict is meant “a person found guilty of a crime and sentenced by the first instance court”.

Information on drug offenses in the country are collected by a number of state agencies and kept in their own information systems. The Ministry of Internal Affairs<sup>1</sup> (MIA) collects and maintains data on drug-related offences, including statistics on drug testing. The Prosecutor General’s office collects data on drug-related criminal charges and proceedings. The Supreme Court of Georgia collects statistics regarding drug-related court hearings and convictions. Ministry of Corrections maintains data on drug-related convicts and prisoners.

For the purpose of the current report, information was collected from all listed agencies via specific written requests, websites of the agencies, or publicly available reports conducted by relevant agencies.

### 9.2. DRUG-RELATED CRIME

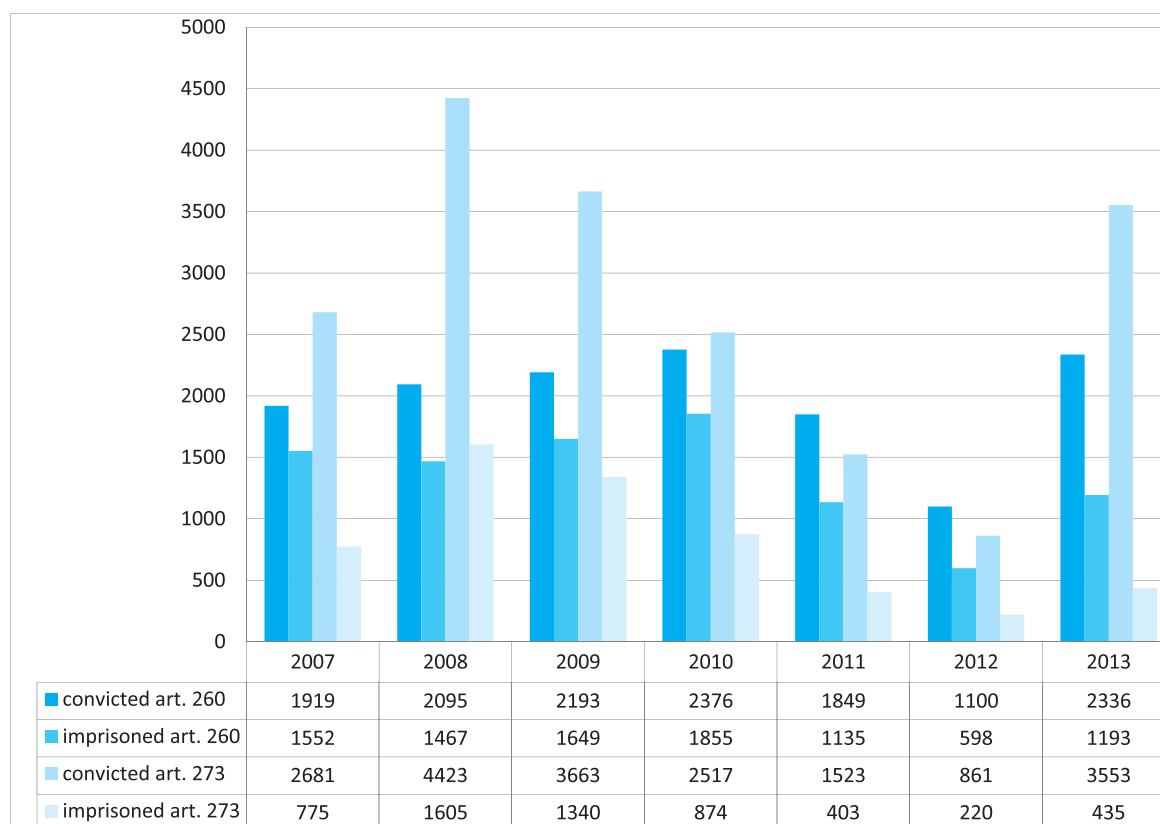
#### 9.2.1. Drug law offences

According to the data from the *Supreme Court of Georgia*, a total of 6,456 individuals were convicted for drug related offences in 2013 at the courts of first instance. In overwhelming majority of cases – 6,230 (96.5%) – the charges related to the violation of Articles 260 (unauthorised possession) and 273 (repeated drug use) of the Penal Code of Georgia. Following the peak in 2008, there was a steady reduction in the number of convictions and related imprisonment until 2012 – see Figure 16. However, in 2013 there was more than a twofold increase in both the number of individuals convicted and sentenced to imprisonment for consumption and possession of illegal substances.

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1. MIA is a state agency responsible for public security. It incorporates a number of law enforcement agencies – Patrol Police, Criminal Police, Counterintelligence Department, Counterterrorist Department, Border Police, Security Police and Regional Police Agencies. All MIA divisions operate as parts of a highly centralized vertical state agency and have a united data collection and maintenance system.

**Figure 16: Annual number of convictions in 2007-2013 for articles 260 and 273 of the Penal Code of Georgia (Supreme Court of Georgia, 2007-2014a)**



### 9.2.2. Sentences for Drug Law Offences

Data provided by the Supreme Court of Georgia suggest that a total of 6,456 individuals were convicted at the first instance courts in 2013 for committing drug crimes – see Table 15.

In 6,230 (96.5%) cases, charges were related to Article 260 (unauthorised possession) and Article 273 (repeated drug use) of the Penal Code of Georgia. In 44.8% of cases person convicted for possession of drugs (Article 260) was sentenced to imprisonment, 12% of individuals convicted for repeated drug consumption (Article 273) were sentenced to imprisonment. In addition, a noticeable number of people were imposed monetary fines as additional (to the primary sentence) penalty. In overwhelming majority of cases (87.4%), convicts were also signing a plea bargain. In the Georgian reality, a plea bargain implies collaboration with the investigation (providing information related to other significant crimes) and willingness to pay significant amount of money in which case they are not imprisoned or the term of imprisonment is significantly reduced. In 2013 there was only one case of acquittal related to drug crimes.

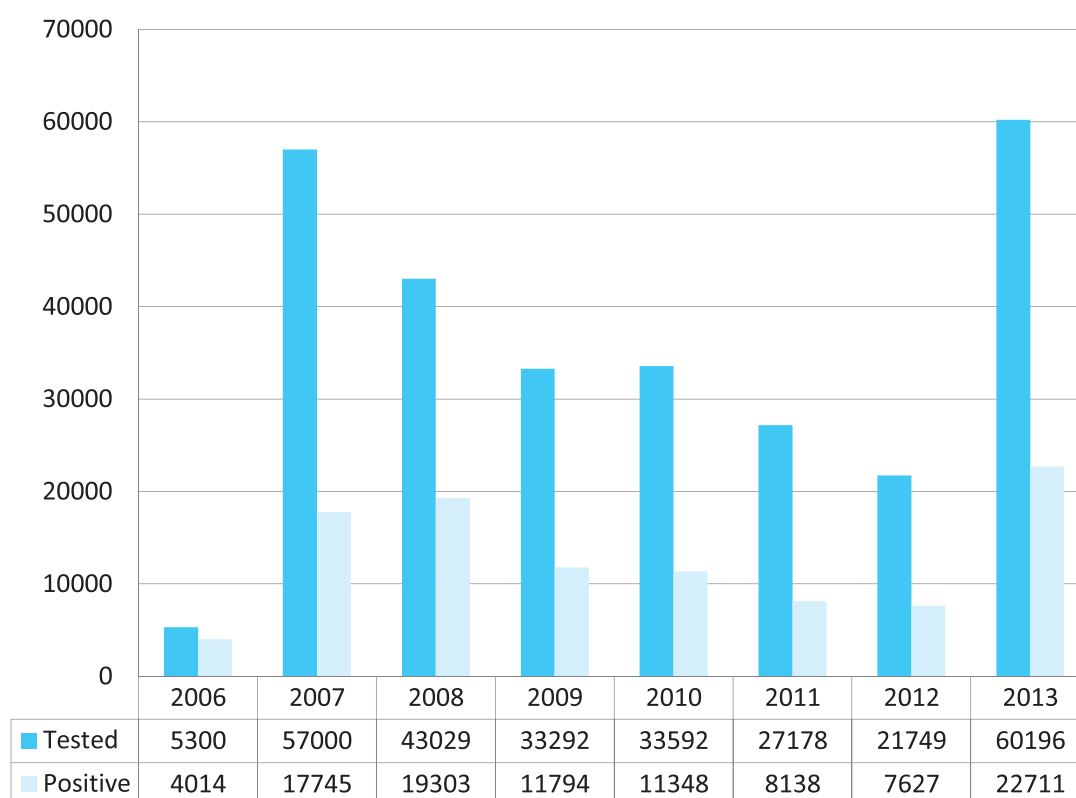
**Table 15: Number of individuals and cases charged and sentenced for drug-related crime (Chapter XXXIII of the Penal Code of Georgia) in the First Instance Court in 2013 (Supreme Court of Georgia)**

Articles of the Penal Code of Georgia	Court hearings with decision		Among them were sentenced					Fine as additional penalty	Plea bargain	Acquitted
			Inprisonment	Conditional sentence	Fine/Penalty	Community Service	Conviction suspended after Amnesty			
	Cases	Persons	Persons	Persons	Persons	Persons	Persons	Persons	Cases	Persons
<b>260</b>	2,337	2,660	1,193	1,421	27	1	18	1,485	2,234	1
<b>262</b>	49	52	21	10	21			21	48	
<b>273</b>	3,553	3,570	435	2,561	531	29	14	671	3,197	
<b>261, 263-272, 274</b>	170	174	32	128	14			95	166	
<b>Total</b>	6,109	6,456	1,681	4,120	593	30	32	2,272	5,645	1

### 9.2.3. Administrative offences related to drug use

According to the data from Ministry of Internal Affairs, a total of 60,196 individuals were tested for the presence of drug metabolites in 2013. Rapid toxicological urine analysis yielded 22,711 positive results. This scale of drug testing was the highest in the history of massive street drug testing launched since 2007. The annual number of people tested was declining steadily between 2007 and 2012, however, 2013 showed three-fold increase if compared to the previous year – see Figure 17. Notably, the share of positive results has remained stable over all years with only 1 out of 3 tests being positive for metabolites of any controlled substances.

**Figure 17: Number of individuals tested for drugs and number of positive results, 2006-2013 (MIA, 2007-2014b)**



The overwhelming majority of individuals presented for toxicological drug testing were male with only 599 (1%) females being tested – see Table 16. The share of positive results among women was lower compared to positive test results among men with only about 1 out of 6 test results confirming the presence of metabolites of controlled substances in urine.

**Table 16: Distribution by sex of the individuals who underwent drug testing (MIA, 2007-2014b)**

Number of tests	Total	Male	Female
<b>Total</b>	60,196	59,597	599
<b>N of Positive</b>	22,711	22,604	107
<b>Positive in %</b>	37.7%	37.9%	17.9%

The majority of individuals tested for drugs (72.3%) were from ages 26 to 45 – see Table 17. Interestingly the highest share of positive test results was found in the age group above 45 (1 out of 2.5) and the lowest share was in the youngest age group tested, 16-18 years of age (1 out of 7 tests performed). No individuals younger than 16 were tested.

**Table 17: Age distribution of the individuals who underwent drug testing (MIA, 2007-2014b)**

Age	16-18	19-25	26-45	>45
<b>Total</b>	302	11,301	43,531	5,062
<b>Positive</b>	43	2,869	17,632	2,167
<b>% of positive</b>	14%	25%	40.5%	42.8%

Due to the fact that many drug users in Georgia are poly-drug users (Vadachkoria, 2015), (Sikharulidze, 2015) and in majority of cases urine is tested for presence of several (suspected) substances, the overall number of positive test results was 32,048 in a sample of 22,711 individuals whose urine contained any controlled substance – see Table 18. Substances of the opioid group were the most often identified during the drug testing (36.6%) and were followed by THC (marijuana) (29%). Cocaine accounted for the smallest portion among all substances found during the toxicological testing (0.07%).

**Table 18: Number of tests by substances identified in 2013 (MIA, 2014a)**

	Opioids	Buprenorphine	Marijuana	Methadone	Amphetamine / Methamphetamine	Cocaine	Ecstasy	Tramadol	Synthetic Cannabinoids	Psychoactive drugs
<b>Jan</b>	591	39	475	111	89	3	16	12	-	396
<b>Feb</b>	634	24	259	98	88	2	13	5	-	385
<b>March</b>	913	18	187	164	106	2	29	6	-	521
<b>April</b>	989	27	143	137	127	2	16	14	-	518
<b>May</b>	1,022	50	127	208	135	3	14	15	-	490
<b>June</b>	1,121	52	294	165	93	1	16	16	-	432
<b>July</b>	995	60	664	182	133	4	13	6	121	392
<b>Aug</b>	1,049	64	1,075	257	205	3	38	17	110	574
<b>Sept</b>	1,429	92	1,533	236	203	1	10	24	112	574
<b>Oct</b>	1,191	87	1,836	204	196	1	8	10	91	596
<b>Nov</b>	925	102	1,633	196	165	2	9	7	79	486
<b>Dec</b>	899	90	1,036	112	186	1	2	14	61	395
<b>Total</b>	11,755	705	9,262	2,07	1,726	25	175	146	574	5,61

According to the data from Supreme Court of Georgia, in 2013 there were 13,751 first instance court decisions issued related to Article 45 of the Administrative Code of Georgia (see Table 19). In the vast majority of cases (93.8%), the decision was to apply a fine (GEL 500, € 226, and in a few cases (2.3%) the person was punished with administrative detention.

**Table 19: Number of individuals by the First Instance Court Decisions on Article 45 in 2013 (Georgia, 2014)**

Court Decisions	Number of individuals (n = 13,751)	%
<b>Administrative detention</b>	319	2,3
<b>Monetary fine</b>	12,899	93.8
<b>Freed from administrative responsibility</b>	259	1.9
<b>Case referred to the Prosecutor's office for further investigation</b>	274	2



According to the data on drug testing in 2013, from 60,196 tested persons positive results were detected only in 22,711 cases; and only 15 individuals appealed against the results of drug testing and in 12 cases the results were revoked. There has been serious concern raised by experts and human rights advocates in relation to the fact that “*tens of thousands of people are subject to administrative and criminal proceedings (including sentencing to prison terms) as a consequence of positive rapid immunoassay test results*” (Otiashvili, 2012). It has been suggested that possibly “*no other jurisdiction uses the results of rapid screening as evidence of drug use because of the issues related to the often low specificity of the tests, cross-reactivity, and the stability of these devices (their ability to resist certain conditions, such as temperature and humidity)*” (Otiashvili, 2012). Authors of the thematic report further argue, “*Elsewhere these results are considered preliminary and indicative, and advanced confirmatory laboratory tests are required for judicial proceedings.*”<sup>1</sup> (UNDCP, 2001a, UNDCP, 2001b). In Georgia, the results of these rapid and inaccurate tests are used as one of the main sources of evidence in court, leading to heavy fines or the imprisonment of thousands of people each year.

#### 9.2.4. Other drug related crime

Based on data provided by Supreme Court of Georgia, there were 15,166 individuals, including 561 (3.4%) women, convicted for committing any crime under the Penal Code of Georgia in 2013 by first instance courts. Among them 1,202 (7.9%) were under the influence of controlled substances at the time of offence – see Table 20. The highest share of convicts who committed crimes under the influence of controlled substances were individuals who violated Article 260 and Article 273 – 519 and 644 respectively. Among overall convicts almost every second individual (42%) was convicted for committing drug related crime, and every forth was committed for repeated use of drugs (article 273).

**Table 20: Number of crimes committed in 2013 and crimes committed under drug influence (Supreme Court of Georgia, 2014)**

Types of crime	Article of Penal code of Georgia	Convicted in total	Among them women	Committed under the influence of drugs
<b>Total</b>		15,166	561	1,202
<b>Intentional murder</b>	108	159	3	1
<b>Illegal deprivation of liberty</b>	143	82		1
<b>Theft</b>	177	3,112	171	10
<b>Robbery</b>	179	255	2	3
<b>Illegal purchase, possession, manufacturing, shipping, trafficking or sale of firearms</b>	236	533	2	1
<b>Hooliganism</b>	239	235	3	1
<b>Illegal drug production, manufacturing, purchase, storage, trafficking, sale</b>	260	2,660	34	519
<b>Illegal import, smuggling or international transit of drugs in Georgia</b>	262	52	5	2

1. UNDCP. (2001). Rapid on-site Screening of Drugs of Abuse. *Scientific and Technical Notes*. “Workplace and forensic screening for drugs of abuse is usually performed for medico-legal purposes. It includes forensic (search) and monitoring (control) operations or routine checks, providing a fast indication, or supporting a suspicion, for the abuse or the presence of illicit drugs. A positive result from a screening device is considered to be a presumptive result based on a selected cut-off concentration of a drug. Results are intended to separate presumptive positives from true negatives. In other words, when something in a biological specimen has reacted with the test, results provided by these devices indicate whether a drug or drug metabolite may be present. A final (evidential) detection of the presence of a drug of abuse requires appropriate laboratory procedures and approved analytical techniques. Only those samples that are positive by both screening and confirmatory methods should be reported as positive. The reasons for this are clear, since the consequences of a positive test result are often grave, involving corrective/punitive action, loss of a job, or even criminal proceedings”.

<b>Consumption of drugs</b>	273	3570	10	644
<b>Other drug related crimes</b>	261, 263-272, 274	174	2	5
<b>Violation of traffic safety or vehicle maintenance rule</b>	276	588	15	5
<b>Crime against the judiciary</b>	264-381	221	7	5
<b>Other crimes</b>		1351	160	5

### 9.3. PREVENTION OF DRUG-RELATED CRIME

There is no Crime Prevention Strategy adopted by the country. Subsequently, no specific prevention interventions targeting drug-related crime are implemented. In 2012, the Ministry of Justice established a Centre for Crime Prevention and launched a Rehabilitation and Re-socialization State Program. The main goal of the program is to support the rehabilitation of former prisoners released from the penitentiary system and to support their successful reintegration into the society. Former prisoners with a history of drug use or drug-related crime are eligible for this support, however, no specific drug-related interventions are provided.

In 2014 to respond to emerging problem of using new psychoactive substances by youth, the Ministry of Internal Affairs established an interagency council (uniting representatives of the Ministries of Justice; Finances; and Labour, Health and Social Affairs), named *National Commission Supporting Suppression of Distribution of New Psychoactive Substances* that aims at combating new psychoactive substances use and trafficking (see also 1.3.2). Together with the Council, MIA initiated changes in the drug legislation in order to regulate turn over of new psychoactive substances; laboratories providing drug-testing were equipped with more sensitive diagnostic test-kits; and initiated a national scale campaign “No New Psychoactive Drugs – Lets Change Attitude Together”. The latest is described in the *Prevention* chapter of this report – see 3.6.

### 9.4. INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM

No data on interventions in the criminal justice system are available so far. Institutional mechanisms of restorative justice (such as a diversion-mediation program as an alternative to the court process and imprisonment) started in the country in 2010d are not yet applied to drug related offences and this is not foreseen to change in the near future.

### 9.5. DRUG USE AND PROBLEM DRUG USE IN PRISONS

The Penitentiary Department is one of the largest departments of the *Ministry of Corrections and Legal Assistance*. Currently, penitentiary system includes 15 prisons with two medical establishments (multi-profile Central Correctional Hospital and TB Hospital), one correctional establishment for juveniles and one women’s special establishment. The majority of the institutions are mixed-type (semi-opened or semi-closed) establishments that are located in different regions of Georgia. The majority of the establishments (12) are located in East Georgia, while three establishments are located in West Georgia (Ministry of Corrections of Georgia, 2014).

Harsh drug legislation and legal practice has resulted in a dramatic increase in the number of people entering the prison system due to drug related offences and/or having drug related problems at the time of imprisonment. In a survey of 300 inmates, 213 (71%) respondents said they used narcotic drugs without doctor's prescription at least once. 137 (46%) out of all respondents have injected drugs at least once in their lives. None of respondents responded positively to the question about injecting drug use experience during the last year (while in prison). 55% of injecting drug users and 17% of non-injecting drug users had the experience of paying administrative fines for drug use (Lomidze et al., 2012). Based on the results of another study in total, 27.8% of women prisoners had been convicted of, or charged with, drug-related offences including drug dealing, transit, transportation and possession in large quantities (Penal Reform International, 2013).

In recent years number of sources has confirmed that Georgian prisons became virtually drug free. This information has been confirmed by both surveys conducted among inmates and information collected from former prisoners (Curatio International Foundation, and Center for Information and Counseling on Reproductive Health - Tanadgoma, 2013, Lomidze et al., 2012, Kvavilashvili and Pilauri, 2012). However, civil society activists and human rights advocates have argued that the cost of the elimination of drug smuggling into Georgian prisons – restriction of freedom and violation of fundamental human rights, degrading and humiliating treatment of inmates, beating and torture – had no analogue in civilized world and cannot be deemed acceptable, as well as “shifting” drug addicts to massive use of sedatives (Otiashvili et al., 2014, Georgian Harm Reduction Network and Eurasian Harm Reduction Network, 2014).

The new government has acknowledged abuse of prescription psychoactive drugs as a major problem for the penitentiary system and launched a relevant program to address the problem. It has been suggested that while the system became free of illicit drugs, the majority of inmates with drug use history have become dependent on psychoactive medicines (sedatives, neuroleptics and anti-depressants) prescribed by prison doctors or provided by the prison administration during their detention (Ministry of Corrections of Georgia, 2013). More than 2,400 inmates have been identified to be dependent on high dosages of sedatives as reported<sup>1</sup>.

## **9.6. RESPONSES TO DRUG-RELATED HEALTH ISSUES IN PRISONS**

### **9.6.1. Abstinence oriented drug treatment**

The Department of Addictology was recently opened at the Central Correctional Hospital (CCH) within the penitentiary system of Georgia, which offers drug free residential detoxification to the inmates. Eleven beds are available at the department staffed with a doctor-narcologist, nurse and psychologist. However, no long-term post-detox treatment (rehabilitation) is available there. The Health Strategy of the Ministry of Corrections and Legal Aids (MCLA) sets the target to introduce maintenance and substitution therapy to prisons from 2015 and drug dependence rehabilitation programs by 2016. However, no further details pertaining to the nature and extent of the program are provided in the MCLA Health Strategy for 2014-2017 document (Ministry of Corrections of Georgia, 2013).

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1. Overall number of prison population in 2013 was 9,093 (Geostat, 2015)  
[http://www.geostat.ge/index.php?action=page&p\\_id=602&lang=eng](http://www.geostat.ge/index.php?action=page&p_id=602&lang=eng)

### 9.6.2. Harm Reduction Measures

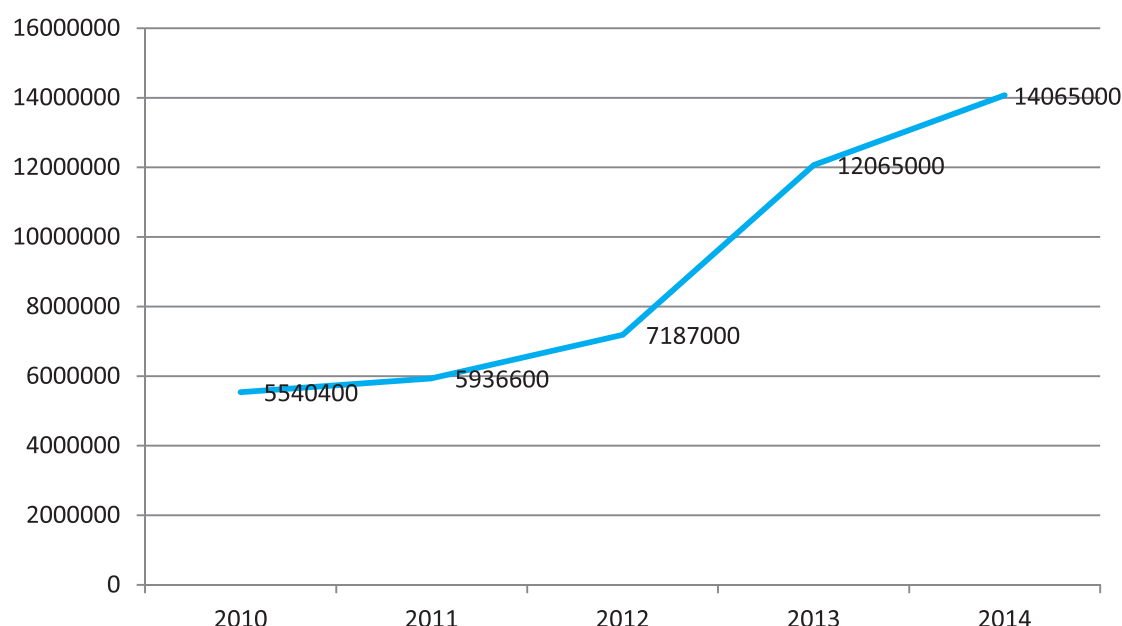
Detoxification with methadone is available in two pre-trial detention facilities – in Tbilisi (80 slots) and Kutaisi (50 slots). So far this treatment has been focusing on short and mid-term interventions (up to 6 months) with aim to detoxify inmates with opioid dependence in order to get them drug free by the time they are transferred to permanent detention institution. In its Health Strategy 2014-2017, MCLA sets the target to a) introduce long-term maintenance treatment with methadone, and b) to expand it to the permanent detention facilities (Ministry of Corrections of Georgia, 2013).

Other harm reduction programs have not been introduced into Georgian prisons. No sterile injection equipment is available for prisoners. Condoms are distributed by NGOs providing testing and counselling for HIV.

### 9.6.3. Access to and provision of health care services for drug users in prison

Overall, prison healthcare reform is considered one of the most successful initiatives under the new government. With a dramatic reduction in the number of prisoners new leadership of the MCLA took some effective steps to improve health care delivery in the penitentiary system. Health budget was dramatically increased – 100% increase between 2012 and 2014 as it is shown in Figure 18:

**Figure 18: Penitentiary Healthcare Budget 2010-2014, in GEL<sup>1</sup> (MCLA, 2014)**



Composed of multidisciplinary teams, Primary Healthcare Units are established in all prisons and fully correspond to the Georgian Healthcare standards. If the treatment of an inmate is not possible at the medical unit within the penitentiary establishment, he/she can be transferred to the Central Correctional Hospital. In case an inmate cannot be treated at the CCH, he/she may be transferred to one of the civil sector medical establishments. TB patients are treated at the separate TB Hospital (Medical Establishment for Tubercular Inmates in Ksani). Dental service is available in all penitentiary institutions. Voluntary counselling and testing for HIV/AIDS and universal (delivered to all those in need) ART are

1. 2010 GEL/€ ~ 2.36, 2011 GEL/€ ~ 2.34, 2012 GEL/€ ~ 2.12, 2013 GEL/€ ~ 2.21, 2014 GEL/€ ~ 2.34

available for all inmates and are delivered by the same health facility (*AIDS Centre*) as in the civil sector using the same protocols and medicines. TB and HCV testing and treatment is organized in a similar way. With regard to the availability of HCV treatment, there has been general breakthrough in the country – joint efforts by civil society organizations and the government resulted in a 60% reduction in price for HCV medications. As a result, this treatment can be now available for 1,000 prisoners for free, and at a significantly reduced price for 10,000 patients in the general society.

#### **9.6.4. Reintegration of drug users after release from prison**

Pre-release programs are at the embryonic stage in Georgia. MCLA reports that such programs are available in three facilities, including a women's facility. Psychologists and social workers start to work with inmates 4-6 months prior to their release (Kvavilashvili and Pilauri, 2012). In 2014, EC funded a project "Promotion of Social Reintegration: establishment of social bureaus for former prisoners and probationers and improving pre-release programs in prisons" (see chapter 8.3) which is functional in the four largest cities of Georgia – Tbilisi, Batumi, Kutaisi, Zugdidi. The opening of a "half way house" institution which will serve prisoners before release and prepare them for re-socialization is planned.

In addition prisoners with diagnosis of TB, HIV/AIDS, Hepatitis C whose treatment was initiated during their imprisonment, are referred to the relevant facilities in civil sector upon their release.

## 10. DRUG MARKETS

### 10.1. INTRODUCTION

The Ministry of Internal Affairs (MIA) is the major and often the only source on data related to illicit drug markets and drug seizures. Annual statistics concerning drug seizures were obtained through specific written requests sent to the MIA. Some information was collected from the website of the MIA and number of reports by international organizations and local NGOs.

### 10.2. SUPPLY TO AND WITHIN THE COUNTRY

With no indications of organized local production of illicit drugs, Georgia traditionally has been considered a transit country for illicit heroin smuggled from Afghanistan and Iran through Azerbaijan to Turkey, Russia and Western Europe. A certain share of heroin transited through the country is destined for local consumption. There are fragmented reports on the local cultivation of cannabis plants in certain regions of the country, however, its scale is not known.

Law enforcement interventions targeting traditional injection drugs, such as heroin and buprenorphine, resulted in significant decrease in the availability of these drugs on illicit drug market. Reduction in availability of heroin and buprenorphine contributed to the emergence and spread of home production of injection preparations. Amphetamine-type stimulants (ATS) called “Vint” or “Jeff” produced from available over the counter medicines containing ephedrine and pseudoephedrine became drugs of choice for the drug injecting population in Georgia. In addition, production and injection use of home-manufactured opioid desomorphine (“Krokodil”) produced from codeine-containing medicines became widespread.

Both home-made stimulants and home-made opioids are usually prepared and injected by a group of 3-5 people. At the final stage of the process, the solution is drawn into a 20 ml syringe and then front-loaded into individual 2-5 ml syringes. The solution is injected 2-5 times a day, is not stable and there are no reports indicating production of relatively large volumes will keep for more than the next few days. No dealing of “Vint”, “Jeff” or “Krokodil” solution has been reported, suggesting that preparations are exclusively cooked for personal use.

Development in substance use patterns and drug markets obviously depends on a complex set of contributing factors and national socio-economic context. Not surprisingly, in many cases drug use trends and markets in Georgia were shaped by policy response, legislative framework and law enforcement practice implemented at particular periods of time. It has been argued that the relatively long-lasting effect of buprenorphine injection (compared to heroin or opium) and less obvious external signs of intoxication contributed to its popularity in the Georgian drug use setting (Otiashvili et al., 2010). Since the mid-2000s, there has been a dramatic increase in police activity aimed at random street searches and (urine) testing of people for drugs, which, in the event of drugs being found or a drug-positive urine toxicology result, leads to harsh penalties (Otiashvili et al., 2008). Thus, buprenorphine might have



attracted drug users because of its moderate clinically visible signs after its intake. Furthermore, for several years the police did not check suspects for the presence of buprenorphine in their urine, but rather concentrated on the traditional opiates such as heroin. This lack of detectability could in fact have added to the ‘attractiveness’ of buprenorphine and other drugs for local drug users. Similarly, a pattern of increased home-made stimulants and home-made opioids injection followed the reduced availability of heroin and other “traditionally” used opioids opium, buprenorphine and codeine. This was partially preconditioned by the fact that police traditionally targeted heroin and opioid markets and users switched to alternatives which did not necessarily require involvement with the illegal drug market. Again, for an initial period of time neither “Vint” and “Jeff” nor “Krokodil” were properly detected through urine toxicology testing. Importantly, these alternatives were remarkably cheaper – approx. GEL 10–15 (€ 4.5–6.5) per single dose of “Vint”, “Jeff” or “Krokodil” as compared to GEL 100–150 (€ 45–65) per single dose of heroin or buprenorphine.

### 10.2.1. New Psychoactive Substances

Topic of new psychoactive substances (NPS) was intensively discussed in media in 2013-2014. Anecdotal and media reports suggested widespread use (smoking, injection) of preparations mostly purchased through online resources and delivered via small scale individual international shipments. Based on those reports, new substances are mostly synthetic cannabinoids, stimulants and hallucinogenic drugs, all termed by the nickname “Bio” by general public and drug users in Georgia. There have been a number of media reports describing cases of overdose and death associated with abuse of “Bios”. However, it has been unclear which particular substances or combinations were consumed as well as to what could have been the actual cause of death in each specific case. There are no evidence-based data available on the nature of NPS used in Georgia, prevalence of use, or characteristics of users. Some media reports suggest that NPS are mostly used by younger experimenter and not to a large extent by problem drug users. However, it is difficult to confirm or reject such claims.

As described in Chapter 1.2 and New Development in Drug Policy, in 2014, MIA initiated number of amendments to the legislation concerning unauthorised handling of new psychoactive drugs. By Autumn of 2014, representatives of the Ministry reported a significant reduction in use of new psychoactive drugs - “According to the May-August data of 2014, the import of new psychoactive substances across the borders has decreased approximately by 11 times, in comparison to the data of the same period of 2013” (Ministry of Internal Affairs of Georgia, 2014). However, it is not clear what the actual evidence behind the statement was.

## 10.3. SEIZURES

The Table 21 shows quantities of illicit drugs seized by the MIA within the period of 2006-2013:

**Table 21: Amount of seized drugs in the period 2006-2013 (MIA, 2006-2014)**

	2006	2007	2008	2009	2010	2011	2012	2013
<b>Heroin (kg)</b>	8.6	16.2	12.1	2.3	1.3	0.9	0.3	117
<b>Opium (kg)</b>	0.2	0.2	0.05	0.04	0.02	0.002	0.01	0.05



<b>Marijuana (kg)</b>	24	23.6	28.3	4.7	33.34	32.12	30	71.6
<b>Tramadol (kg)</b>	0.07	0.1	0.7	0.08	0.03	0.03	0.01	0.1
<b>Cannabis plants (kg)</b>	123.3	65	41.6	no data available	117	70.4	21	217.8
<b>Methadone (kg)</b>	0.02	0.2	0.3	0.07	0.007	0.004	0.042	0.009
<b>Subutex®(kg)</b>	—	—	—	—	—	0.02	0.006	0.01
<b>Subutex® (in pills)</b>	10,958	16,232	13,757	5,072	3,175.5	—	—	—

These data are based on the official letter provided by the MIA in response to requests submitted by authors of current reports. The webpage of the MIA also reports a number of historically major seizures in 2014 including the seizure of 2,800 kg of “liquid” heroin and 5.3 tons of cannabis plants (Ministry of Internal Affairs of Georgia, 2014).

#### 10.4. PRICE/PURITY

No data on drug prices and drug purity are available so far in Georgia because data collection and monitoring is not based on the standard indicators defined by EMCDDA.

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## ACRONYMS

ART –	Antiretroviral Treatment
ATS –	Amphetamine-type stimulants
BSS –	Bio-Behavioural Surveillance Survey
CCH –	Central Correctional Hospital
CCM –	Country Coordinating Mechanism (on HIV/AIDS)
DRD –	Drug Related Death
EC –	European Commission
EMCDDA –	European Monitoring Centre for Drugs and Drug Addiction
ESPAD –	European School Survey Project on Alcohol and Other Drugs
EUDAP –	European Drug Prevention Program
FSW –	Female Commercial Sex Worker
GARP –	Global AIDS Report
GFATM –	Global Fund on AIDS, Tuberculosis and Malaria
GHPP –	Georgian HIV Prevention Program
GHRN –	Georgian Harm Reduction Network
HBV –	Viral Hepatitis B
HCT –	HIV Counselling and Treatment
HCV –	Viral Hepatitis C
HIV/AIDS –	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HR –	Harm Reduction
HRDU –	High Risk Drug Use
IDU –	Injecting Drug User
LEPL –	Legal Entity Public Legal Body
LTP –	Lifetime prevalence
MARPs –	Most at Risk Populations
MdM –	Médecins du Monde
MES –	Ministry of Education and Science
MCLA –	Ministry of Corrections and Legal Assistance
MH –	Mental Health

MIA –	Ministry of Internal Affairs
MoJ –	Ministry of Justice
MoLHSA –	Ministry of Labour, Health and Social Affairs of Georgia
MSM –	Man having Sex with Man/ Men having Sex with Men
MSY –	Ministry of Sports and Youth Affairs
NCDC -	National Centre for Disease Control
NGO –	Non-Governmental Organization
NSP –	Needles and Syringe Exchange Program
OSGF –	Open Society Georgia Foundation
OSI –	Open Society Institute
OST -	Opioid Substitution Therapy
PDI –	Peer Driven Intervention
PDU -	Problem Drug Use
PWID -	People Who Inject Drugs
PWUD –	People Who Use Drugs
RPR -	Rapid Plasma Reagin
RDS -	Respondent-driven Sampling
SAMSHA –	Substance Abuse and Mental Health Self Administration
SCAD -	Southern Caucasus Anti-Drug Programme
STI –	Sexually Transmitted Diseases
UNAIDS –	United Nations AIDS Fund
UNODC –	United Nations Office on Drugs and Crime
UNGASS –	United Nations General Assembly Special Session
USAID –	United States Agency for International Development
VCT –	Voluntary Testing and Counselling
WHO –	World Health Organization

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