

# Impact of the COVID-19 epidemic on drug markets and behavior of people who use drugs in Georgia

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## **Main abbreviations**

ASI - Addiction Severity Index

CMHPA - Center for Mental Health and Prevention of Addiction

COVID-19 – Corona Virus Disease

EDM – Electronic Dance Music

ESPAD - European School Survey Project on Alcohol and Other Drugs

GHRN - Georgian Harm Reduction Network

HCV – Hepatitis C Virus

HIV – Human Immunodeficiency Virus

IBBSS - Integrated Bio-Behavioural Surveillance Survey

LGBTQ - Lesbian, Gay, Bisexual, Transgender and Queer

NPS – New Psychoactive Substances

OR - Odds Ratio

OST – Opioid Substitution Treatment

PWID – People Who Inject Drugs

PWUD – People Who Use Drugs

SVM - Syringe Vending Machine

TLFB – Timeline Follow Back

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## Executive summary

The aim of the study was to describe potential impact of coronavirus disease epidemic (COVID-19) on trends in illicit drug use, drug supply, risk behaviors and utilization of drug-related services among people who use drugs (PWUD) regularly in Georgia. The study employed mix-method approach and utilized quantitative and qualitative methodologies to collect and analyze data. Prospective cohort of 50 Georgians who use drugs regularly participated in online quantitative survey conducted repeatedly every other week in April – September, 2020. Cohort participants were also invited to take part in phone-based qualitative interviews at 3- (end of June) and 6-month (end of September) follow-up time points. In addition, 4 key informants (experts in illicit drugs field in Georgia) were interviewed repeatedly every month to collect data on their perceptions in relation to changes in illicit drug supply and drug users' behaviors. Finally, a major online illicit drug market *Matanga* was monitored to examine trends in illicit drug sales on its Georgian segment.

Results of the study suggest that the reduction in incomes, coupled with COVID-19 related measures introduced by the government resulted in shifts in drug related behaviors. Many individuals who use drugs switched to use alternative substances when preferable drugs were not available. Overall, study participants used fewer variety of different substances by the end of the study if compared to the baseline use. Findings of the cohort study with regard to availability, quality and prices for specific drugs were mixed and inconclusive. There was an increase in the availability of diverted medicinal methadone and buprenorphine on a market, that followed a decision to allow for 5-day take-home dosing of these medications for all opioid substitution treatment (OST) patients. The scale of the diversion, however, remained unclear.

Market players, both sellers and buyers showed remarkable flexibility while adjusting to new environment and market conditions. When stable contacts with dealers were affected PWUD searched for new contacts and supply options. This manifested, for example, in increased level of interactions between networks of PWUD and reinforcement of the role of middleman as an important actor in drug supply. The study once again highlighted the role of a social supply in Georgian drug scene.

When access to sterile needles and syringes was limited due to imposed restrictions on movement, drug users exercised risk-containing injection behaviors. However, when access to sterile equipment was restored, study participants tended to return to relatively safe injection practices. Despite some interruptions in service delivery during the first weeks of lock-down, providers of treatment and harm reduction services showed remarkable flexibility and were able to implement effective strategies to deliver services. For delivery of harm reduction services such approaches included using mobile vans more extensively, intensifying utilization of self-testing technologies and delivering prevention equipment to clients where they lived. Utilization of syringe vending machines located in Tbilisi sharply increased at that time. Demand for OST increased as soon as epidemic-related restrictions were enforced. OST providers were able to adjust quickly and effectively to new situation – all new clients were admitted to treatment and take-home dosing was implemented. Patients in quarantine received medication without any interruption.

Results of an online market monitoring suggest that, despite COVID-19 related restrictions, the *Matanga* platform was actively used to purchase illicit drugs. Over 6 months of monitoring there were more than 22,000 sale transactions, and total revenues exceeded \$4.5 million. Cannabis products accounted for the largest volume of sales, both in terms of a number of transactions and in terms of revenues generated. It is challenging to understand to what extent the online market was able to rapidly respond to emerging trends in the demand for specific substances. Seemingly, online shops were able to follow the demand at least to some extent. It was unclear what factors impacted on the final unit cost of a specific substance and why prices for some drugs offered through online market have increased over the studied period, and for others have not.

Results of this study provide useful implications for public health policy development. Harm reduction and treatment services need to develop and implement clear protocols for ensuring uninterrupted service delivery during lock downs that can be enforced in a future in response to similar epidemics or any other emergency situations. Such protocols should consider positive experience accumulated during the COVID-19 related restrictions, such as flexible dosing of substitution medication, utilization of HIV self-testing technologies, mobile van-based outreach, vending machines for dispensing HIV prevention equipment, but also should elaborate additional new strategies and means that would allow for rapid adjustments to emergency contexts. OST programs need to develop and implement clear and flexible protocols for medication take-home dosing. Rigid requirements for daily visits serve as a barrier to seek treatment for many individuals who might potentially benefit from this treatment. Treatment protocols and regulations need to ensure a balanced approach to medication dispensing practices while weighting against risks for diversion of treatment medications and enormous public health benefits associated with OST. Finally, continuous monitoring of online platforms for illicit drug sales can provide useful data to better understand the dynamics of illicit drug market, timely identify emerging patterns in drug supply and can be an important source of data for a national early warning system.

## Background: Drug situation in Georgia prior to COVID-19

### Prevalence of drug use

The first general population survey on drugs conducted in 2015 resulted in estimates for past 30 day use of tobacco, alcohol and herbal cannabis being 29.7% (95% CI 28.2%-31.3%), 49.2% (95% CI 47.0%-51.4%) and 1.2% (95% CI 0.9%-1.7%) respectively (Kirtadze et al., 2018). Past 30 day use of psychoactive medications without doctor's prescription was 4.9%. Consumption of other illicit drugs was almost non-detectable in that study. Based on the results of the recent European School Survey Project on Alcohol and Other Drugs (ESPAD) use of illicit drugs among 16 years old school student was relatively similar to the average European rates and the prevalence of use of new psychoactive substances (NPS) was lower if compared to the prevalence rates among European counterparts. Prevalence of lifetime use was 16% for any drug, 14% for cannabis products, 2.2% for MDMA/ecstasy, 1.9% for LSD, 1.3% for cocaine and 1% for amphetamines (ESPAD Group, 2020).

With an estimated 52,000 people who inject drugs (PWID), the 2.2% prevalence of injection drug use in Georgia ranks third highest in the world (Bemoni Public Union & Curatio International Foundation, 2016; UNODC, 2019). For the past decade the problem/high risk drug use patterns in the country can be characterized as polydrug use of opioid products, such as heroin and buprenorphine, and stimulants with a substantial share (however, declining in recent years) of home-made injectable preparations (Beselia et al., 2019). It has been suggested that the harsh drug policies and legal sanctions for people who use drugs, as well as the high prices and fluctuating availability of traditional drugs, have pushed drug users towards the exploration of alternative sources of drugs and stimulated the proliferation of a user-driven home production of psychoactive drugs (Otiashvili et al., 2016). The concurrent and often-unstructured use of multiple substances has remained an important characteristic of drug scenes in the country. However, available recent data show a reduction in the use of home-produced preparations and an increase in a proportion of ready-to-use opioids and stimulants among PWID (Beselia et al., 2019). This includes new psychoactive substances (NPS) that are becoming increasingly available on diversified illicit markets (Beselia et al., 2019). The fluctuating availability of traditional drugs, low detectability of many NPS by police, high potency, ease of acquisition, and low prices all have been contributing to this shift. Often, NPS can be used in addition to regular injecting drugs.

Use of psychoactive substances in a recreational, mostly nightlife, setting is an emerging phenomenon in Georgia. About two thirds of attendees of electronic dance music (EDM) events reported using drugs in the past 30 days, the majority of respondents had experience with two or more drugs consumed in this setting with the most prevalent substances being MDMA/ecstasy, cannabis products, synthetic cannabinoids, amphetamines, and ketamine (Beselia, Kirtadze I., & Otiashvili, 2018; Otiashvili et al., 2019). The majority reported mixing drugs with alcohol to achieve the desired effects. In many instances, consumers did not know what substance they were using and fully relied on information provided by others, often-unknown individuals.

## Health correlates and service provision

The HIV prevalence among PWID in Georgia is relatively low (2.3%) if compared to other countries in the region such as Belarus (30.8%), Ukraine (22.6%) and Russian Federation (26%) (UNAIDS, 2019). The coverage by HIV prevention interventions among PWID, including low threshold harm reduction services, has expanded in the past decade. Harm reduction services for PWID are available through 18 fixed harm reduction sites and 8 mobile van based laboratories for HIV and hepatitis C virus (HCV) testing that also provide needle and syringe exchange services. In 2019, such services (testing and counselling, needle and syringe distribution and other auxiliary services) were provided to about 28,000 PWID and their partners (Georgian Harm Reduction Network, 2020). Treatment for substance use disorders is available in 10 narcological (addiction medicine) clinics providing abstinence-oriented treatment in- and out-patient services, 20 state-funded sites for OST using methadone as a substitution medication, and 8 private/commercial OST sites that use Suboxone® (buprenorphine + naloxone). Some 12,000 opioid dependent PWID received OST with methadone or buprenorphine in 2018 (Beselia et al., 2019). This treatment is provided in 2 out of 15 penitentiary facilities in Georgia but only in the form of detoxification during which methadone is prescribed in tapering doses within 3- to 6-month period (Boci et al., 2017; Kirtadze I. et al., 2019). Prison needle and syringe programs are not available. HIV treatment is free and universally available in the country. The lack of available data does not allow discussing other health consequences of drug use, for example the rates of deaths that occur as a consequence of psychoactive substance use.

## Drug supply and distribution routes

Traditional distribution schemes for conventional drugs in Georgia (face-to-face contact with dealer) have been influenced by small-scale “freelance” dealing<sup>1</sup> and massive kitchen-based self-production of drugs (Otiashvili, Tabatadze, Balanchivadze, & Kirtadze, 2016). Recent studies however suggest the diffusion of alternative distribution models. Mobile applications (e.g., *Telegram*) and online markets (e.g., *Matanga*) have been actively utilized for drug procurement in Georgia (Natenadze, 2019) with about a quarter of respondents (who used NPS) in one study reporting purchasing their drugs online (Subeliani et al., 2020). The virtual dealers employ a common *modus operandi* – upon the receipt of the payment the consumer is provided with the coordinates and a photo of the place where their purchase (the drug) has been hidden in advance. Festival and nightclub attendees reported that in a majority of cases drugs were obtained from friends (Subeliani et al., 2020). One in five reported obtaining drugs at the EDM venue. When doing so, a vast majority claimed they were given the substance for free, mostly by friends, but also by someone they did not know.

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<sup>1</sup> Illicit drug distribution by individuals not affiliated with any organized drug supply networks, but who are engaged in drug supply on occasional basis



## Study methodology and analytical approach

The aim of the study was three-fold:

*Aim 1: To describe changes in drug-related behavior among individuals who use illicit psychoactive drugs regularly in terms of types, amounts and combinations of substances used, routes of administration, ways of obtaining illicit substances, prices and perceived quality/purity of those substances.*

*Aim2: To examine stakeholders' perspectives regarding changes in availability, pricing, quality of drugs, behavior of PWUD, availability and utilization of services.*

*Aim 3: To examine changes in online drug market.*

The study relied on multiple sources to collect data and employed a combination of methodologies to triangulate the results.

### Prospective cohort study of individuals who use drugs regularly

*Recruitment.* Research team utilized a snow-ball sampling with 8 relatively heterogenous seeds (injection and non-injection users, club drug users, representatives of lesbian, gay, bisexual, transgender and queer (LGBTQ) to recruit PWUD regularly. For the purpose of this study, regular use was defined as at least weekly use of illicit psychoactive substances (excluding cannabis products). Communication with participants was done via mobile phones (SMS, calls). *Quantitative data collection.* A free online platform *Kobotoolbox* was used to collect data every other week. Participants had a 3-day window period to login and complete the survey. In the morning on every data collection time-point each participant received SMS-reminders with survey link, session number and participant ID. The study timeline is presented in **Figure 1**. *Instrument.* Study team used a locally developed structured 39-items multi-choice (Q16-39 for follow-up) questionnaire that covered socio-demographics, types and patterns of drug use, supply methods, drug prices and quality, availability and utilization of drug-related health services. The questionnaire utilized modified modules of standardized instruments Timeline Follow Back (TLFB) (Robinson, Sobell, Sobell, & Leo, 2014; Sobell et al., 1996), Addiction Severity Index (ASI) (McLellan et al., 1992) and risk behaviour questionnaire used for Ukrainian Integrated Bio-Behavioural Surveillance Surveys (IBBSS) (Dumchev, Sazonova, Salyuk, & Varetska, 2018). Prior to launch, the survey tool was tested with potential participants. Study outcome variables and measures are presented in **Table 1**.

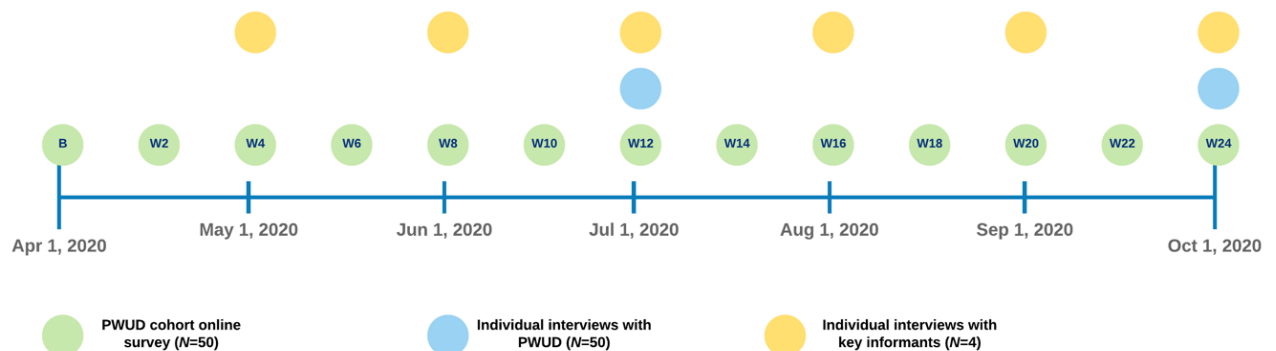
**Table 1. Outcome variables, measures and assessment time points.**

Outcome variable	Measure	Time point
Socio-demographic characteristics	Age	Week 0 (baseline)
	Gender	Week 0
	Education	Week 0
	Employment status	Week 0
	Source of income	Weeks 0-24 (0, 2, 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24)
Drug use	Drugs ever used	Week 0
	Age of first use (by drug)	Week 0
	Dugs used in the past 12 months	Week 0
	Dugs used in the past 14 days	Weeks 0-24
	Route of administration (by drug)	Weeks 0-24
Drug supply	Source of drugs (by drug)	Weeks 0-24
	Price paid/dose	Weeks 0-24
	Perceived change in price	Weeks 0-24
	Perceived change in quality	Weeks 0-24
	Perceived access to drugs	Weeks 0-24
Frequency of use	Times/day	Weeks 0-24
	Days/week	Weeks 0-24
History of overdose	Number of overdoses ever	Week 0
	Number of overdoses in the past 14 days	Weeks 0-24
	Drug caused last overdose	Weeks 0-24
Drug treatment experience	Number of treatment episodes ever (by type)	Week 0
	Currently in treatment (by type)	Weeks 0-24
	Treatment initiation in the past 14 days (by type)	Weeks 0-24
	Number of days in treatment in the past 14 days (by type)	Weeks 0-24
Risk behavior related to the spread of infections	Frequency shared needle/syringe in the past 14 days	Weeks 0-24
	Receiving (yes/no) already filled in syringe in the past 14 days	Weeks 0-24
	Using syringe (yes/no) filled from other syringe in the past 14 days	Weeks 0-24
	Sharing injection instruments (yes/no) in the past 14 days	Weeks 0-24
	Frequency having clean needle/syringe for each injection in the past 14 days	Weeks 0-24
	Frequency shared vaporizer, inhaler, tube, pipe in the past 14 days	Weeks 0-24
Access to harm reduction	Source of clean needles/syringes in the past 14 days	Weeks 0-24
	Reasons not having clean needles/syringes in the past 14 days	Weeks 0-24
	Perceived change in access to harm reduction	Weeks 0-24
COVID-19 experience	Being tested for COVID (yes/no) and test results (-/+)	Weeks 0-24
	Being hospitalized for COVID (yes/no) and number of days	Weeks 0-24

**Statistical analysis.** The sociodemographic and behavioral profile of the study participants was described using frequencies and proportions (for categorical variables) and means for continuous variables, as appropriate. Analysis utilized mixed-effects generalized linear models, accounting for within-subject correlation across time points, to test the hypothesis of

a linear trend for selected outcome variables. The assessment number, ranging from 1 to 13, was used as a continuous variable representing time. Odds Ratios (ORs) for the assessment number represent an incremental increase or decrease in the estimated odds of achieving the outcome in the subsequent assessment. The models were adjusted for the duration of drug use, sex, and baseline lifetime exposure to OST. **Qualitative data collection.** Qualitative telephone interviews were conducted with participants at 12 (40 interviews) and 24-week (34 interviews) time-points. The interview guide covered topics related to perceived changes in drug supply and drug use behaviors, and factors influencing them. With the consent of respondents interviews were recorded using a voice recording mobile application. **Qualitative data analysis.** Two research assistants conducted individual interviews and transcribed recordings. Data were analyzed using software for qualitative analysis Nvivo v.11 (QSR International Pty Ltd., 2019). We utilized a framework analysis approach for this study. Following the reading and rereading of the textual data the list of key themes was developed. A set of codes that were organized into categories was agreed and was applied to transcripts. However, if new ideas and new ways of categorizing were identified in the text, the list of hierarchical codes was amended. This approach helped to identify commonalities and differences in data and to draw descriptive and explanatory conclusions clustered around themes.

**Figure 1. Study timeline.**



## Prospective cohort study with key informants

**Recruitment.** Four key informants were recruited from the pool of individuals working in the field of psychoactive substance use in the country that were familiar to the study team. Final composition of key informants' group was: head of harm reduction site, head of OST site, head of a largest private detoxification clinic and head of drug users' community organization<sup>2</sup>. **Data collection.** Key informants were interviewed at the end of each study month (6 interviews with each respondent) via phone and were asked to provide their perspective about changes in drug market and user behavior during the last month. Interview guide covered following four domains: (1) drug markets (availability, supply channels, quality, prices), (2) behavior of PWUD with regard to drug procurement and ways of consumption, (3) risk containing

<sup>2</sup> Study team intended to include representative of Ministry of Interior; however, the ministry did not respond to a relevant request.

behaviors, and (4) availability and utilization of drug-related health services. Interviews lasted 15-30 minutes and were recorded with the permission of the respondents. Qualitative data analysis followed the same steps as with qualitative data from PWUD cohort.

### ***Ethical aspects of the study.***

This study was approved by the Bio-ethics Committee of the School of Arts and Sciences at Ilia State University in Tbilisi, Georgia. Informed consents were obtained from all participants. Research staff complied with common international standards for human subject protection and data safety. No identifiable personal information was obtained from cohort participants. PWUD cohort participants received reasonable monetary incentives for participating in the study.

### **Monitoring online illicit market**

We used a locally developed software to monitor and record transactions on a major online drug market *Matanga* used in Georgia. The software consisted of two parts: a scraper written in Python and an exporter written in Golang. They were both located on a server in Germany. This server run the scraper each hour. The scraper visited *Matanga* through Tor so that it could be anonymous and avoid being banned. It collected all relevant product information and saved it on the server. It visited each region page under Georgian segment of the webpage. To accomplish this the scraper used Selenium, a simulator which made *Matanga* think it was accessed from a normal browser. The exporter was a simple website which allowed authorized access to all the data collected by the scraper. It can be used to convert and export data to comma separated values (CSV) format. It exported raw snapshots, transactions and productions (new offers). The raw snapshots were unmodified raw data which just showed the inventory of *Matanga* on a given hour. The transaction data, on the other hand were an estimation of how much products were sold based on the snapshot data calculated by counting the differences in the weights and numbers of items in stock. The production data were similar to transaction data but were calculated inversely – instead of counting the reductions in the weight of a product in stock at a given time, they counted increases. Each time an increase was detected by the software, it was counted as a production (new offer), in other words, it was assumed that new units of the product were added to the sales list. This also applied to new products appearing on the store. To estimate transactions, the following variables were used: name of the item, name and code of the seller, count of units, volume of the unit (grams or number of tablets and blotters), unit cost. Qualified substance use researcher fluent in Russian, English and Georgian cleaned the data manually and grouped items in unique categories of substances. Information that was not relevant for drugs was filtered and deleted, for example announcements for courier vacancies.

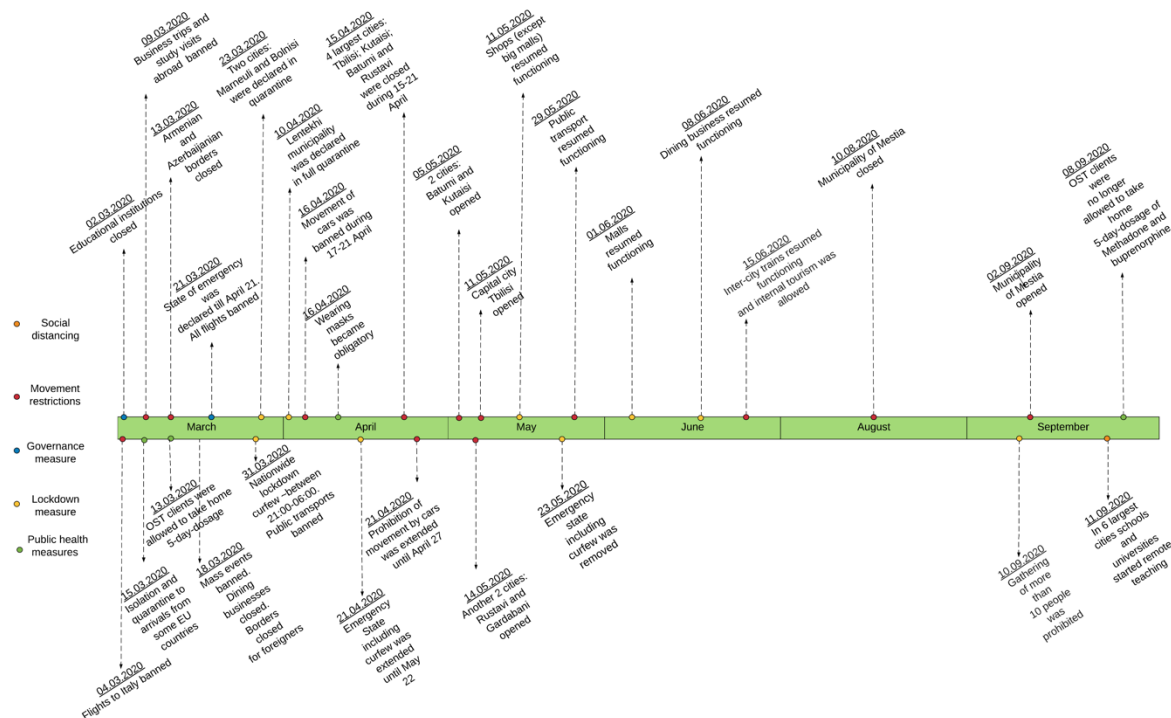
## Results

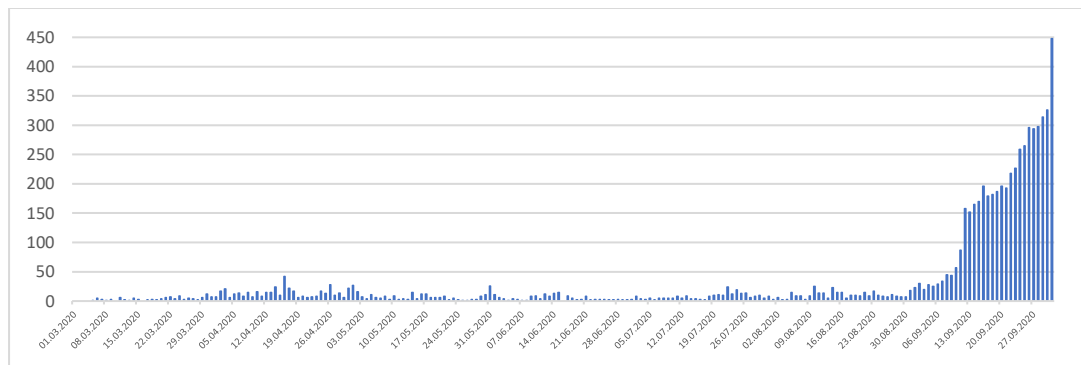
Results of the implemented studies are presented in a way to provide meaningful understanding of the changes that occurred during the period of the study. Section starts with the description of the characteristics of PWUD cohort participants (socio-demography and drug use) and then presents the results in relation to specific outcomes of interest (e.g. drug use, perceived availability on the market) and relevant changes that occurred over the study period. In relation to specific outcomes, the results of online quantitative survey are presented first and then relevant results of qualitative studies (both with PWUD and key informants) are introduced to supplement quantitative findings and provide insight into the context which surrounded the observed developments in illicit drug markets and PWUD behaviors.

### Overview of the COVID-19 related epidemiological situation and restrictive measures implemented by the government

*In Georgia the first case of COVID-19 was documented on March 5.* During the March-May there were number of steps undertaken by the government in response to COVID-19 emergence and restrictive measures were gradually removed starting from late May – see **Figure 2** for details. Strict measures that included some form of total lockdown helped to keep the incidence of new infection relatively low until a number of new cases started to surge in mid-September – see **Figure 3**.

**Figure 2. Timeline of regulatory and restrictive measures implemented by the government in response to COVID-19 epidemic.**



**Figure 3. Number of new COVID-19 cases March-September, 2020.**

## Characteristics of the PWUD cohort

There were 13 sessions for online quantitative survey conducted every other week starting from April 7 and ending on September 24. One participant dropped out after the sixth session. Overall, 40 sessions (6.15%) were missed out of 650 planned sessions. Mean age of participants was 36 (range 18-60), the vast majority were males, and slightly more than a half were employed at baseline. Full- or part-time job as a main source of income was reported by 54% at baseline - see **Table 2** for details. 34% (n=17) had a history of at least one treatment episode for substance use related disorders. Over the course of the study 27 participants reported being tested for COVID-19 and none was positive.

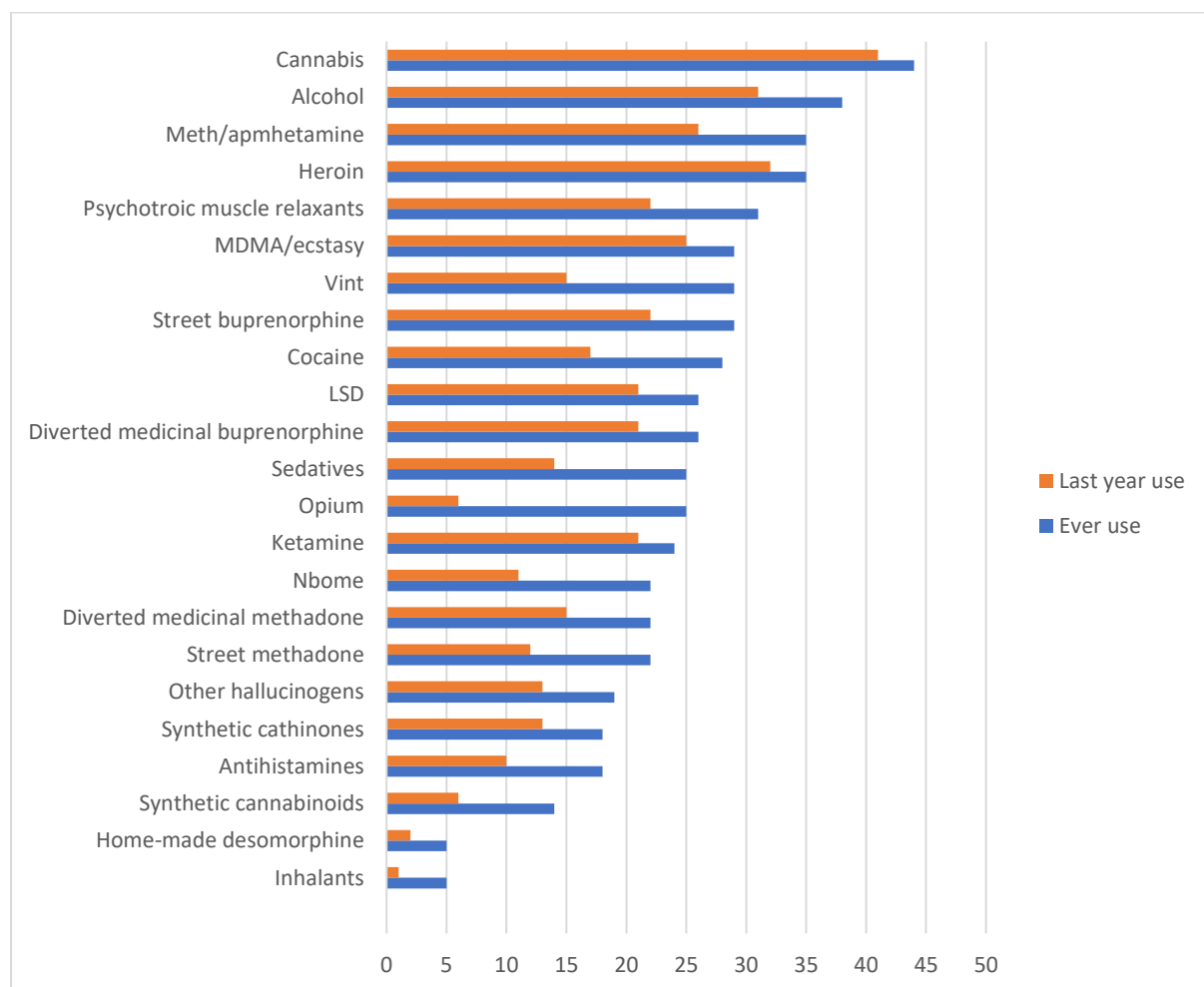
**Table 2. Socio-demographic characteristics of participants at baseline (N=50).**

Variable	N (%)
<b>Age</b>	
15-19	1 (2)
20-24	6 (12)
25-29	8 (16)
30-34	7 (14)
35-39	11 (22)
40-44	7 (14)
45-49	6 (12)
50-54	2 (4)
55-59	1 (2)
60-64	1 (2)
Mean (SD)*	36 (9.88); SE ( $\pm 1.4$ ); Median 36.5; Mode 38; min=18, max=60; percentiles: 25 <sup>th</sup> - 27.75; 50 <sup>th</sup> - 36.50; 75 <sup>th</sup> - 42.25;
<b>Sex</b>	
Male	39 (78)
Female	10 (20)
Nonbinary	1 (2)
<b>Education</b>	
Incomplete high school	5 (10)
Completed high school	8 (16)
Completed high school-vocational	4 (8)

Incomplete university	13 (26)
Completed university	20 (40)
<b>Employment status</b>	
Employed	27 (54)
Student and employed	2 (4)
Retired/social benefit	1 (2)
Unemployed	20 (40)
*- Standard Deviation	

Expectedly, cannabis products were the most often used substances both ever in life and in the past 12 months. They were followed by alcohol and heroin. Use of amphetamine and methamphetamine, MDMA/ecstasy and psychotropic muscle relaxants (such as gabapentine, pregabalin) was also relatively high – see **Figure 4**.

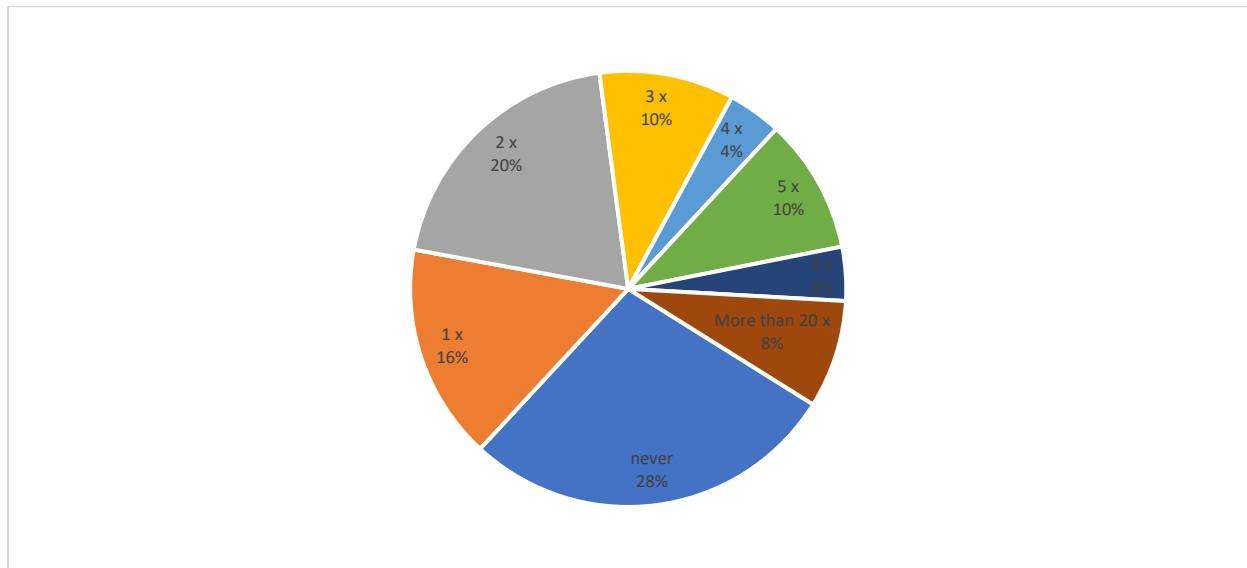
**Figure 4. Lifetime and past year prevalence of use of psychoactive substances at baseline (N=50).**



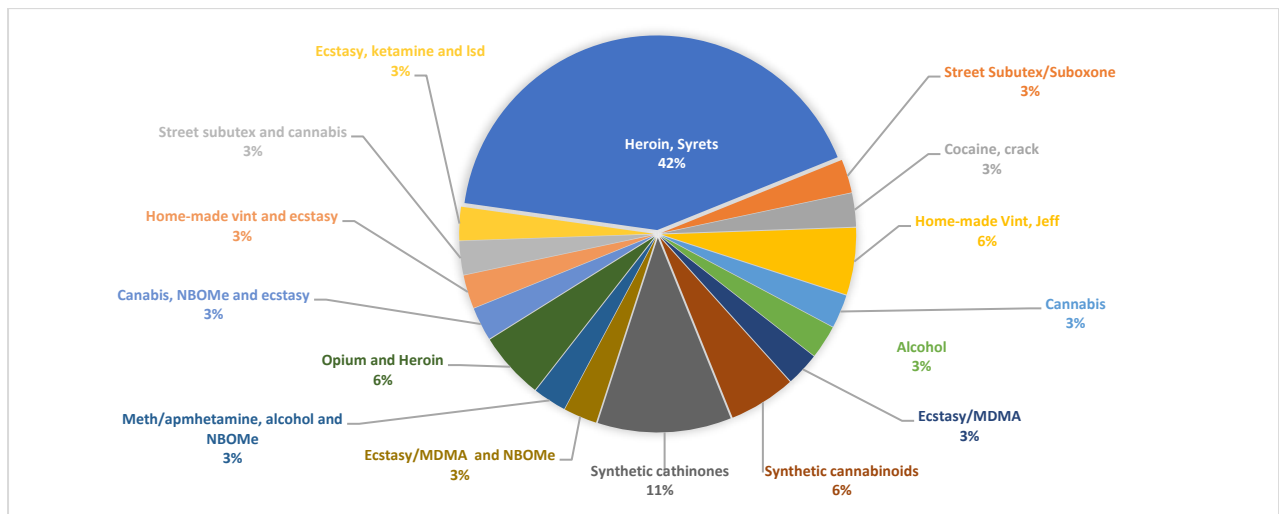
72% (n=36) of participants reported ever experiencing an overdose (see **Figure 5**) with heroin/syrets<sup>3</sup> being the most frequently named as a substance that caused an overdose at the last episode (see **Figure 6**).

<sup>3</sup> Slang name for poor quality heroin

**Figure 5. Lifetime experience in drug related overdose at baseline (N=50).**



**Figure 6. Substance (or combination of substances) reported at baseline as a main reason for an overdose at the last episode of overdose (N=50).**



## Trends in reported behaviors, perceived changes in drug markets and availability of services

### Source of income

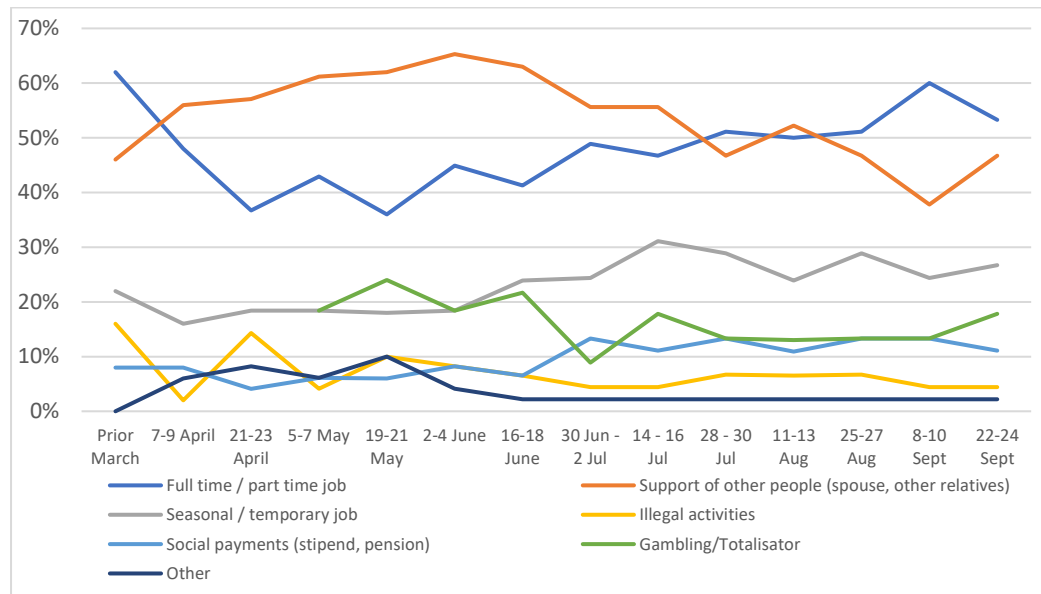
Prior to COVID-19 the major source of income for most study participants (62%) was employment. Incomes from full- and part-time job decreased in April-June during lock-down



period and then recovered in July-September. In parallel, support received from other people became a major source of income and remained as such until mid-July (see **Figure 7**). Both trends, i.e. higher likelihood of having a full- or part-time job and odds for receiving less support from others with each following assessment timepoint, were statistically significant (see for the results of mixed-effect model analysis **Table 3**).

**Figure 7. Changes in the main source of income over the study period.**

(Note – for a better understanding of the impact on incomes we show pre-COVID-19 (prior to March) data as well. Response option “Gambling/Sports betting” was added to the online survey after the second data collection session).



**Table 3. Results of mixed-effect model for testing a linear association between specific outcomes of interest and time (assessment).**

(The odds ratios show by how much the odds of the outcome will increase (positive coefficient) or decrease (negative coefficient) with each next assessment).

Outcome of interest	Time		
	Coef.	p-value	aOR (95% CI)
Illicit methadone use	-0.06	0.372	0.9 (0.8-1.1)
Medical methadone use	-0.16	0.000	0.9 (0.8-0.9)
Alcohol use	-0.07	0.051	0.9 (0.9-1.0)
Price became more exp	-0.13	0.000	0.9 (0.8-0.9)
Access to drugs became harder	-0.12	0.000	0.9 (0.8-0.9)
HR access becoming worse	-0.41	0.000	0.7 (0.6-0.8)
Being on OAT	0.10	0.324	1.1 (0.9-1.4)
Syringe sharing	-0.09	0.321	0.9 (0.8-1.1)
Sharing injection tools	0.09	0.085	1.1 (1.0-1.2)
Always having a new syringe for injection	0.10	0.046	1.1 (1.0-1.2)
Having full or part-time job	0.19	0.000	1.2 (1.1-1.3)
Support from others	-0.14	0.000	0.9 (0.8-0.9)

Prefilled syringe use	-0.13	0.006	0.9 (0.8-1.0)
Front loading	-0.09	0.076	0.9 (0.8-1.0)

Qualitative interviews with PWUD cohort participants suggest that many respondents were affected financially, specifically during the heavy lock-down measures imposed in March-May. Some lost their jobs and others were pushed to close their businesses. In such situation they received a financial support from families or friends.

*“I was working in a touristic industry and now there are no tourists, so yes, it hit me hard”.*

For some participants, however, no major changes with respect to their regular incomes occurred. As one respondent stated he “.. just switched to remote work and (his) incomes were not really affected”. No major changes occurred for those who were on social assistance programs either. Following the removal of major restrictive measures in June, the situation started to improve and some participants reported having back their jobs back.

*“At the beginning of the pandemic I lost my job and relied only on a help from others. Now I have been back to my job for 2 months and work full time..”*

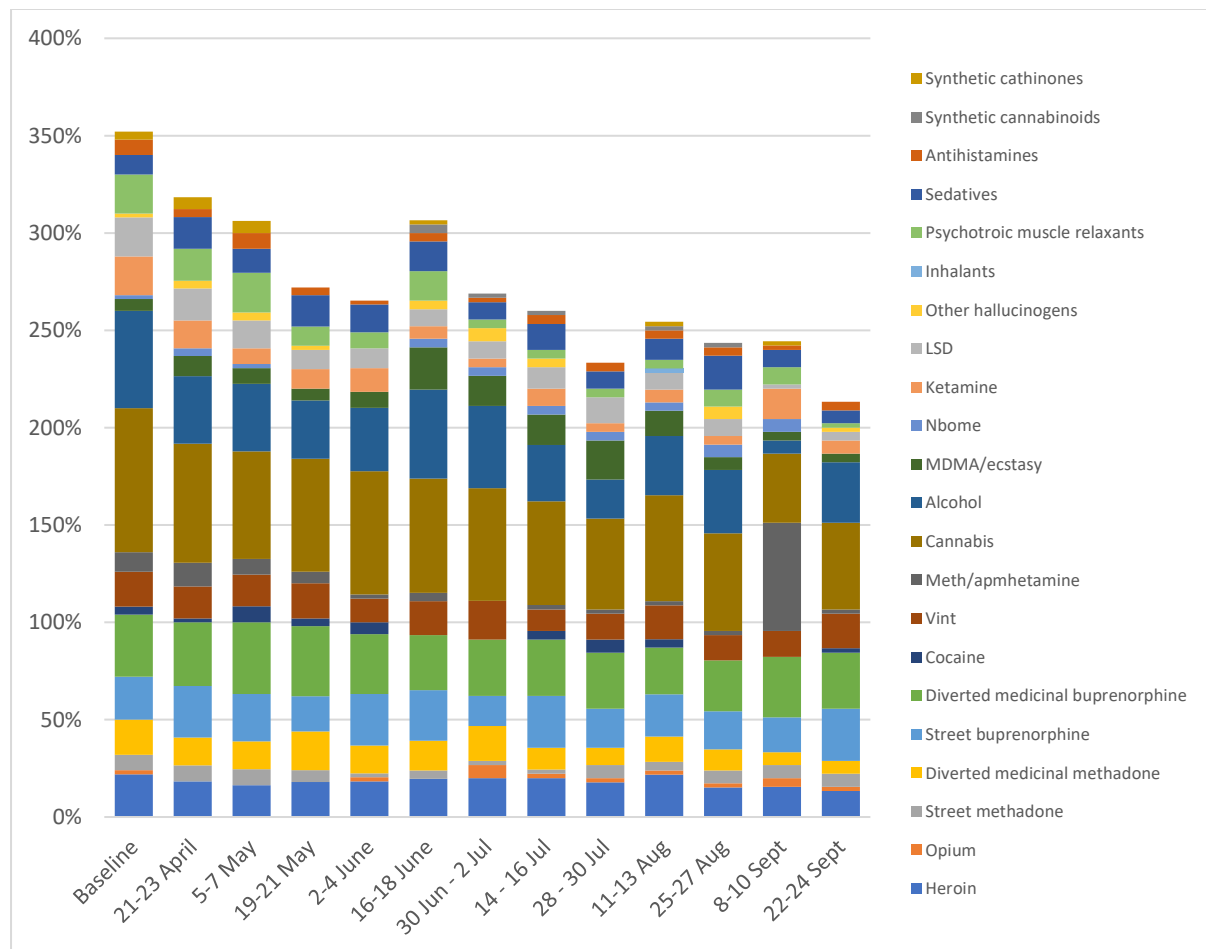
## Drug use

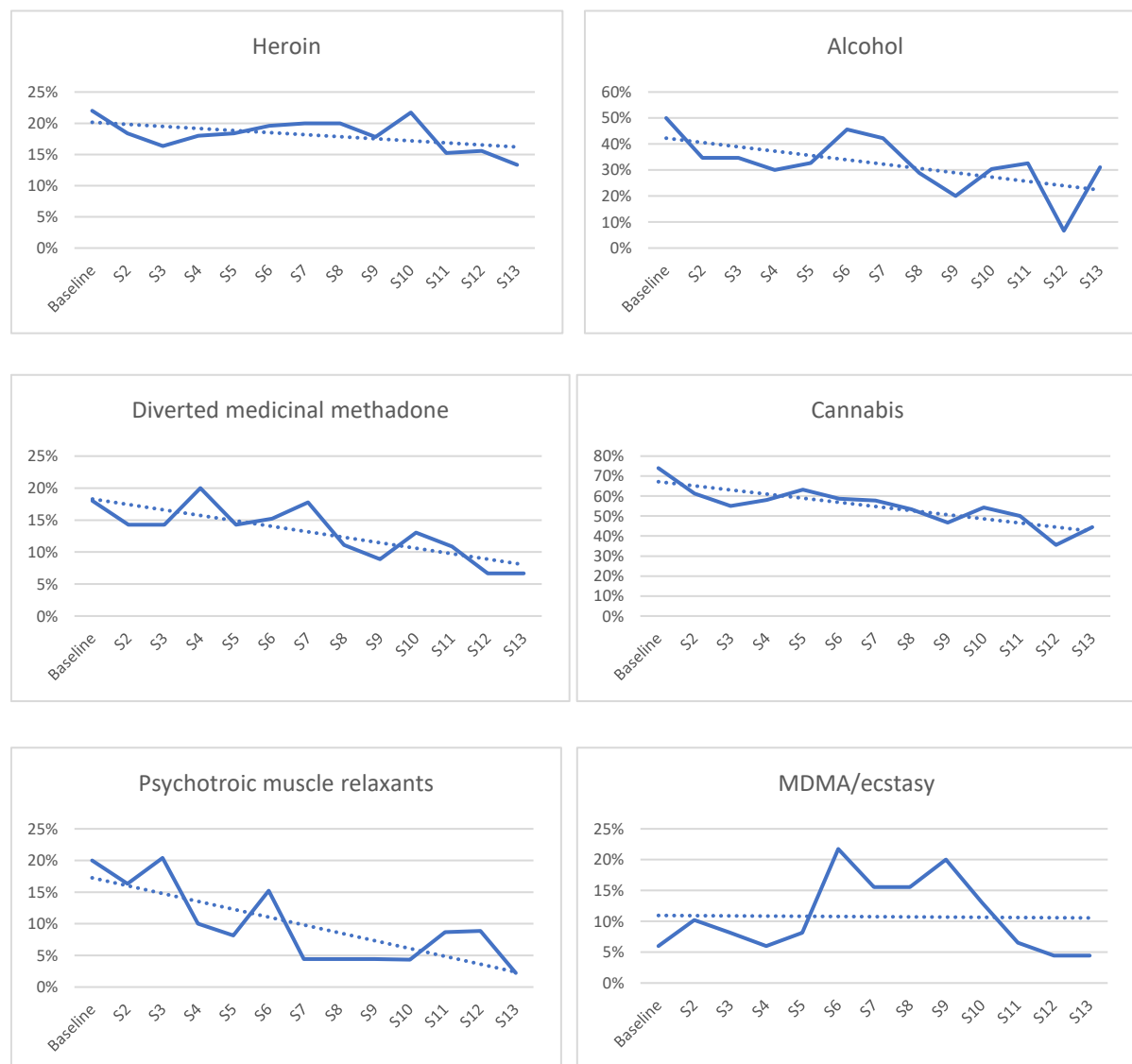
There was a number of observable trends in relation to the prevalence of consumption of various substances during the period studied. The prevalence of use of cannabis products gradually decreased over the course of the study from 74% at baseline (14 days prior to April 7) to 44% by the end of September (see **Figure 8**). Alcohol was the second most prevalent substance at baseline (50%) and the prevalence declined in April-May (the strictest lock-down period), almost returned to baseline level in June (when restrictions were largely removed), and again went down by the end of September (31%). Buprenorphine diverted by OST patients was the third most prevalent substance used at baseline. The prevalence was relatively stable over the study period with (32% at baseline versus 29% in September). The prevalence of heroin use decreased gradually from 22% (baseline) to 13% (September). Use of methadone diverted from OST programs followed similar trend – the prevalence was relatively stable in April-June at rates of 15-18% and then decreased by the end of September to 7%. According to the mixed effect model the trend in reduction of consumption of diverted methadone was statistically significant. Use of MDMA/ecstasy increased during June-August (when compared to the prevalence in April-May) and then went down again. This might be linked to the removal of specific restrictions in June and a remarkable number of open-air EDM festivals organized in July-August. Prevalence of use of psychotropic muscle relaxants was fluctuating over the period of the study. Notably, use of these medications was not reported during the 12-month in a pre-COVID-19 period. Consumption of street methadone<sup>4</sup> was only reported in September. Use of ketamine and psychotropic muscle relaxants went down over the course of the study. There was a spike in use of methamphetamine in September. Trends in use of other substances were relatively stable. Overall, available data may suggest that over the course of the epidemic the prevalence of use of most drugs has decreased, i.e. study participants used relatively fewer number of different substances at the end of the follow-up period if compared to baseline (see **Figure 9**).

<sup>4</sup> Street methadone in this context refers to an illicitly produced substance that is called ‘methadone’ by PWUD and that is available on the illicit market in many former Soviet Union countries. It comes as a powder and is injected and is sometimes also referred to as ‘crystal methadone’.

At session 8 (mid-July) three respondents reported not using any illicit drugs and one of them used only alcohol. Out of these three participants one remained abstinent from any psychoactive substances (including alcohol) until the end of the study (end of September). Two others stayed abstinent for about a month and then used drugs again. At the last session (S13, end of September) there was yet another participant who reported not using any psychoactive substance during the past two weeks.

**Figure 8. Proportion of respondents (%) reporting the use of particular drugs in the past 14 days.**  
(Note – sum exceeds 100% due to use of multiple substances by individual participants).



**Figure 9. Past 14-day prevalence of use of specific substances.**

Qualitative interviews provide useful insight into the changes in drug use behavior of study participants. Due to the reduced availability of favorite substances, people started using alternative drugs. In many cases these were substances that were relatively familiar to individuals and had been used many years ago. In some cases, individuals switched to substances that they had never been tried before. Among other factors that shaped the new trends, respondents named stress and emotional context surrounding the first weeks of COVID-19 cases in the country and “social panic” that accompanied it.

*“..due to lockdown people started using such substances, that they almost never used in other times. ..I myself did not try vint<sup>5</sup> for couple years and used it now few times, I would never do that if not those lock-downs”*

In addition, people were pushed to use just what was available to them.

*“I use now what is available. For example, lot of cannabis and Ketamine. I have never used Ketamine so often. Now I tried vint as well. I would not use it if other drugs were available”.*

<sup>5</sup> Home produced long-acting stimulant prepared through the reduction of pseudoephedrine

Some respondents referred to “*plenty of free time and boredom*”, and stressful context of the epidemic and reported increasing the frequency of drug use.

*“I had lot of free time, there was nothing to do, no hanging out with people, and lot of depression around, so you need more drugs to deal with depression...I can say that I used vint and psychedelics more often at that time, and smoked pot really too much”.*

On the other hand, those who reported reducing the frequency of use named difficulties in obtaining drugs, high prices and low quality as main reasons. For some users the principal reason for less frequent use was a closure of night clubs and other spaces where they frequently used to consume drugs.

*“It’s difficult to get stimulants nowadays, so I reduced my use - I did not use for some time because cannot find drugs”.*

*“I usually used drugs in clubs, sometimes at home. I was buying for overnight club use. Now clubs are closed and I even do not buy drugs and only use when someone offers me”.*

Accounts of key informants (field experts) provide additional details into the motives of people who use drugs that influenced drug consuming behavior. Those who usually consumed drugs in a nightlife setting were moving towards using ketamine and LSD. One respondent (key informant) noted that “*it makes no sense to use ecstasy at home, so you better use LSD or ketamine*”. Similarly, another PWUD respondent stated “*when clubs were open, I was buying and using these drugs quite often. But now nothing’s going on and you don’t really want to sit alone at home under the ecstasy*”.

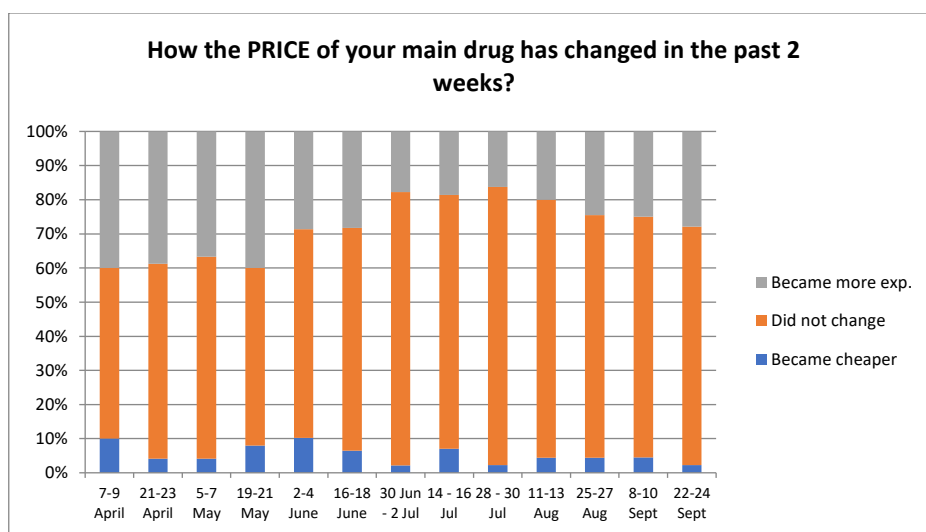
Key informants’ accounts further suggest that since the availability of traditional opioids was reduced and the process of getting drugs became too complicated, some users switched to methadone and buprenorphine that were allegedly diverted by OST clients. These substances were frequently injected. In addition, some individuals consumed alcohol during the days when they cannot obtain drugs (opioids).

One key informant shared his observations at EDM festivals. In July-August festivals and clubs slowly returned to pre-COVID operations. Respondent noted that some young people who used to use club drugs and NPS (largely through non-injecting routes) moved to buprenorphine injections. Getting buprenorphine was less risky since one did not need to communicate with dealer but could get the drug from someone who is in the OST program.

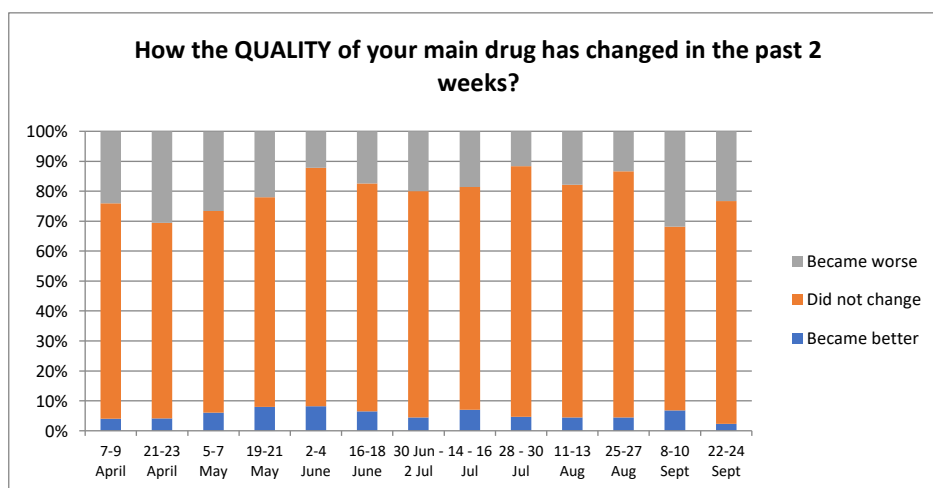
### **Price and quality**

In a quantitative online survey, the majority of participants reported a stable quality (based on their perceptions) and price over the course of the study (see Figure 11 **Figure 10, Figure 11**). However, in April-May some noticeable share of participants (around 40%) believed that the price of their main drug increased (it is not possible to distinguish which drug in particular). The results of a mixed-effect generalized linear model analysis show statistically significant reverse trends in the perception of participants regarding the increase in price and difficulty in getting their main substances. In other words, with each next assessment more respondents believed that the price of their main drug did not increase and more respondents reported that obtaining their main drug of choice did not become more difficult.

**Figure 10. Perceived changes in the price of respondent's main drug.**

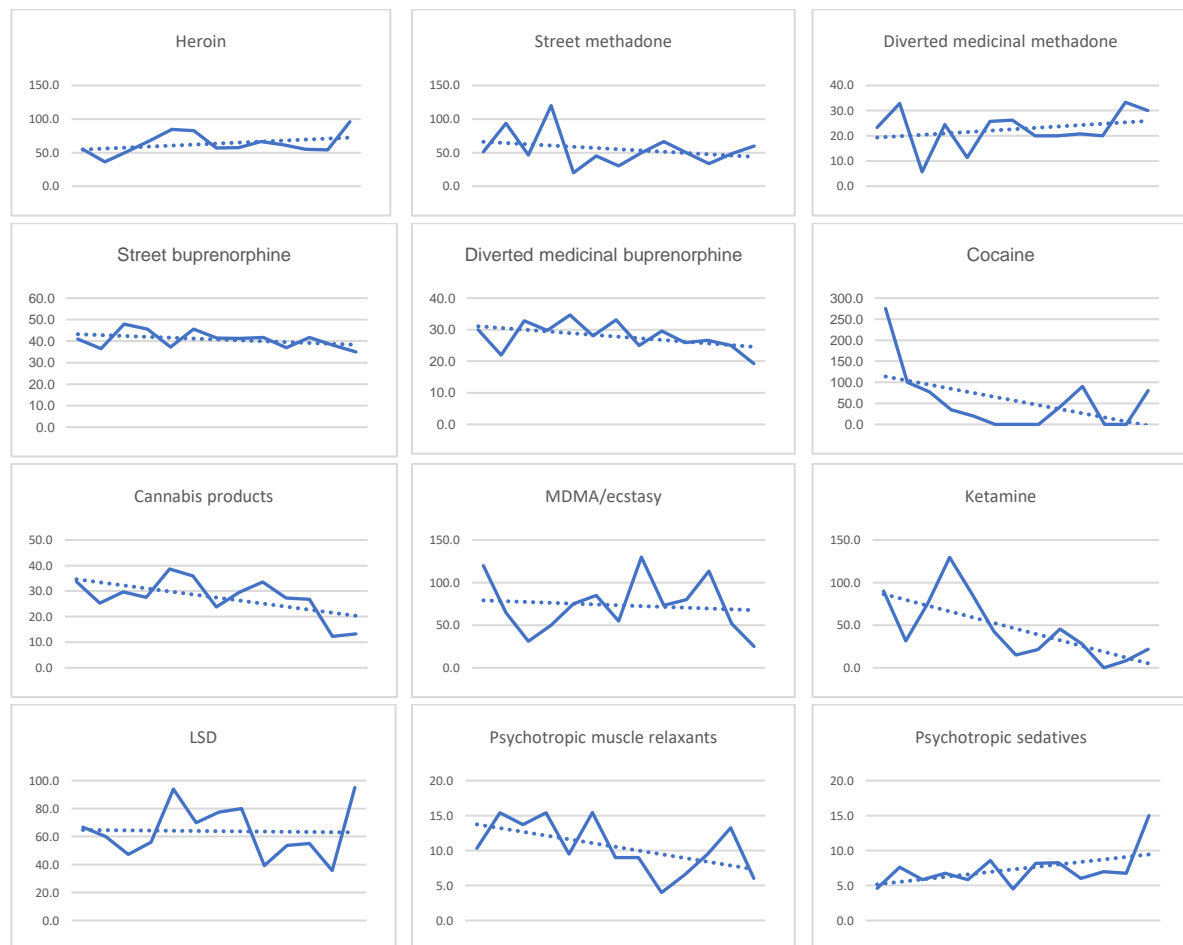


**Figure 11. Perceived changes in the quality of main drug.**



When looking into the data on exact prices paid by cohort participants for various drugs, the picture is somehow heterogenous. Throughout April-September, price paid for an average single dose of a specific drug increased to different degree for heroin, diverted medicinal methadone and psychotropic sedatives – see **Figure 12**. Prices decreased to different degrees for street methadone, street buprenorphine, cocaine, cannabis products, ketamine and MDMA/ecstasy. However, interpretation of these results needs to be done with caution since an “average single dose” for most substances can have a remarkable variability between individuals who use drugs. In addition, at certain assessment points some substances were used by a very low number of respondents (e.g., cocaine) which makes interpretation even more challenging.

**Figure 12. Trends in prices (in GEL<sup>6</sup>) paid for an average single dose of specific drugs.**



In qualitative interviews opinions about changes in price and the quality of drugs were mixed. An overall perception of respondents was that the quality of some drugs, such as MDMA and heroin decreased during the pandemic, specifically by the end of studied period (September). As was stated by one respondent, drug checking<sup>7</sup> often showed very small share of the substance (intended to be procured) in the sample, or the desired substance was completely absent in the sample. Some participants believed that the most affected in terms of quality were club drugs while the quality of opioids and cannabis was not much changed.

*“You would not find MDMA nowadays, but if you do, then it will be a fake one or will be so adulterated. If you divide one gram in two parts – it will be hardly enough for you. We used to divide one gram into 6-7 doses”*

When asked about changes in price of drugs, opinions of respondents differed with some believing that prices have increased for most drugs, and others stating that prices did not change much.

<sup>6</sup> The conversion rate at the time of this study was 1 EUR=3.8 GEL.

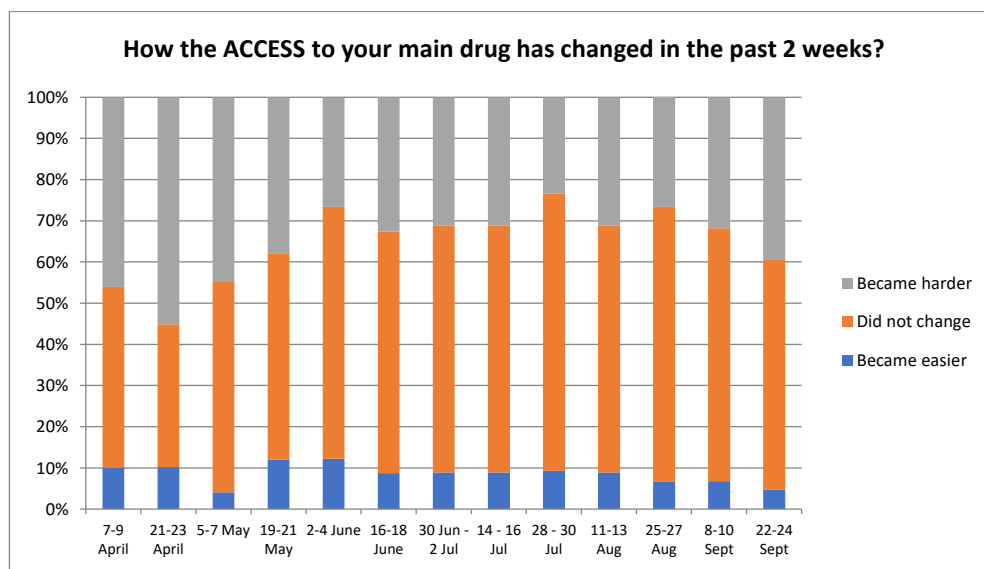
<sup>7</sup> In this case drug checking refers to testing the content of the substance at EDM event using a colorimetric reagent test kit.

*“Absolutely everything (is more expensive now), except for opiates. In the past, you would buy MDMA for 250 Gel, but if you can get it now, it costs 400-500 GEL. Ecstasy is now 120-150 GEL and you are lucky if it’s normal, but we used to buy it for 60-80 GEL”.*

### Availability of drugs

Results of the quantitative online survey show that the perceived availability and access to main drug of choice was remarkably affected, specifically in April-May. At session 2 (end of April) majority of respondents believed that it was harder to obtain drugs if compared to previous periods (see **Figure 13**).

**Figure 13. Perceived changes in the availability of a main drug.**



In qualitative interviews virtually all respondents agreed that the availability of many drugs was significantly reduced, specifically during the first weeks of COVID-19 related restrictions. For some respondents this was particularly evident in case of stimulants and cannabis products. However, others suggested that the most affected substance was heroin which was largely procured via person-to-person contacts with dealers. Some speculated that supply of stimulants and club drugs was most affected because there was a sharp decline in the demand for these substances since clubs and festivals were all shut down. In addition, some participants believed that supply of club drugs was also impacted because these substances were mostly sold on online drug markets.

*“I had a stable market (supply via online shop) for stimulants and was buying without any difficulties. Suddenly there was a problem, I wanted to buy Ketamine and it was not there any more”.*

Respondents noted that there were fewer seller and less variety of drugs offered through online markets. They further suggested that some sellers made adjustments with regard to places where dead drops were hidden. In many cases locations for dead drops moved to Tbilisi suburbs, quiet places where there was a less police movement and surveillance.



Virtually all respondents reported that they observed a sharp increase in the availability of methadone and buprenorphine diverted from OST programs. These were both sold by OST clients and supplied through friendship networks for free.

*“Suboxone and methadone from programs were easy to get, they [patients] received medication to take home and they easily sold it”.*

No major changes were noted in July-September when COVID-19 related restrictions were largely lifted. As one respondent stated the drug market started to return to *“business as usual”*. Heroin was brought as an example – with the partial removal of COVID-19 related restrictions it became available again through traditional person-to-person supply from dealers. *“Trade goes on as normal, hands to hands in Phonichala”*<sup>8</sup> [district of Tbilisi].

Respondents’ accounts indicate that starting from July access has improved most notably in relation to cannabis products. Some participants suggested that people started to grow cannabis plants at their homes when *“there was a COVID-related panic”* in March and April. Diverted medicinal methadone and buprenorphine remained available for both sale by OST clients and social supply. However, from September 8, OST programs returned to daily disposal of substitution medications which, according to the views and opinions of respondents, resulted in a sharp decrease in the availability of diverted medications for illicit consumption. When referring to changes in the drug scene that occurred in July-September, qualitative interviews further suggest that homemade production of “conifer vint” from ephedra plant was widespread (seasonal trend). Finally, respondents indicated that there has been observed ‘a noticeable’ presence of illicit methadone on a market. As one respondent stated *“there is now a lot of crystal methadone from Russia out there”*.

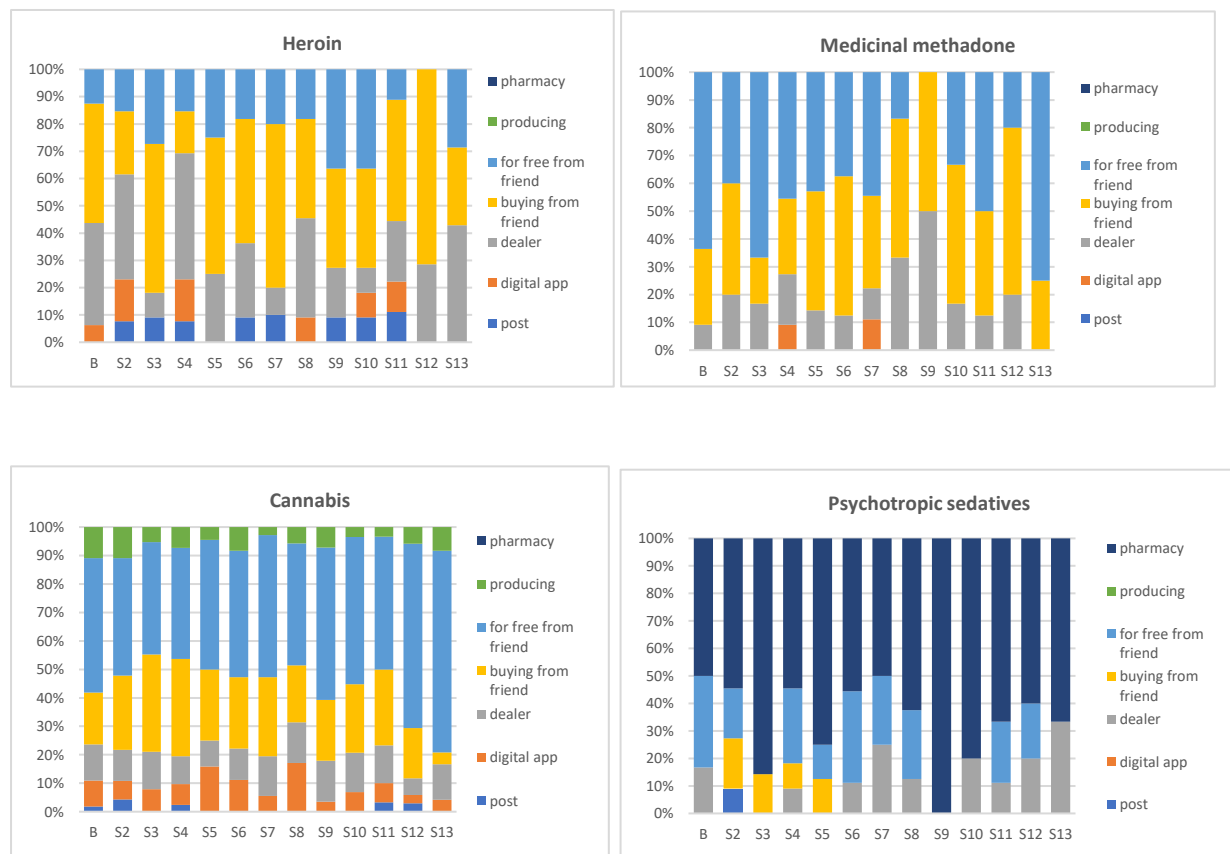
### **Ways of obtaining drugs**

Results of the quantitative survey suggest that there were remarkable variations in ways to obtain specific drugs during the study period (see **Figure 14**). Diverted medicinal methadone and buprenorphine were largely bought from friends or received for free from friends. Free of charge supply to social network members was particularly characteristic for cannabis products. Cocaine was purchased largely via mobile applications. Mobile applications were also frequently used to procure ketamine, MDMA, NBOMe and meth/amphetamines, if compared to the procurement of other substances. Expectedly, antihistamines<sup>9</sup>, psychotropic muscle relaxants and sedatives were vastly obtained from pharmacies. We did not notice any sensible trends in relation with the ways to obtain specific drugs over the study period. Results show that in relation to most substances remarkable share of participants obtained them from friends, both bought or received free of charge.

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<sup>8</sup> District of Tbilisi; anecdotal data suggest it is a home for retail heroin trade

<sup>9</sup> Used in combination with opioids to prolong the effect of opioids and to make it stronger.

**Figure 14. Changes in ways of obtaining specific drugs.**

Results of qualitative interviews indicate that PWUD, specifically those who used to get drugs from online markets needed to adjust to the new situation. Respondents' accounts suggest that in some cases, the dead drops were not in places that were indicated by online sellers, or a customer could not get to the place due to restrictions in movements. It was a time-consuming and risky to obtain drugs during the lockdown. Often, it was difficult to move in the city due to lack of transportation options and restrictions that were introduced by the government. There was an increased police presence in the streets, so going to pick up dead drops and moving with drugs through the city was very challenging and risky. One respondent noted that it became so easy to get methadone or buprenorphine that was diverted from substitution treatment programs, that those, who used to purchase these medicines from online markets moved to buy them through in person contacts from OST patients, or get them as a gift from friends.

*"I used to buy those (drugs) through Internet, but during corona virus I often get it for free from my friend"*

Participants shared few novel ways for supply of drugs during the lockdown period. For example, it was possible to receive drugs delivered to your home.

*"if previously I was going to dealer's place, now he brings drug to my place".*

Many respondents from PWUD cohort stated that they were unable to stay in stable contact with dealers, so they had to look for new sources again and again.

*"I can say that we look for new channels almost every day. Trying this, trying that. Nowadays I don't know a stable dealer who stays active and has stable supply".*

Since established contacts with dealers in many cases were affected, some people started to act as a middleman dealer (called გგბო (*phekhi*) – Georgian word for foot). In addition, some

PWUD who had money and were able to support their drug use financially became conscious regarding the COVID and tried to limit their interactions. Those of them who used to procure (heroin) from dealers personally moved to “hire” other drug users with less financial resources, so the former would buy the drug from a dealer and bring it in exchange of a personal dose.

*“My dealer disappeared, so I found someone, who knows another dealer and this middleman brings drugs for profit”.*

*“Those familiar dealers disappeared and it is difficult to get (drugs), it goes through too many hands and comes in a small quantity”.*

One respondent reported receiving purchased drugs in a preloaded syringe. The substance in the syringe was buprenorphine and was hidden in a quiet place (glued to the tree) by the middleman (see **Picture 1**). The respondent however acknowledged that this was a risk-containing way for him to buy drug in a preloaded syringe.

*“It became risky, because you do not know what is there in the syringe when you think you are buying opiates”.*

**Picture 1. Syringe with preloaded drug glued to the tree in Tbilisi suburb and ready for pick up.** (April 2020, photo taken by Tamar Mgebrishvili).



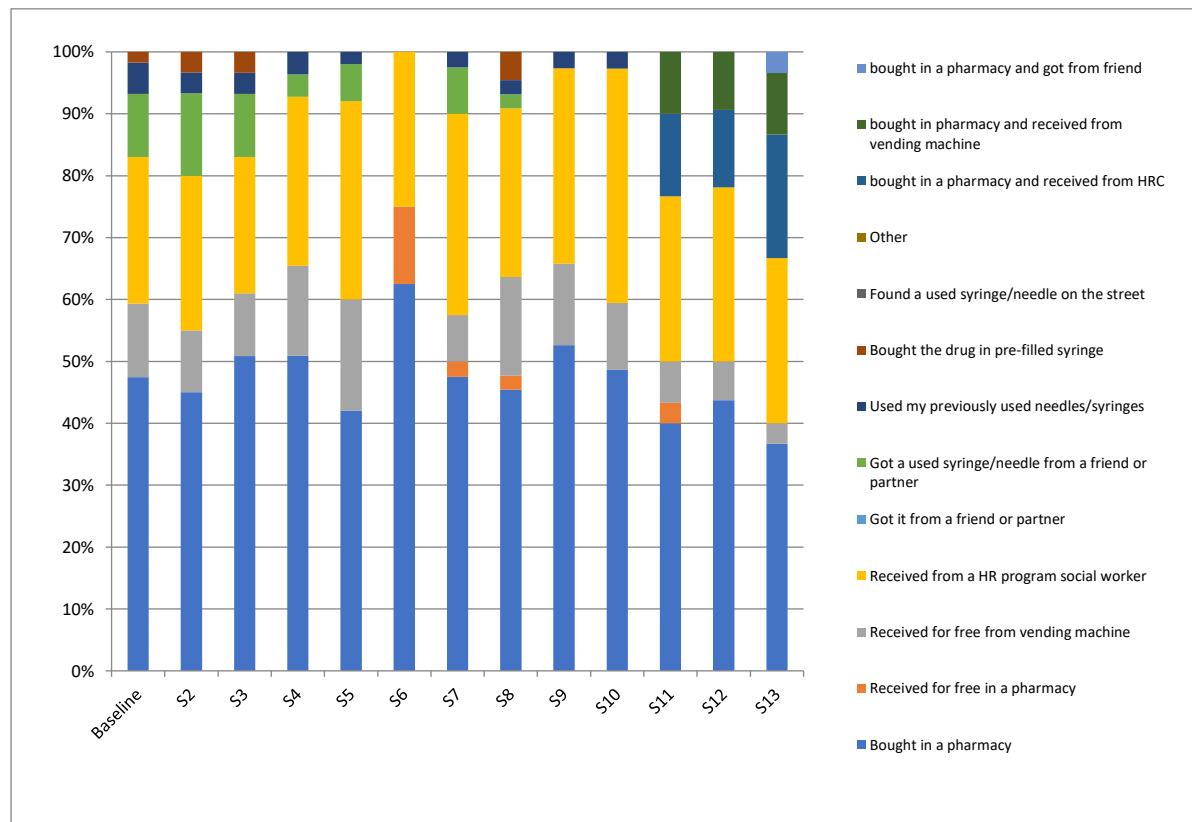
Finally, participants reported their observations in relation to the interactions between relatively small established PWUD networks. In Tbilisi neighborhoods PWUD started to communicate with other users and networks in order to look for drugs together.

### **Risk taking behavior**

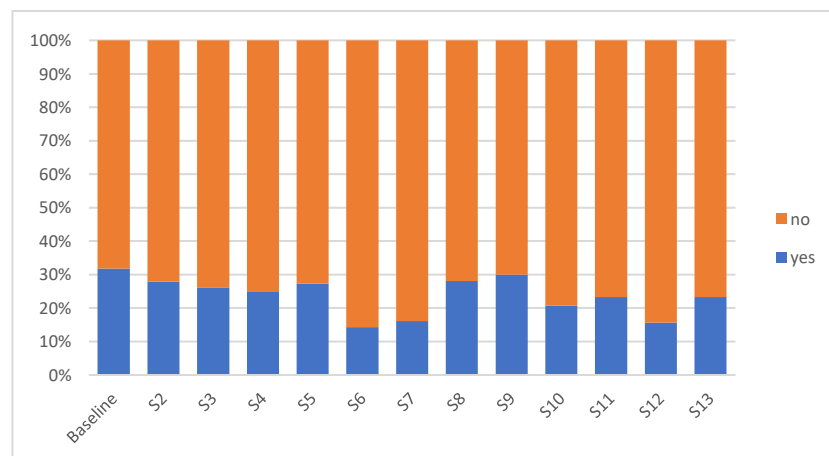
Quantitative survey included several questions covering potentially high-risk injection behaviors. About 80% of the participants reported injection use of drugs over the study period. With regard to main sources to get sterile equipment the most prevalent way throughout the study period was buying in pharmacy (see **Figure 15**). During the first weeks of lock down noticeable share of participants reported receiving used needles and syringes from others (friend, partner). During the same period (April-May) more than a quarter of participants reported obtaining drugs in prefilled syringes in the past 14 days (see **Figure 16**). In a mixed-effect model, odds of always having a new syringe for injection increased with each following assessment and odds of receiving drugs in a prefilled syringe decreased over the same time.

*“Where did you get clean needles/syringes in the past 14 days? (check all that apply)”*

**Figure 15. Distribution of responses (%) to the question “Where did you get clean needles/syringes in the past 14 days? (check all that apply)”.**

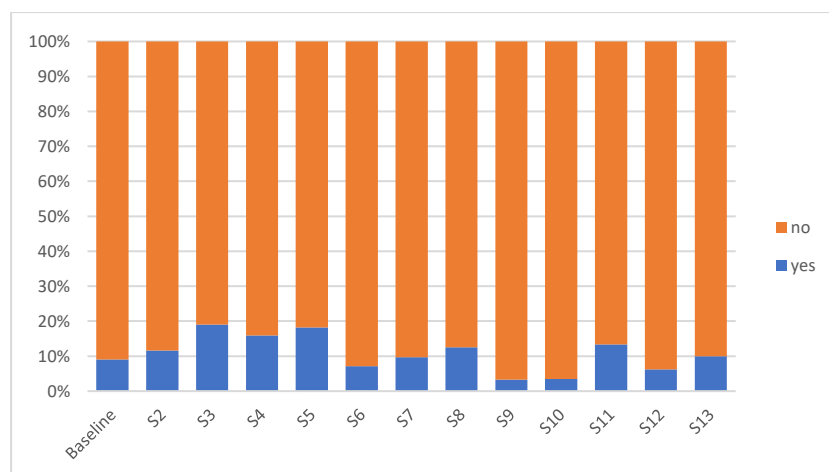


**Figure 16. Distribution of responses (%) to the question “Have you received/ bought an injection from an already filled syringe (i.e. you did not see how it was filled) in the last 14 days?”**



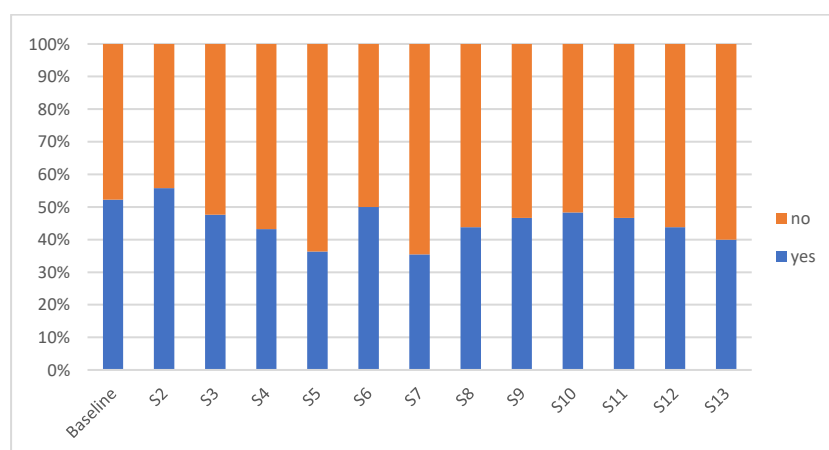
Another observed risk behavior reported by participants was a direct and reverse filling (front and back loading) of syringes (see **Figure 17**).

**Figure 17. Distribution of responses (%) to the question “In the last 14 days when you injected drugs, did you use a syringe, filled by someone from his / her already used syringe (direct or reverse filling, several doses in one syringe)?”.**



However, the most prevalent risky practice was related to sharing common instruments for preparation and injection of drugs. During the strictest lock-down measures almost half of the sample did share common equipment with others at least once in 14 days prior to the survey (see **Figure 18**).

**Figure 18. Distribution of responses (%) to the question “Have you used common instruments for sharing (preparation) of a drug at least once in the last 14 days?”.**

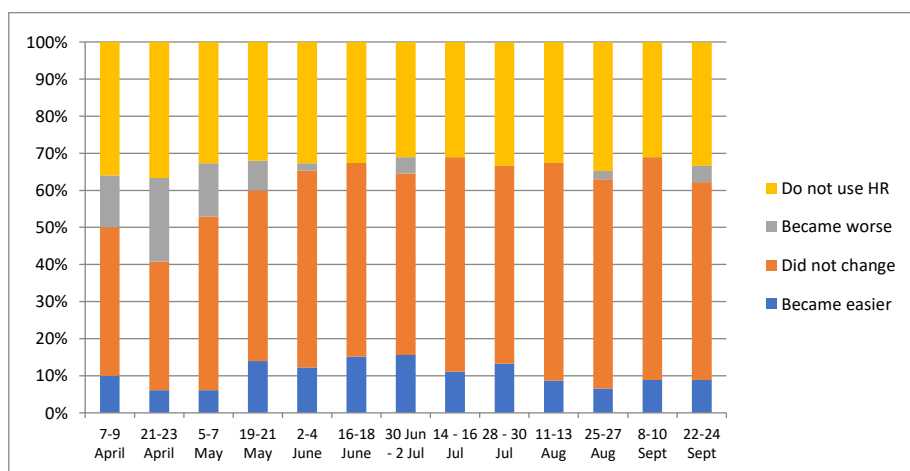


Results of qualitative interviews suggested some general, potentially risk containing practices. As a common trend, no social distancing was respected during the process of drug preparation and use. This was acknowledged in relation to all kinds of drugs. Increase in use of vint suggested that there were elevated “traditional” risks associated with its use – toxicity of the ingredients and of the final product, group character of preparation and use, frequent injections, and risky sexual behavior. Interestingly, one respondent noted that there was a popular myth among drug users – some of them believed that vint prevented users from catching a COVID-19 infection.

### **Availability and demand for services**

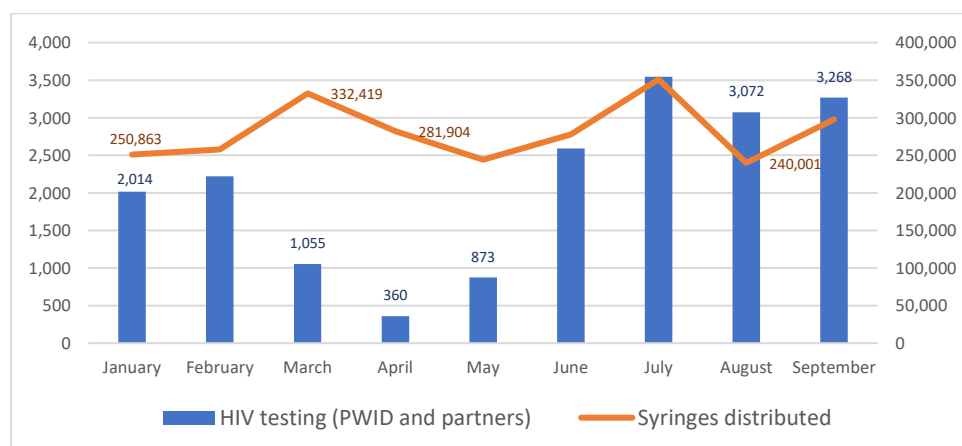
Around two thirds of the cohort reported using some harm reduction services while participating in the study. Participants reported that access to programs was particularly affected during the first two months of the study (April-May) and then gradually recovered (see **Figure 19**). Based on the results of the mixed-effects model this trend in perceived improvement in accessibility of harm reduction services was statistically significant.

**Figure 19. Perceived ease of access to harm reduction services (%).**



Interviews with key informants indicate that access to needle and syringes programs became problematic in some places because harm reduction sites cut working hours and had to comply with social distancing requirements. Provision of voluntary counseling and testing services was particularly affected. These findings are in line with the program data of the Georgian Harm Reduction Network (GHRN) who is the single major provider of low threshold harm reduction services to PWID in the country. GHRN data show a reduction in HIV testing rates and in distribution of sterile injection equipment in March-May (see **Figure 20**). It needs to be noted that a decline in a number of syringes distributed in August-September was related to the temporary shortage of sterile equipment caused by problems in supply chain that was affected by COVID-19 related delays in international cargo shipments.

**Figure 20. Monthly rates of HIV testing and distribution of sterile syringes to PWID in Georgia in January-September, 2020 (Source – GHRN program data).**



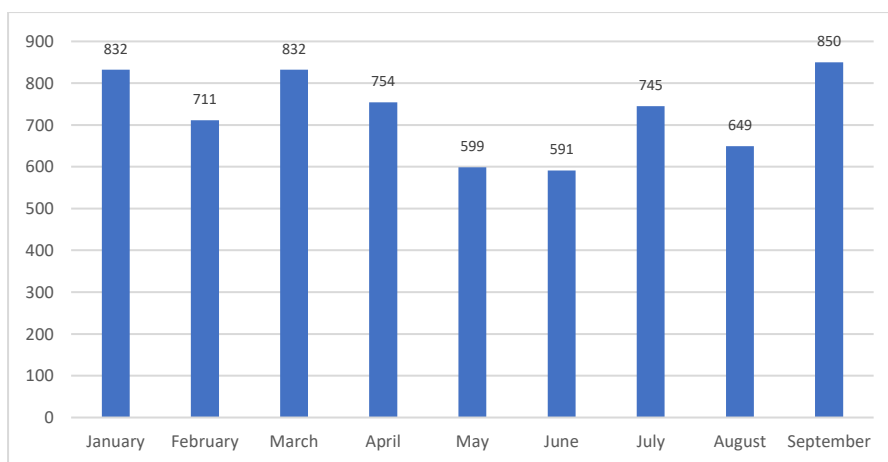
Those respondents who were using harm reduction services noted that programs made reasonable adjustments in working format and employed flexible strategies to ensure continuous provision of services. For example, services extensively used mobile vans and prioritized offering HIV-self testing to their clients. One respondent noted that he would call his social worker who would bring sterile equipment to his place.

*“Yes, when offices were closed, I was calling my social worker, so he would bring syringes to my home”.*

In addition, there was a significant increase in utilization of syringe vending machines (SVM) installed in Tbilisi in July 2019 – the number of sterile kits distributed through SVMs increased by 80% in April, if compared to February (Otiashvili et al., 2020). In this situation SVM proved to be an effective model for uninterrupted provision of sterile equipment while ensuring noncontact mode of service delivery.

Results of a qualitative study with key informants show that demand for, but also physical accessibility of detoxification services declined during the first weeks of lock-down when there were heavy restrictions imposed on transportation. Respondents suggested that some people might have been cautious to get to hospital because of a COVID-19 situation. Utilization of detoxification services went back to normal starting from July. Respondent shared their perception that the overall demand for OST increased in April and May. Results of qualitative interviews with cohort participants suggested that among other factors, the rise in demand was related to the lack of traditional opioids on the market, but also to the attractiveness of treatment with take-home dosing allowed. One respondent who applied and was admitted to methadone treatment stated that the major motivation for him was the possibility to get 5-day dosing. Another respondent shared that he was thinking to apply to OST due to difficulties in obtaining drugs. Study participants acknowledged that OST programs responded very quickly and effectively to the epidemic. Following the decree of the Ministry of Health, a 5-day take home dosing was introduced for all OST clients in March. When an OST patient was COVID infected the substitution medication was delivered to the patient at a quarantine site. When regions were put in lockdown and movement was restricted, the medication was supplied to OST patients located in that region without an interruption. Finally, new patients were admitted into the program even if they were isolated (as a mandatory quarantine measure) upon arrival from abroad. Participants' accounts indicate that by the end of May, the demand for OST went down from relatively high in March. As one respondent suggested, *“there was a kind of panic among drug users in March”* and things seemed to be returning to “normal” in June. These findings are in line with the data of the Center for Mental Health and Prevention of Addiction (CMHPA) which is the single major provider of state-funded OST programs in the country – see **Figure 21**. As of note, five participants in the study cohort were on OST at baseline and stayed in treatment until the end of data collection. Six participants initiated OST during the study.

**Figure 21. Monthly rates in new admissions to state funded (methadone) OST programs in January-September, 2020 (Source – CMHPA program data).**



Respondents in both groups (PWID and service providers) highlighted that the decision of health authorities to stop allowing 5-day take home dosing for OST patients caused a major frustration among clients and medical personnel neither of whom were prepared for this change. As an expected consequence of that decision, demand for and admissions to OST programs increased by the end of September. Notably, as reported by clients and confirmed by toxicological analysis performed at treatment intake, many newly admitted clients used illicit/street or diverted medicinal methadone prior to admission. Inflow of new patients was so large that some OST sites had to stop admissions since there were no more slots available. Some respondents believed that a return to daily dosing posed significant risks for virus transmission.

*“This is very bad. I spend an hour to get to the site every day, and I am under the risk every day. I stand in a line and then in a small room without mask with 10-20 patients”.*

Following the request submitted to the government by the group of public health and human rights organizations and patients’ activists’ groups, the Ministry of Health reversed its decision to ban take-home dosing. Since mid-October dispensing of a 5-day supply of substitute medication was again allowed for all OST clients. Apparently, surge in a new COVID-19 cases in the country was among factors that influenced this decision.

## Monitoring online illicit drug market

### Description of *Matanga* platform

*Matanga* offers a wide selection of psychotropic drugs that can be purchased online and then collected at a specific location as a hidden dead drop. The webpage can be accessed using a conventional browser (e.g., Google chrome). Visitor can view products and prices, but registration is required in order to make a purchase. *Matanga* is a web browser and it has easy-to-use android application with built-in Tor browser as well. The webpage displays the list of countries and cities to choose from. For Georgia, delivery is offered to Tbilisi (various districts), Imereti region (Kutaisi), Adjara region (Batumi and Kobuleti), and Samegrelo-Zemo Svaneti region (Anaklia) (see **Picture 2**). The main language of the webpage is Russian, however, English names for substances are also often used.



**Picture 2. Map of Georgia with locations - red dots - where drugs can be picked up (left) and screenshot of Matanga webpage with drugs offered to Tbilisi customers (right).**



Starting from August, Georgian text has been added in some instances, mostly to cannabis products that may suggest a local origin of those products. Customers can choose to make a purchase of the drug that is already hidden somewhere (so it can be collected immediately following the payment and receipt of coordinates), or to make a pre-order (when offered/announced by a seller), so that the substance will be dropped off somewhere within 48 hours and a buyer will receive coordinates of the location. In some cases, sellers offer testers – a small volume of the substance to allow customers making an informed decision on a future purchase(s) and in exchange for a review in the rating panel. Registered user has his/her portal and has access to various rubrics such as “My orders”, “My tickets”, “Parameters”. *Matanga* offers simple system of incentives to its users to recruit new users (buyers and sellers) – 1% of any transaction made by a recruited individual will be paid to a recruiter. It provides detailed step-by-step instructions how to register as a buyer or as a seller (shop), fill in your balance, make transactions (in bitcoins and other crypto currency, or actual currency using a regular debit/credit card), how to install Tor browser on your phone. The webpage contains adds to recruit couriers for drug delivery at different locations. Customers can provide feedback on their experience with particular sellers. When making a purchase, a user can select a place where a drug is hidden (street, entry hall of the apartment building, park), type of a dead drop (mourner in the ground, attached to metal by a magnet), and means to find a location (GPS coordinates, photos). For regular customers sellers offer discounts as can be seen in this example: “Customer’s comment - 13.01.2020. *Everything is excellent, for many times already*) did not I deserve a discount? Seller’s response - *After the fifth purchase.*”

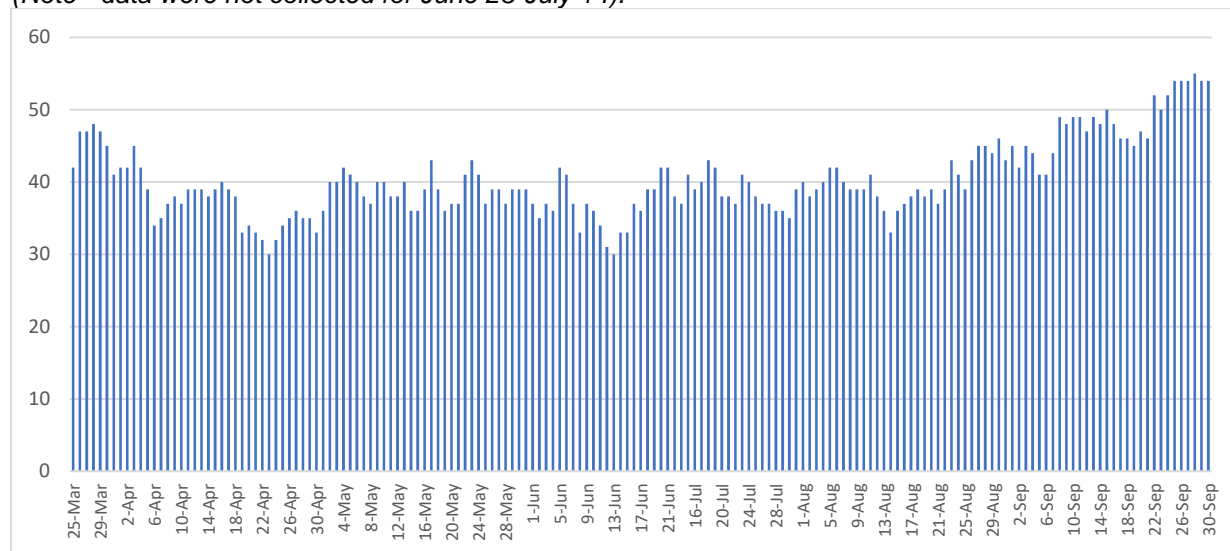
## Results of monitoring

The *Matanga* market discontinued from June 23 on its old web address and the research team was able to identify the new address (where the site migrated) by July 14. Thus, the data reported below does not include transactions between June 23-July 14. Over the period of April-September 2020 there were 1,369 unique listings posted, out of which 1,312 were unique drug listings. The remaining included 49 listings for job offer and 8 listings for weed cooking butter, cannabis seeds and marijuana cupcakes. On average day the webpage offered 138 listings with different substances (min 118, max 142). Over the period of the study there were

124 unique vendors offering products but only 14 vendors were present on the market regularly, at least one day every month. On average 40 vendors were operating per day on a Georgian segment of *Matanga* (min 30, max 55) (see **Figure 22**).

**Figure 22. Daily number of unique vendors offering products for Georgian customers.**

(Note - data were not collected for June 23-July 14).



Over the reported period there were 22,364 unique sale transactions with the total value of 4,577,155.05 USD<sup>10</sup>. There were 19 categories of substances offered and sold on the market over the course of the study. The value of the smallest purchase was 1.5 USD (cannabis tester) and the value of the largest purchase was 14,615.00 USD (methadone). Cannabis product sales accounted for the highest value of sales (48.5% of total sales) and for the largest number of transactions (67.1% of total transactions) (see **Table 4**). After cannabis, cocaine was the most often sold substance and was followed by MDMA/Ecstasy. In terms of revenues, cannabis was followed by cocaine and methadone (largely in crystal form). MDMA/Ecstasy, heroin, alpha-PVP, methamphetamine and NBOMe were also sold in relatively large amounts.

On average day, the revenue was 27,083.76 USD and the minimum and maximum daily revenues were 8,189.65 and 287,406.22 respectively (see **Figure 23**). There were unusually high revenues on August 11, 12 and 15. It was not clear what caused these spikes in mid-August.

<sup>10</sup> The conversion rate during the study period was 1 EUR=1.145 USD

**Table 4. Substances, transactions, quantities sold and revenues on Georgian segment of Matanga (March 25-September 30, 2020).**

(Note - data were not collected for June 23-July 14).

Substance	Form of substance and unit of measurement	Quantity sold	Number of transactions	Average unit cost (USD)	Revenue in USD	Transaction %	Revenue %
Cannabis products	Herbal (gr)	61,190.93	15,011	36.3	2,218,578.5	67.1%	48.5%
	Hashish (gr)	1659.5	276	41.2	68,328.8	1.2%	1.5%
	Sum	62850.43	15,287		2,286,907.3	68.4%	50.0%
Cocaine	Powder (gr)	3405.8	1,792	239.1	814,178.5	8.0%	17.8%
MDMA/Ecstasy	Pill	5,172.70	501	21.7	112,297.6	2.2%	2.5%
	Powder	1,923.47	973	124.5	239,488.4	4.4%	5.2%
	Sum		1,474		351,786.0	6.6%	7.7%
Methadone	Powder/crystal (gr)	713.27	813	599.2	427,423.0	3.6%	9.3%
	Syrup (ml)	32	8	16.8	536.0	0.0%	0.0%
	Pill	56	17	20.8	1,165.0	0.1%	0.0%
	Sum		838		429,124.0	3.7%	9.4%
Heroin/Syrets	Powder (gr)	531.38	462	332.3	176,597.3	2.1%	3.9%
Buprenorphine*	Pill	1,068	308	37.1	39,626.3	1.4%	0.9%
Morphine	Pill	7	4	70.7	495.0	0.0%	0.0%
Gabagamma**	Pill	2740	109	1.4	3,776.0	0.5%	0.1%
alpha-PVP	Crystal (gr)	616.4	542	215.7	132,981.8	2.4%	2.9%
Amphetamine	Powder/crystal (gr)	25.4	25	210.2	5,340.0	0.1%	0.1%
Ketamine	Powder/crystal (gr)	39.5	20	137.5	5,431.0	0.1%	0.1%
DMT	Powder/crystal (gr)	0.5	1	220.0	110.0	0.0%	0.0%
LSD	Stamp/blotter	2954	416	35.1	103,751.3	1.9%	2.3%
Magic Mushrooms	Mushroom (gr)	1	1	55.0	55.0	0.0%	0.0%
Mephedrone	Powder (gr)	53.5	54	132.4	7,084.0	0.2%	0.2%
Methamphetamine	Powder/crystal (gr)	3197	141	37.9	121,256.4	0.6%	2.6%
NBOMe	Piece/stamp	6994	834	11.9	82,885.2	3.7%	1.8%
NZT-52 ***	Flour/powder (gr)	85	53	182.0	15,470.0	0.2%	0.3%
Synthetic cannabinoid	Powder (gr)	15	3	20.0	300.0	0.0%	0.0%
<b>Total</b>			<b>22,360</b>		<b>4,577,155.0</b>	<b>100.0%</b>	<b>100%</b>

\* buprenorphine is sold as "subutex", "suboxone" and "buprenorphine"

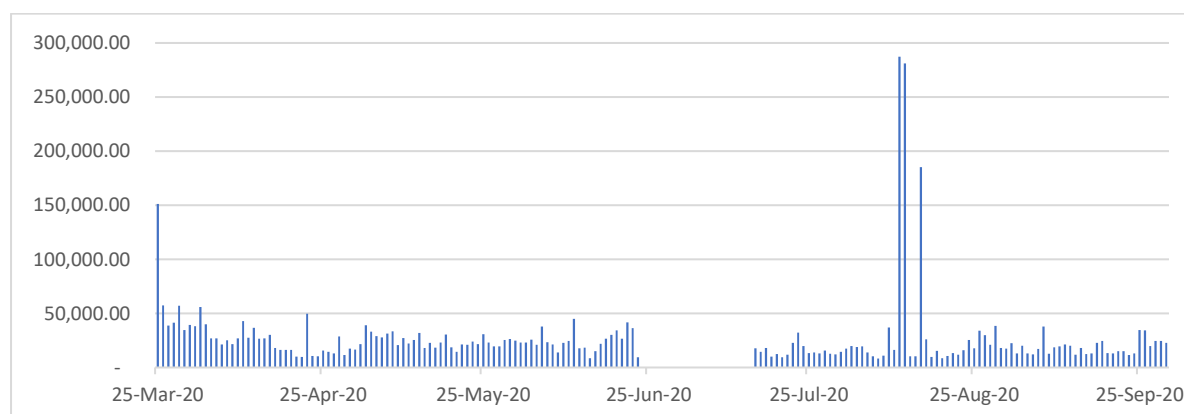
\*\* active substance is Gabapentin – muscle relaxant with pain relieving effect

\*\*\* unconfirmed data suggest this is Modafinil - psychotropic medication for treatment of excessive sleepiness caused by narcolepsy

Morning glory appeared in August listing but never been sold

**Figure 23. Daily revenues on a Georgian segment of Matanga in USD.**

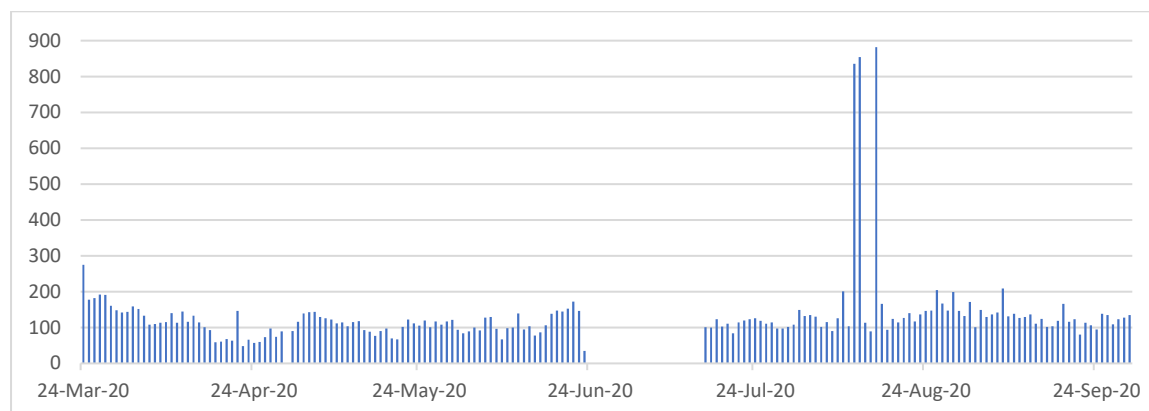
(Note - data were not collected for June 23-July 14).



With the total 22,364 transactions over the reported period, the average number of daily transactions was 132 (min. 35, max. 882) (see **Figure 24**). On August 11, 12 and 15 there were unusually high numbers of transactions – 835, 854 and 882 respectively.

**Figure 24. Daily number of transactions on a Georgian segment of Matanga.**

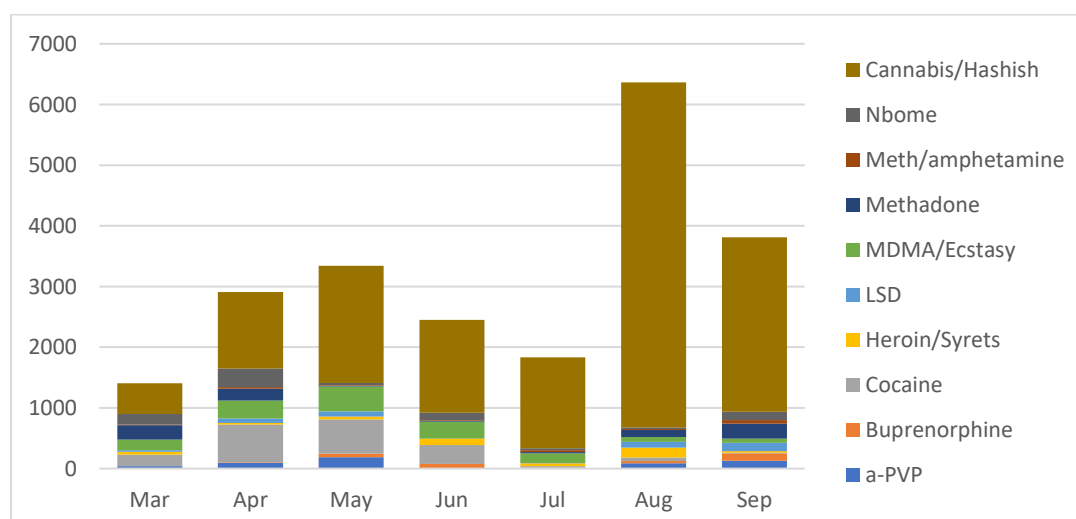
(Note - data were not collected for June 23-July 14).



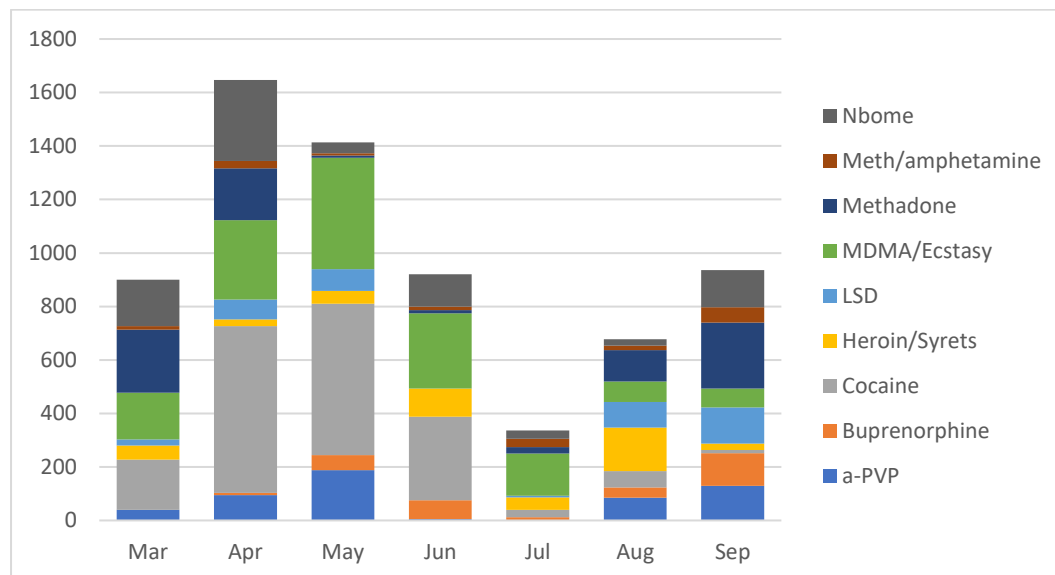
Considering monthly trends, the smallest number of transactions was made in July (1,853) and the largest in August (6,364) (see **Figure 25**). However, in August cannabis products accounted for the vast number of transactions. When excluding cannabis related transactions, April was the month with the largest number of sale transactions (see **Figure 26** for details). Combined monthly transaction rates steadily decreased through April-July and then went up in August. For almost all main products sold on *Matanga* there was a gradual decrease in a number of sales from April to July which was followed by a gradual increase for some drugs. Notably, sales of cocaine and MDMA/Ecstasy did not recover by the end of monitored period (September). When cannabis related transactions excluded, methadone accounted for the largest number of sales transactions among all other substances in September. Sales transactions for buprenorphine and LSD were the largest in September if compared to other months.

**Figure 25. Monthly transactions for 10 main substances.**

(Note - data were not collected for June 23-July 14).

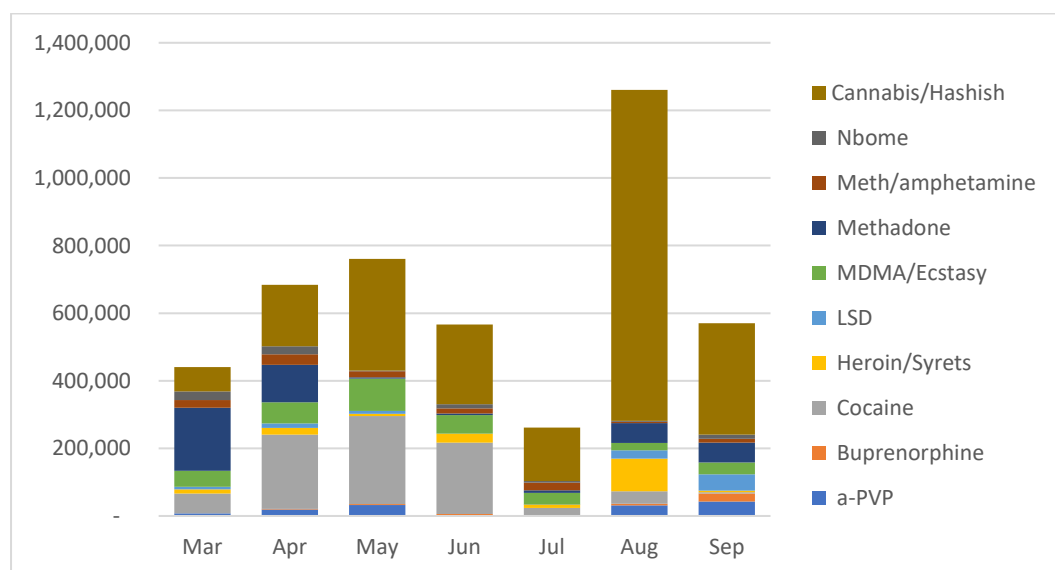


**Figure 26. Monthly transactions for 9 main substances (cannabis excluded).**  
(Note - data were not collected for June 23-July 14).

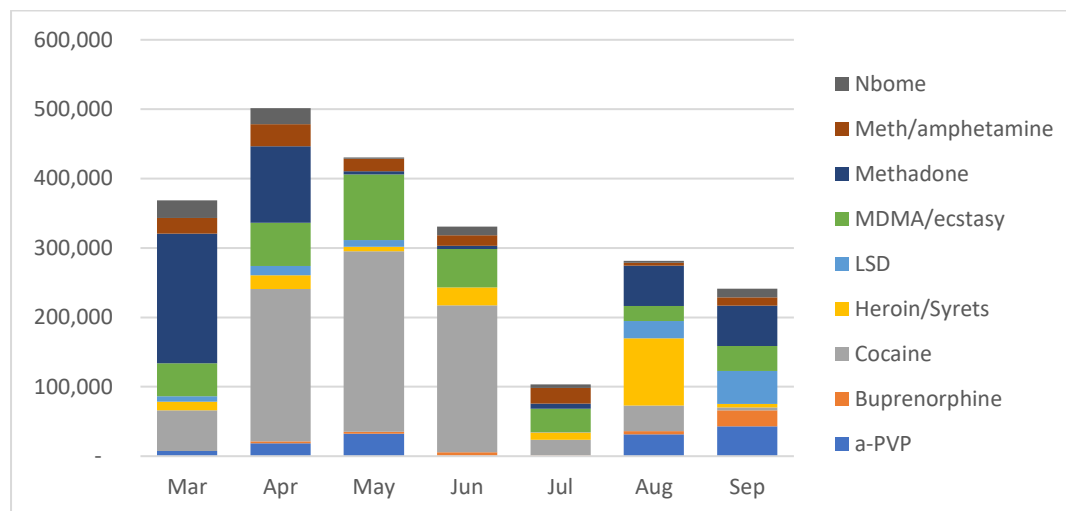


The highest revenues were generated in August (\$1,260,161) and the lowest in July (\$263,899) (see **Figure 27**). When excluding cannabis products, April was the month with the highest revenue (\$501,634) (see **Figure 28**). Similarly, to the trend in a number of transactions, monthly revenues gradually decreased by July and then started to recover. Cocaine related revenues were most affected during the April-September period, and LSD related revenues had the largest increase. When cannabis related revenues excluded, methadone accounted for the highest revenues among all other substances in September. Buprenorphine and LSD related revenues were the highest in September if compared to revenues from these substances in other months.

**Figure 27. Monthly revenues from 10 main substances.**  
(Note - data were not collected for June 23-July 14).

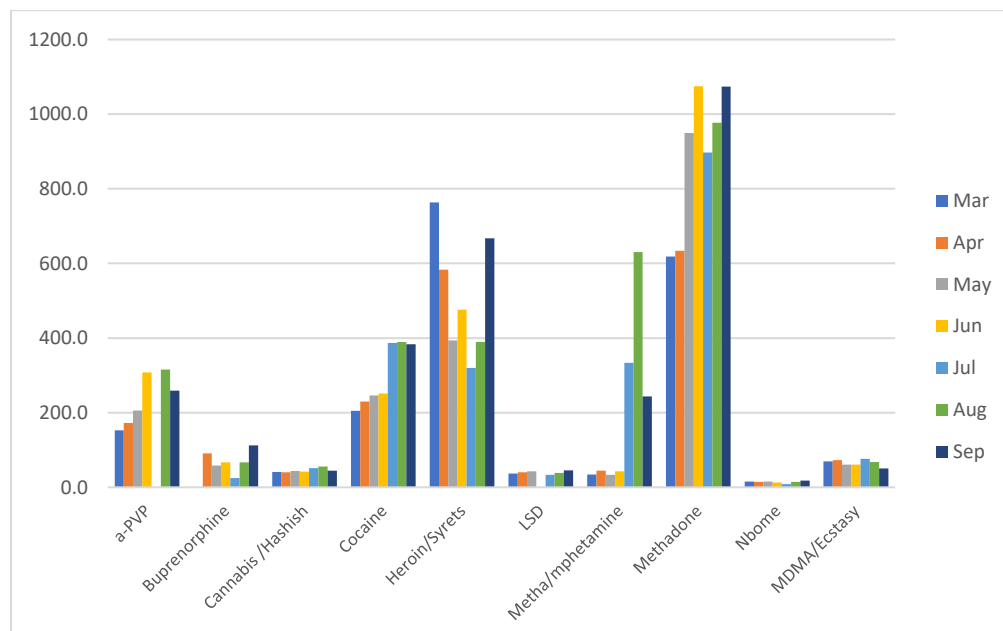


**Figure 28. Monthly revenues from 9 main substances (cannabis excluded).**  
(Note - data were not collected for June 23-July 14).



**Figure 29** shows monthly trends in average unit costs of products offered and sold on *Matanga*. Average unit costs for alpha-PVP, cocaine, meth/amphetamines and methadone gradually increased and almost doubled over the six months of the monitoring. It was not clear however, why prices increased for these specific substances and not for other substances.

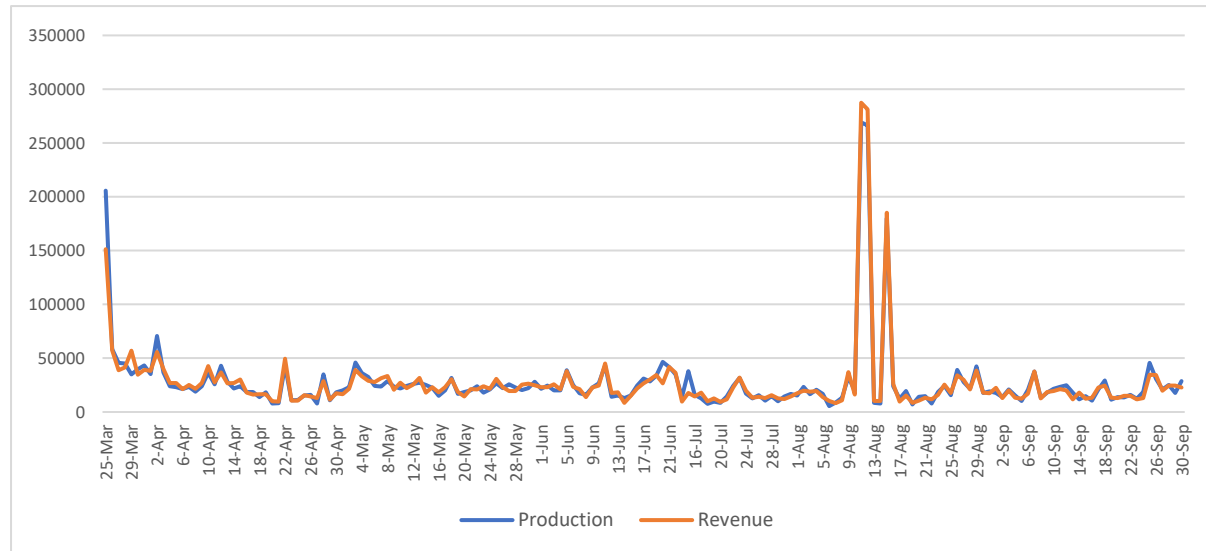
**Figure 29. Changes in unit cost of substances offered on a Georgian segment of Matanga.**  
(Note - data were not collected for June 23-July 14).



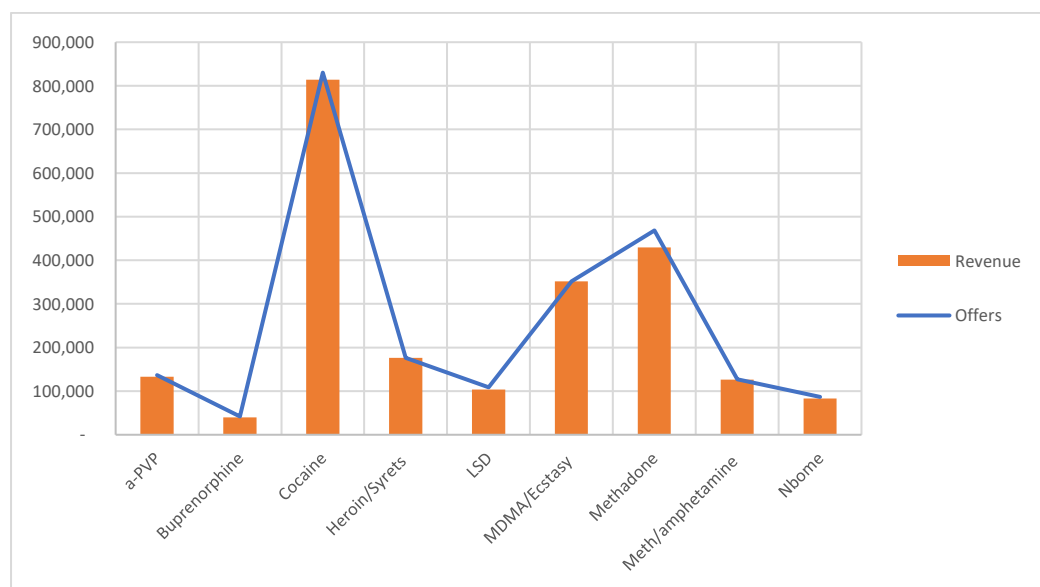
It was important to understand if there was any meaningful relationship between supply and demand for products that were offered for sale. In other words, research team was interested to know what share of substances that were offered on the platform was actually sold and how fast. Results of the monitoring suggest that there was a virtually exact match in a value of daily offers and daily revenues throughout the study period (see **Figure 30**). When looking at drug-

specific sales, there was similar match between a value of total offers for a specific product and a revenue from a sale of that product over the period of the study (see **Figure 31**).

**Figure 30. Trends in a value of daily offers and daily revenues in USD.**  
(Note - data were not collected for June 23-July 14).



**Figure 31. Value of total offers for a specific product and a revenue from a sale of that product over the period of the study in USD.**  
(Note - data were not collected for June 23-July 14).



## Limitations to be considered when interpreting study results

The sample was small and study participants were not representative of all people who use drugs on a regular basis in Georgia. Thus, other individuals, such as those who live in remote areas, who use drugs might have responded differently to the changes in the overall context in the country and in illicit drug markets in particular. In addition to a small sample size, some drugs were used by a small proportion of study participants which might further affect the external validity of the results, specifically in relation to those low prevalent drugs.

For an online market monitoring a principal assumption was that a disappearance of any item from a shop listing meant it was sold. The possibility that for some reasons sellers removed a product from a listing without selling it cannot be excluded, however such an action would be highly unlikely. Since the scraper software run hourly, it would potentially miss transaction if the product was placed for sale and was actually sold within a single hour. It was not feasible to track and account for discounts that were given to individual customers. Finally, the *Matanga* market discontinued from June 23 on its old web address. Research team was able to identify a new address (where the site migrated) by July 14, so the data presented did not include transactions for the period between June 23 and July 14.

## Conclusions and implications for public policy

- With the closure of businesses and restrictions on movement many individuals who use drugs lost their regular sources of income and relied on a support from family members and friends. The reduction in incomes, coupled with COVID-19 related measures introduced by the government and changes in illicit market dynamics resulted in shifts in drug related behaviors. Many PWUD switched to use alternative substances when favorite drugs were not available. In some cases, these were substances that were tried/used at some point in a drug career, in other cases they used completely new (for them) drug. New environment mediated contrasting changes - some PWUD started to use drugs more frequently *“due to plenty of free time and boredom”*, and others reduced the frequency of use due to difficulties in obtaining their favorite drugs.
- There was a general perception among PWUD respondents and key informants that it was more difficult to obtain drugs, specifically during the strictest lock-down measures, if compared to the pre-COVID-19 period. However, opinions with regard to which drugs were most affected in terms of availability were mixed. Findings regarding perceived changes in price and quality of drugs were also inconclusive with the majority of participants believing that the overall tendency was an increase in prices and decrease in a quality of substances available on the market. However, when compared with objective data reported by participants on prices paid for specific drugs and with the



relevant findings of online market monitoring, trends in drug prices reported as a general perception of participants look mixed, inconclusive and difficult to interpret.

- There was a notable (for study participants) increase in the availability of diverted medicinal methadone and buprenorphine on a market, that followed an unprecedented (for Georgia) decision to allow for 5-day take-home dosing of these medications for all OST patients. Both substances were seemingly diverted by some OST patients and were distributed for free to friends or sold through one's network of people who use drugs. The scale of this phenomena however remained unclear. It was also unclear to what extent this development facilitated the recruitment of new users or those who had a history of drug use but who stayed abstinent until these medications became relatively easily available for non-medical consumption. Results of this study did not show any increase in use of diverted substitution medications in a study sample. Both medicinal methadone and buprenorphine were used by the study cohort (i.e., were available on the market) prior to a change in take-home dosing regulations – the prevalence of use of diverted medicinal buprenorphine was 32% and the prevalence of use of diverted medicinal methadone was 18% at baseline. These rates did not increase over the course of the study. On the contrary, the prevalence of use of medicinal methadone declined and was 7% at the last interview session. Again, it is difficult to speculate if this decline was caused by the reduction in the availability of medicinal methadone on a market after take-home dosing was banned in the beginning of September.
- Market players showed remarkable flexibility while adjusting to a new environment and market conditions. For example, for drugs that were purchased through online platforms dead drops were moved to Tbilisi suburbs and isolated places to avoid detection by the law enforcement while police presence was intensified in central districts of the city. When stable contacts with dealers were affected, people searched for new contacts and supply options. In doing so, otherwise relatively closed PWUD networks started to interact with each other and tried to join forces in an attempt to identify new channels of supply. PWUD with financial resources frequented using the “service” of middlemen, so in this way they would reduce legal risks associated with illicit market interactions, but also limit their overall contacts while trying to avoid virus transmission. Overall, the role of a middleman seemingly increased and was redefined as an important player in a new landscape of a drug market. The alarming finding was that in some instances injection preparations were supplied to customers in a preloaded syringe. In fact, this was a very first instance that drug related research documented such practice in Georgia. As a general, but important observation, this study once again highlighted the role of a social supply in Georgian drug scene - significant share of reported drug interactions occurred as a free giving/sharing among friends and members of social network.
- Results of this study suggest that when access to sterile injection equipment was limited due to imposed restrictions on movement, drug users exercised risk-containing injection behaviors. First weeks of lock-down were accompanied by a rise in risky practices, in particular receiving used syringe and sharing instruments and tools for drug preparation and distribution. Such practices, however, were abandoned as soon as lock-down measures were gradually lifted and access to sterile equipment was restored.

- Despite some interruptions in service delivery during the first weeks of lock-down, harm reduction programs showed remarkable flexibility and were able to implement effective strategies to deliver services. Useful approaches included using mobile vans more extensively, intensifying utilization of self-testing technologies and delivering prevention equipment to clients where they lived. It was also documented that the utilization of syringe vending machines located in Tbilisi sharply increased at that time.
- Utilization of detoxification treatment was affected during the strictest lock-down measures. Use of these services, however, recovered as those measures were lifted. Demand for OST increased as soon as pandemic-related restrictions were enforced. Apparently, reduced access to illicit drugs and attractiveness of take-home dosing were among main factors that contributed to the rise in demand. OST programs were able to adjust quickly and effectively to new situation – all new clients were admitted to treatment and take-home dosing was implemented. Patients in quarantine received medication without any interruption.
- Results of an online market monitoring suggest that despite COVID-19 related restrictions the *Matanga* platform was actively used to procure illicit drugs among Georgian drug users. Over the period of monitoring there were more than 22,000 sale transactions and total revenues exceeded \$4.5 million. It is not clear what share of the overall drug transactions in the country the *Matanga* platform accounted for, or what was the share of this specific webpage in the overall Internet and mobile app mediated drug sales.
- *Matanga* offered a wide variety of psychotropic substances to Georgian customers – 19 categories of different drugs – almost all substances that were used by study participants, except for home-produced preparations. Cannabis products occupied the largest volume of sales, both in terms of a number of transactions and in terms of revenues generated. Among all other substances, cannabis supposedly was the only product that was produced locally along with being illegally trafficked to the country. A sharp rise in cannabis offers and sales in August (and partially in September) could be associated with its harvest by local growers that occurred at that time.
- It is challenging to interpret specific trends that were observed. Drug supply through online drug market did not seem to be seriously affected during the lock-down period. If assumed that data for the last days of March were characteristic of the overall pre-COVID-19 period, then it would be possible to conclude that restrictive measures did make impact on the volume of the market both in terms of number of sales episodes and value of sales. However, such a conclusion would be overly superficial. It cannot be excluded that along with the introduction of COVID-19 related restrictions in mid-March, while expecting even harsher quarantine measures to come, PWUD opted to stock-up their desired products. In such case, relatively high sales in the last week of March would not be indicative of a general market dynamic in a pre-COVID-19 period.
- An important finding was that daily offers and daily sales were vastly equal throughout the studied period. In other words, customers were willing and able to buy all and every substance offered by sellers and in amounts available at that particular day. It is not clear to what extent shops (sellers) were able to monitor and analyze the demand for specific substances and to what degree they strategically supplied specific drugs in amounts that were matched to the market demand. One would rather speculate that the market for psychoactive substances (at least an online illicit market) in Georgia is undersupplied and it can potentially absorb more drugs that are currently offered for

online sales. Surge in cannabis supply and sales in August can be seen as one supporting evidence of that. At the same time, a relatively high share of pre-orders in an overall number of listings (about one third) can be seen as a tool used by sellers to optimally manage their illicit trade and avoid oversupply of those drugs (or batch sizes) that, as they perceive, are not on a guaranteed demand.

- It is challenging to understand to what extent an online market was able to rapidly respond to emerging trends in a demand for specific substances. It might be a coincidence that offers and sales of methadone and buprenorphine were highest in September, the month when 5-day take-home dosing of substitution medications was stopped which resulted in a relative shortage of these (diverted by OST clients) medicinal products on illicit market.
- Available data does not allow to explain why prices for some drugs offered through online market have increased (substantially) and for others have not. Overall increase in drug prices would theoretically be expected considering additional difficulties and potential risks in trafficking drugs into the country while cross-border travel was limited. However, it is unclear what additional factors may or may not impact on the final unit cost of a specific substance and what reasons caused such a dramatic rise in end prices for some drugs, but not for others.
- For some substances changes in prices reported by the cohort participants and documented on the *Matanga* market did not follow a similar trend. For example, the price paid by cohort participants for a “single average dose” of cocaine dropped remarkably in September, if compared to prices in April. On the contrary, a unit price of cocaine sold on the *Matanga* market increased by 90% in the same period.
- Findings from the cohort self-reports should be interpreted with caution however. The sample was relatively small itself. In addition, some substances were used by a tiny proportion of participants (e.g., cocaine use was reported by 1 participant in September) and it is not possible to identify any “generalizable” trend based on these reports. Importantly, trends in prices were similar for both sources for those drugs that were used by a relatively larger proportion of cohort participants, such as heroin, street buprenorphine and MDMA/ecstasy. For cannabis products no major changes in prices were observed on the online market, while many cohort participants reported a reduction in price over the course of the study. One possible explanation for this disagreement can be that very few study participants supplied their cannabis from online market, as suggested by self-reports. The majority received cannabis products for free from friends (or bought from friends), specifically during the last weeks of the study (August-September), which coincided with the harvesting period for locally grown cannabis plants. Thus, it is possible that prices for local cannabis distributed through person-to-person contacts dropped in this period, while prices for imported cannabis sold on the *Matanga* remained relatively stable.

There are number of important public health implications that can be drawn based on this study. Harm reduction and treatment services need to develop and implement (when needed) clear protocols for ensuring uninterrupted service delivery during lock downs that can be enforced in a future in response to similar epidemics or any other emergency situations. Such protocols should consider positive experience accumulated during the COVID-19 related restrictions, such as flexible dosing of substitution medication, utilization of HIV self-testing technologies, mobile van-based outreach, vending machines for dispensing sterile injection

equipment, but also should elaborate new strategies and means that would allow for rapid adjustments to emergency context. In addition, prevention and education components of these services should include information to raise the awareness of PWUD about specific risks associated with new practices identified by current research, for example distribution of injection solutions in preloaded syringes.

OST programs need to develop and implement clear and flexible protocols for medication take-home dosing. Rigid requirements for daily visits serve as a barrier to seek treatment for many individuals who might potentially benefit from this treatment. Treatment protocols and regulations need to ensure a balanced approach to medication dispensing practices while weighting against risks for diversion of treatment medications and enormous public health benefits associated with OST.

Finally, continuous monitoring of online platforms for illicit drug sales can provide useful data to better understand the dynamics of illicit drug market. Among others, such monitoring can help to timely identify emerging patterns in drug supply in the country and can be an important source of data for a national early warning system.

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## COVID-19 impact on drug markets

**Q1. Age:**

**Select the correct answer from the listing below and write the answer number in the box**

**Q2. Gender:**

1. Male
2. Female
3. Nonbinary

**Q3. What is the highest level of education you completed:**

1. No education
2. Completed primary school (grades 1-4)
3. Incomplete high school education (grades 5-9)
4. Completed high school education (grades 10-12)
5. Completed high school-vocational education (technical college)
6. Incomplete university education (completed third year)
7. Completed university

**Q4. Employment:**

1. Unemployed
2. Employed (full time, part time, self-employed)
3. Student and employed
4. Student
5. Retired/social benefits

Please insert <u>X</u> in the relevant cell to indicate “yes” or “no” for every substance listed; indicate the age of first use in the last column	Q5. Have you ever used without doctor's prescription		Q6. Age of the first use
	yes	no	
1. Heroin, syrets			
2. Opium, black, shirka			
3. Street Methadone			
4. Methadone from program			
5. Street Subutex/Suboxone			
6. Subutex/Suboxone from program			
7. Cocaine, crack			
8. Vint, jeff, Ephedr/Connifera vint			
9. Amphetamine, metamphetanine(pill, powder, cristal)			
10. Cannabis (marijuana, hashish)			
11. Alcohol			
12. Ecstasy, MDMA			
13. NBOMe			
14. Ketamine			
15. LSD			
16. Other hallucinogens (mushrooms, psilocybin, belladonna)			
17. Volatile solvents, inhalants (glue, benzene, “rastvaritel”)			
18. Psychotropic myorelaxants (Lirica, Gabba-gamma, Baclosan, Gabapentine, Rivotril)			

19. Psychotropic, sedatives, tranquilizers (benzos, Diazepam, Relanium, Fenasepam, Ciclodol)			
20. Antihistamines, alone or as additions to the main drug (Dimedrol, Pipolphen, Suprastin)			
21. Synthetic cannabinoids (spices)			
22. Synthetic cathinones (bath salts, PVP, alpha-PVP, MDPV, Mephedrone)			
23. Other			

**Q7. Indicate which substance you used in the past 12 months without doctor's prescription prior to March 2020, and indicate what was the usual route of administration for each substance**

[display only substances checked in Q5]

	1. injection	2. Drinking/Swallowing/eating	3. smoking	4. vaporizing	5. snorting	6. inhaling	7. supra/sub-lingual
1. Heroin, syrets							
2. Opium, black, shirka							
3. Street Methadone							
4. Methadone from program							
5. Street Subutex/Suboxone							
6. Subutex/Suboxone from program							
7. Cocaine, crack							
8. Vint, jeff, Ephedr/Connifera vint							
9. Amphetamine, metamphetanine (pill, powder, cristal)							
10. Cannabis (marijuana, hashish)							
11. Alcohol							
12. Ecstasy, MDMA							
13. NBOMe							
14. Ketamine							
15. LSD							
16. Other hallucinogens (mushrooms, psilocybin, belladonna)							
17. Volatile solvents, inhalants (glue, benzene, "rastvaritel")							
18. Psychotropic myorelaxants (Lirica, Gabba-gamma, Baclosan, Gabapentine, Rivotril)							
19. Psychotropic, sedatives, tranquilizers (benzos, Diazepam, Relanium, Fenasepam, Ciclodol)							
20. Antihistamines, alone or as additions to the main drug (Dimedrol, Pipolphen, Suprastin)							
21. Synthetic cannabinoids (spices)							



22. Synthetic cathinones (bath salts, PVP, alpha-PVP, MDPV, Mephedrone)							
23. Other							

	<b>Q8. Indicate where from you usually obtained the substance prior to March 2020 (check up to 2 sources, however indicating ONE main source would be preferable)</b> <span style="color: red;">[display only substances checked in Q7]</span>							
	1. Buying through internet and receiving by post	2. Buying via digital app and receiving coordinates of place where the drug was hidden in advance	3. Buying from dealer face-to-face	4. Buying from intermediary /friend/acquaintance	5. Receiving for free from friend/acquaintance	6. Producing/cooking/growing myself	7. Psychotropic pharmacy	8. Other
1. Heroin, syrets								
2. Opium, black, shirka								
3. Street Methadone								
4. Methadone from program								
5. Street Subutex/Suboxone								
6. Subutex/Suboxone from program								
7. Cocaine, crack								
8. Vint, jeff, Ephedr/Connifera vint								
9. Amphetamine, metamphetanine (pill, powder, cristal)								
10. Cannabis (marijuana, hashish)								
11. Alcohol								
12. Ecstasy, MDMA								
13. NBOMe								
14. Ketamine								
15. LSD								
16. Other hallucinogens (mushrooms, psilocybin, belladonna)								
17. Volatile solvents, inhalants (glue, benzene, "rastvaritel")								
18. Psychotropic myorelaxants								

(Lirica, Gabba-gamma, Baclosan, Gabapentine, Rivotril)								
19. Psychotropic, sedatives, tranquilizers (benzos, Diazepam, Relanium, Fenasepam, Ciclodol)								
20. Antihistamines, alone or as additions to the main drug (Dimedrol, Pipolphen, Suprastin)								
21. Synthetic cannabinoids (spices)								
22. Synthetic cathinones (bath salts, PVP, alpha-PVP, MDPV, Mephedrone)								
23. Other								

	Q9. (If buying a drug or ingredients for preparing a drug) How much did you pay for your single average dose prior to March 2020 (in national currency) [display only substances checked in Q7]
1. Heroin, syrets	
2. Opium, black, shirka	
3. Street Methadone	
4. Methadone from program	
5. Street Subutex/Suboxone	
6. Subutex/Suboxone from program	
7. Cocaine, crack	
8. Vint, jeff, Ephedr/Connifera vint	
9. Amphetamine, metamphetanine(pill, powder, cristal)	
10. Cannabis (marijuana, hashish)	
11. Alcohol	
12. Ecstasy, MDMA	
13. NBOMe	
14. Ketamine	
15. LSD	
16. Other hallucinogens (mushrooms, psilocybin, belladonna)	
17. Volatile solvents, inhalants (glue, benzene, "rastvaritel")	
18. Psychotropic myorelaxants (Lirica, Gabba-gamma, Baclosan, Gabapentine, Rivotril)	
19. Psychotropic, sedatives, tranquilizers (benzos, Diazepam, Relanium, Fenasepam, Ciclodol)	
20. Antihistamines, alone or as additions to the main drug (Dimedrol, Pipolphen, Suprastin)	
21. Synthetic cannabinoids (spices)	
22. Synthetic cathinones (bath salts, PVP, alpha-PVP, MDPV, Mephedrone)	
23. Other	

Report here <b>ONLY</b> on substances that you used regularly (at least once a week) for 3 months prior to March 2020 [display only substances checked in Q7]		
	Q 10. Prior to March 2020, as usual, how many times a day did you use	Q 11. Prior to March 2020, as usual, how many days a week did you use
1. Heroin, syrets		
2. Opium, black, shirka		
3. Street Methadone		
4. Methadone from program		
5. Street Subutex/Suboxone		
6. Subutex/Suboxone from program		
7. Cocaine, crack		
8. Vint, jeff, Ephedr/Connifera vint		
9. Amphetamine, metamphetanine (pill, powder, cristal)		
10. Cannabis (marijuana, hashish)		
11. Alcohol		
12. Ecstasy, MDMA		
13. NBOMe		
14. Ketamine		
15. LSD		
16. Other hallucinogens (mushrooms, psilocybin, belladonna)		
17. Volatile solvents, inhalants (glue, benzene, "rastvaritel")		
18. Psychotropic myorelaxants (Lirica, Gabba-gamma, Baclosan, Gabapentine, Rivotril)		
19. Psychotropic, sedatives, tranquilizers (benzos, Diazepam, Relanium, Fenasepam, Ciclodol)		
20. Antihistamines, alone or as additions to the main drug (Dimedrol, Pipolphen, Suprastin)		
21. Synthetic cannabinoids (spices)		
22. Synthetic cathinones (bath salts, PVP, alpha-PVP, MDPV, Mephedrone)		
23. Other		

**Q12.** How many times had you overdosed on drugs in your lifetime? [skip to [Q14](#) if "0"]

**Q13.** What substance was the cause of overdose at the last overdose episode? [display only substances checked in Q5]

**Q14.** How many times have you ever received treatment due to your drug problems?

		Number of treatment episodes	Check if currently in treatment
0	No treatment		
1	Outpatient detoxification		
2	Detoxification residential		
3	Outpatient substitution		
4	Outpatient drug-free		
5	Drug-free residential		
6	Day care		
7	Psychiatric hospital		
8	Other hospital/ward		
9	Other treatment		

**Q15.** How would you describe your main source of income BEFORE March 2020 [choose all that apply]?

- 1 Full time / part time job
- 2 Seasonal / temporary job
- 3 Social payments (stipend, pension)
- 4 Support of other people (spouse, other relatives)
- 5 Illegal activities
- 6 Other

**Q16. Indicate which substance did you use during the past 14 days without doctor's prescription and by what rout**

	1. injection	2. Drinking/Swallowing/eating	3. smoking	4. vaporizing	5. snorting	6. inhaling	7. supra/sub-lingual
1. Heroin, syrets							
2. Opium, black, shirka							
3. Street Methadone							
4. Methadone from program							
5. Street Subutex/Suboxone							
6. Subutex/Suboxone from program							
7. Cocaine, crack							
8. Vint, jeff, Ephedr/Connifera vint							
9. Amphetamine, metamphetanine(pill, powder, cristal)							
10. Cannabis (marijuana, hashish)							
11. Alcohol							
12. Ecstasy, MDMA							
13. NBOMe							
14. Ketamine							
15. LSD							
16. Other hallucinogens (mushrooms, psilocybin, belladonna)							
17. Volatile solvents, inhalants (glue, benzene, "rastvaritel")							
18. Psychotropic myorelaxants (Lirica, Gabba-gamma, Baclosan, Gabapentine, Rivotril)							
19. Psychotropic, sedatives, tranquilizers (benzos, Diazepam, Relanium, Fenasepam, Ciclodol)							
20. Antihistamines, alone or as additions to the main drug (Dimedrol, Pipolphen, Suprastin)							
21. Synthetic cannabinoids (spices)							
22. Synthetic cathinones (bath salts, PVP, alpha-PVP, MDPV, Mephedrone)							
23. Other							



Pipolphen, Suprastin)								
21. Synthetic cannabinoids (spices)								
22. Synthetic cathinones (bath salts, PVP, alpha- PVP, MDPV, Mephedrone)								
23. Other								

	Q 18. (If buying a drug or ingredients for preparing a drug) for the past 14 days how much did you pay for your single average dose (in national currency)
1. Heroin, syrets	
2. Opium, black, shirka	
3. Street Methadone	
4. Methadone from program	
5. Street Subutex/Suboxone	
6. Subutex/Suboxone from program	
7. Cocaine, crack	
8. Vint, jeff, Ephedr/Connifera vint	
9. Amphetamine, metamphetanine (pill, powder, cristal)	
10. Cannabis (marijuana, hashish)	
11. Alcohol	
12. Ecstasy, MDMA	
13. NBOMe	
14. Ketamine	
15. LSD	
16. Other hallucinogens (mushrooms, psilocybin, belladonna)	
17. Volatile solvents, inhalants (glue, benzene, "rastvaritel")	
18. Psychotropic myorelaxants (Lirica, Gabba-gamma, Baclosan, Gabapentine, Rivotril)	
19. Psychotropic, sedatives, tranquilizers (benzos, Diazepam, Relanium, Fenasepam, Ciclodol)	
20. Antihistamines, alone or as additions to the main drug (Dimedrol, Pipolphen, Suprastin)	
21. Synthetic cannabinoids (spices)	
22. Synthetic cathinones (bath salts, PVP, alpha-PVP, MDPV, Mephedrone)	
23. Other	

	Q19. During the past 14 days, as usual, how many times a day did you use	Q20. During the past 14 days, as usual, how many days a week did you use
1. Heroin, syrets		
2. Opium, black, shirka		
3. Street Methadone		
4. Methadone from program		
5. Street Subutex/Suboxone		
6. Subutex/Suboxone from program		
7. Cocaine, crack		

8. Vint, jeff, Ephedr/Connifera vint		
9. Amphetamine, metamphetanine(pill, powder, cristal)		
10. Cannabis (marijuana, hashish)		
11. Alcohol		
12. Ecstasy, MDMA		
13. NBOMe		
14. Ketamine		
15. LSD		
16. Other hallucinogens (mushrooms, psilocybin, belladonna)		
17. Volatile solvents, inhalants (glue, benzene, "rastvaritel")		
18. Psychotropic myorelaxants (Lirica, Gabba-gamma, Baclosan, Gabapentine, Rivotril)		
19. Psychotropic, sedatives, tranquilizers (benzos, Diazepam, Relanium, Fenasepam, Ciclodol)		
20. Antihistamines, alone or as additions to the main drug (Dimedrol, Pipolphen, Suprastin)		
21. Synthetic cannabinoids (spices)		
22. Synthetic cathinones (bath salts, PVP, alpha-PVP, MDPV, Mephedrone)		
23. Other		

**Q21.** How many times have you overdosed on drugs during the past 14 days? [skip to [Q23](#) if "0"]

**Q22.** What substance was the cause of overdose at the last overdose episode? [display only substances checked in Q16]

**Q23.** Have you initiated or continued drug treatment during the past 14 days? [skip to [Q25](#) if "0"]

		Continued (yes/no)	Initiated (yes/no)
0	No treatment		
1	Outpatient detoxification		
2	Detoxification residential		
3	Outpatient substitution		
4	Outpatient drug-free		
5	Drug-free residential		
6	Day care		
7	Psychiatric hospital		
8	Other hospital/ward		
9	Other treatment		

**Q24.** How many days of the past 14 days have you received treatment? [display treatments checked in Q23]

		Number days in treatment
1	Outpatient detoxification	
2	Detoxification residential	
3	Outpatient substitution	
4	Outpatient drug-free	
5	Drug-free residential	
6	Day care	
7	Psychiatric hospital	
8	Other hospital/ward	
9	Other treatment	

**Q25.** In your opinion, how did the price of your main drug change in the past 14 days?

1. Became cheaper
2. Did not change
3. Became more expensive

**Q26.** In your opinion, how did the quality of your main drug change in the past 14 days?

1. Became better
2. Did not change
3. Became worse

**Q27.** In your opinion, how did the access to your main drug change in the past 14 days?

1. Became easier to get
2. Did not change
3. Became harder to get

**Q28.** In your opinion, how did access to harm reduction programs change in the past 14 days?

1. Became easier
2. Did not change
3. Became worse
4. Did not use harm reduction programs

**Q29.** Think about the times you injected drugs in the past 14 days. How often was it with a needle or syringe that had been previously used by someone else?

1. Always
2. Most times
3. About half the time
4. Occasionally
5. Never
6. I did not inject in the past 14 days [skip to Q36]

**Q30.** Have you received/ bought an injection from an already filled syringe (i.e. you did not see how it was filled) in the last 14 days?

1. Yes
0. No

**Q31.** In the last 14 days when you injected drugs, did you use a syringe, filled by someone from his / her already used syringe (direct or reverse filling, several doses in one syringe)?

1. Yes
0. No

**Q32.** Have you used common instruments for sharing (preparation) of a drug at least once in the last 14 days?

1. Yes
0. No

**Q33.** In the past 14 days, you had a clean needle for each injection:

1. Always
2. Most times
3. About half the time
4. Occasionally
5. Never



**Q34.** Where did you get clean needles/syringes in the past 14 days? (check all that apply)

1. Bought in a pharmacy
2. Received for free in a pharmacy
3. Received for free from vending machine
4. Received from a harm reduction program social worker (i.e. at a syringe exchange site, at an NGO, through outreach)
5. Got it from a friend or partner
6. Got a used syringe/needle from a friend or partner
7. Used my previously used needles/syringes
8. Bought the drug in pre-filled syringe
9. Found a used syringe/needle on the street
10. Other

**Q35.** What were the reasons you did not have enough clean needles/syringes for each injection in the past 14 days? (check all that apply)

0. I had clean needles/syringes for each injection
1. The pharmacy did not work as usual
2. The harm reduction program did not work as usual
3. I don't have enough money
4. The transportation did not work
5. I stayed at home because of the quarantine
6. I was sick
7. Other

**Q36.** Think about the times you smoked, vaporized or inhaled drugs in the past 14 days. How often did you share the device or instrument (vaporizer, tube, pipe, stem tip) with someone else (you used after someone or the other person used it after you)?

1. Always
2. Most times
3. About half the time
4. Occasionally
5. Never
6. I did not smoke, vaporized or inhaled drugs in the past 14 days

**Q37.** How would you describe your main source of income for the past 14 days [choose all that apply]?

1. Full time / part time job
2. Seasonal / temporary job
3. Social payments (stipend, pension)
4. Support of other people (spouse, other relatives)
5. Illegal activities
6. Other

**Q38.** Have you been tested for COVID in the past 14 days?

- 1 Yes and I was negative
- 2 Yes and I was positive
- 3 Yes and I am waiting for the result
- 4 No

**Q39.** Have you been hospitalized, and for how many days, in the past 14 days?

- 1 Yes for suspected COVID-19 (#days)
- 2 Yes for other (non COVID-19 related) reasons (#days)
- 2 No

## Annex 2. Study questionnaire in Georgian

### COVID-გავლენის ონლაინ კვლევის კითხვარი

Q1. ასაკი:

კითხვების პასუხები შეარჩიე ქვემოთ მოცემული ჩამონათვალიდან და პასუხი ჩაუწერეთ კვადრატულ ფრჩხილში არჩეული პასუხის ნომერი

Q2. სქესი:

4. ქალი
5. მამაკაცი
6. სხვა

Q3. რა არის თქვენი განათლება:

1. არ მაქვს არანაირი განათლება
2. სკოლის საწყისი კლასები (1-4 კლასი)
3. დაუსრულებელი საშუალო სკოლა (5-9 კლასი)
4. დასრულებული საშუალო სკოლა (10-12 კლასები)
5. დასრულებული ტექნიკური განათლება (ტექნიკუმი, კოლეჯი)
6. დაუსრულებელი საუნივერსიტეტო/უმაღლესი განათლება
7. დასრულებული საუნივერსიტეტო/უმაღლესი განათლება

Q4. დასაქმება:

6. უმუშევარი
7. დასაქმებული (დროებით სამუშაოზე, არასრული დატვირთვით, თვითდასაქმების ჩათვლით)
8. სტუდენტი დასაქმებული
9. სტუდენტი უმუშევარი
10. პენსია/სოციალური დახმარება

შემდეგ კითხვებში, სათითაოდ მონიშნე კი თუ არა - ნივთიერების გასწვრივ შენთვის სწორი პასუხის სვეტში ჩასვი X და გვერდზე მიუწერე ასაკი	Q5. მონიშნე ოდესმე მოგიხმარია თუ არა		Q6. რა ასაკში მოიხმარე პირველად
	კი	არა	
1. ჰეროინი, სირეცი			
2. ოპიუმი, შავი			
3. ქუჩის მეთადონი			
4. მეთადონი პროგრამიდან გამოტანილი			
5. ქუჩის სუბუტექსი/სუბოქსონი			
6. სუბუტექსი/სუბოქსონი პროგრამიდან გამოტანილი			
7. კოკაინი, კრეკი			
8. ვინტი, ჯეფი, ეფედრას (წიწვის) ვინტი			
9. ამფეტამინი, მეტამფეტამინი (აბი, ფხვნილი, კრისტალი)			
10. კანაფი (მარიხუანა, ჰაშიში)			
11. ალკოჰოლი			
12. ექსტაზი, MDMA			
13. NBOMe, "ენბაუმი"			

14. კეტამინი			
15. LSD			
16. სხვა ჰალუცინოგენები (სოკოები, ფსილოციბინი, ბელადონა)			
17. აქროლადი გამხსნელები (წებო, ბენზინი, ლაქის გამხსნელი, რასტვარიტელი)			
18. ფსიქოტროპული მიორელაქსანტები (ლირიკა, გაბა-გამა, ბაკლოსანი, გაბაპენტინი, რივოტრილი)			
19. ფსიქოტროპულები, დამამშვიდებელი, სედაციური (ბენზოები, დიაზეპამი, რელანიუმი, ფენაზეპამი, ციკლოდოლი)			
20. ამტიპისტამინურები ცალკე ან ნარევეში (დიმედროლი, პიპოლფენი, სუპრასტინი)			
21. სინთეზური კანაბინოიდები			
22. სინთეზური კათინონები - აბაზანის მარილი, PVP, alpha-PVP, MDPV, Mephedrone			
23. სხვა			

**Q7. მონიშნე რაც ბოლო 12 თვეში მოგიხმარია ექიმის დანიშნულების გარეშ და მიუთითე უპირატესად რა გზით მოიხმარდი 2020 წლის მარტის თვემდე [display only substances checked in Q5]**

	1. ინექციით	2. ვსვამდი/ვყლაპავდი/ვჭამდი	3. მოწევით	4. ვაპორაიზერით ვეწეოდი	5. შეწნოსვით	6. ინჰალაციით	7. ენაზე/ქვეშ დადებით
1. ჰეროინი, სირეცი							
2. ოპიუმი, შავი							
3. ქუჩის მეთადონი							
4. მეთადონი პროგრამიდან გამოტანილი							
5. ქუჩის სუბუტექსი/სუბოქსონი							
6. სუბუტექსი/სუბოქსონი პროგრამიდან გამოტანილი							
7. კოკაინი, კრეკი							
8. ვინტი, ჯეფი, ეფედრას (წიწვის) ვინტი							
9. ამფეტამინი, მეტამფეტამინი (აბი, ფხვნილი, კრისტალი)							
10. კანაფი (მარიხუანა, ჰაშიში)							
11. ალკოჰოლი							
12. ექსტაზი, MDMA							
13. NBOMe, "ენბაუმი"							
14. კეტამინი							
15. LSD							
16. სხვა ჰალუცინოგენები (სოკოები, ფსილოციბინი, ბელადონა)							
17. აქროლადი გამხსნელები (წებო, ბენზინი, ლაქის გამხსნელი, რასტვარიტელი)							
18. ფსიქოტროპული მიორელაქსანტები (ლირიკა, გაბა-გამა,							

ბაკლოსანი, გაბაპენტინი, რივოტრილი)							
19. ფსიქოტროპულები, დამამშვიდებელი, სედაციური (ბენზოები, დიაზეპამი, რელანიუმი, ფენაზეპამი, ციკლოდოლი)							
20. ამტიჰისტამინურები ცალკე ან ნარევში (დიმედროლი, პიპოლფენი, სუპრასტინი))							
21. სინთეზური კანაბინოიდები							
22. სინთეზური კათინონები - აბაზანის მარილი, PVP, alpha-PVP, MDPV, Mephedrone							
23. სხვა							

Q8. მიუთითეთ უპირატესად რა გზით შოულობდით 2020 წლის მარტის თვემდე (თუ გიჭირს ერთი ძირითადი შოვნის გზა არჩევა, მონიშნე მაქსიმუმ 2 შოვნის გზა) [display only substances checked in Q7]								
	1. ვიწერი ინტერნეტით და ვიდეო ფოსტით	2. ვყიდულობდი აპლიკაციებით და მიგზავნიდნენ დადებული მისამართების კოორდინატებს	3. ვიღებდი დილერისგან ხელზე	4. ვყიდულობდი შუამავლისგან/მეგობრისგან/ ნაცნობისგან	5. მჭუქნიდნენ მეგობრები/ ნაცნობები	6. ჩემით ვამზადებდი/მომყავდა	7. ვყიდულობდი ფსიქოტროპულ აფთიაქში	8. სხვა
1. ჰეროინი, სირეცი								
2. ოპიუმი, შავი								
3. ქუჩის მეთადონი								
4. მეთადონი პროგრამიდან გამოტანილი								
5. ქუჩის სუბუტექსი/სუბოქსონი								
6. სუბუტექსი/სუბოქსონი პროგრამიდან გამოტანილი								
7. კოკაინი, კრეკი								
8. ვინტი, ჯეფი, ეფედრას (წიწვის) ვინტი								
9. ამფეტამინი, მეთამფეტამინი (აბი, ფხვნილი, კრისტალი)								
10. კანაფი (მარიხუანა, ჰაშიში)								
11. ალკოჰოლი								
12. ექსტაზი, MDMA								
13. NBOMe, "ენბაუმი"								
14. კეტამინი								
15. LSD								
16. სხვა ჰალუცინოგენები (სოკოები,								

ფსიქოლოგიური, ბელადონა)								
17. აქროლადი გამხსნელები (წებო, ბენზინი, ლაქის გამხსნელი, რასტვარიტელი)								
18. ფსიქოტროპული მიორელაქსანტები (ლირიკა, გაბა-გამა, ბაკლოსანი, გაბაპენტინი, რივოტრილი)								
19. ფსიქოტროპული, დამამშვიდებელი, სედაციური (ბენზოები, დიაზეპამი, რელანიუმი, ფენაზეპამი, ციკლოდოლი)								
20. ამტიჰისტამინურები ცალკე ან ნარევში (დიმედროლი, პიპოლფენი, სუპრასტინი))								
21. სინთეზური კანაბინოიდები								
22. სინთეზური კათინონები - აბაზანის მარილი, PVP, alpha-PVP, MDPV, Mephedrone								
23. სხვა								

	Q9. (თუ იხდით ფულს ნარკოტიკში ან ინგრედიენტებში ნარკოტიკის დასაშვადებლად) როგორც წესი, რამდენ ლარს იხდით შენს ერთჯერად დოზაში 2020 წლის მარტამდე [display only substances checked in Q7]
1. ჰეროინი, სირეცი	
2. ოპიუმი, შავი	
3. ქუჩის მეთადონი	
4. მეთადონი პროგრამიდან გამოტანილი	
5. ქუჩის სუბუტექსი/სუბოქსონი	
6. სუბუტექსი/სუბოქსონი პროგრამიდან გამოტანილი	
7. კოკაინი, კრეკი	
8. ვინტი, ჯეფი, ეფედრას (წიწვის) ვინტი	
9. ამფეტამინი, მეტამფეტამინი (აბი, ფხვნილი, კრისტალი)	
10. კანაფი (მარიხუანა, ჰაშიში)	
11. ალკოჰოლი	
12. ექსტაზი, MDMA	
13. NBOMe, "ენბაუმი"	
14. კეტამინი	
15. LSD	
16. სხვა ჰალუცინოგენები (სოკოები, ფსიქოლოგიური, ბელადონა)	

17. აქროლადი გამხსნელები (წებო, ბენზინი, ლაქის გამხსნელი, რასტვარიტელი)	
18. ფსიქოტროპული მიორელაქსანტები (ლირიკა, გაბა-გამა, ბაკლოსანი, გაბაპენტინი, რივოტრილი)	
19. ფსიქოტროპულები, დამამშვიდებელი, სედაციური (ბენზოები, დიაზეპამი, რელანიუმი, ფენაზეპამი, ციკლოდოლი)	
20. ამტიპსისტამინურები ცალკე ან ნარევში (დიმედროლი, პიპოლფენი, სუპრასტინი))	
21. სინთეზური კანაბინოიდები	
22. სინთეზური კათინონები - აბაზანის მარილი, PVP, alpha-PVP, MDPV, Mephedrone	
23. სხვა	

ეს კითხვები ეხება მხოლოდ იმ ნივთიერებებს, რომლებსაც მოიხმარდი რეგულარულად (კვირაში ერთხელ მაინც) ბოლო 3 თვის მანძილზე 2020 წლის მარტამდე [display only substances checked in Q7]		
	Q 10. როგორც წესი, დღეში რამდენჯერ მოიხმარდი 2020 წლის მარტამდე	Q 11. როგორც წესი, კვირაში რამდენი დღე მოიხმარდი 2020 წლის მარტამდე
1. ჰეროინი, სირეცი		
2. ოპიუმი, შავი		
3. ქუჩის მეთადონი		
4. მეთადონი პროგრამიდან გამოტანილი		
5. ქუჩის სუბუტექსი/სუბოქსონი		
6. სუბუტექსი/სუბოქსონი პროგრამიდან გამოტანილი		
7. კოკაინი, კრეკი		
8. ვინტი, ჯეფი, ეფედრას (წიწვის) ვინტი		
9. ამფეტამინი, მეთამფეტამინი (აბი, ფხვნილი, კრისტალი)		
10. კანაფი (მარიხუანა, ჰაშიში)		
11. ალკოჰოლი		
12. ექსტაზი, MDMA		
13. NBOMe, "ენბაუმი		
14. კეტამინი		
15. LSD		
16. სხვა ჰალუცინოგენები (სოკოები, ფსილოციბინი, ბელადონა)		
17. აქროლადი გამხსნელები (წებო, ბენზინი, ლაქის გამხსნელი, რასტვარიტელი)		
18. ფსიქოტროპული მიორელაქსანტები (ლირიკა, გაბა-გამა, ბაკლოსანი, გაბაპენტინი, რივოტრილი)		
19. ფსიქოტროპულები, დამამშვიდებელი, სედაციური (ბენზოები, დიაზეპამი, რელანიუმი, ფენაზეპამი, ციკლოდოლი)		
20. ამტიპსისტამინურები ცალკე ან ნარევში (დიმედროლი, პიპოლფენი, სუპრასტინი))		
21. სინთეზური კანაბინოიდები		
22. სინთეზური კათინონები - აბაზანის მარილი, PVP, alpha-PVP, MDPV, Mephedrone		
23. სხვა		

**Q12.** ცხოვრების მანძილზე რამდენჯერ გქონიათ ნარკოტიკებით გამოწვეული ზედოზირება?

[skip to Q14 if "0"]

**Q13.** გაიხსენეთ ბოლოს ზედოზირების ეპიზოდი, რომელმა ნარკოტიკულმა საშუალებამ გამოიწვია ზედოზირება? [display only substances checked in Q5]

**Q14.** ნარკოტიკულ საშუალებებთან დაკავშირებული პრობლემის გამო ოდესმე მიგიღიათ თუ არა ქვემოთ ჩამოთვლილი მკურნალობა და რამდენჯერ?

		მიუთითეთ რამდენჯერ იმკურნალეთ	მონიშნეთ თუ ამჟამად მკურნალობ
0	არ მიმკურნალია		
1	ამბულატორიული დეტოქსიკაცია		
2	სტაციონარული დეტოქსიკაცია		
3	ამბულატორიული ჩანაცვლებითი თერაპია		
4	ამბულატორიული რეაბილიტაცია		
5	სტაციონარული (რეზიდენტული) რეაბილიტაცია		
6	დღის სტაციონარი		
7	ფსიქიატრიული საავადმყოფო		
8	სხვა საავადმყოფო		
9	სხვა: მიუთითეთ		

**Q15.** ძირითადად რა წყაროდან გქონდა შემოსავალი 2020 წლის მარტამდე [მონიშნეთ ყველა შესაძლო სწორი პასუხი]?

- 1 სრული დასაქმება/ნაწილობრივი დასაქმება
- 2 სეზონური/დროებითი სამუშაო
- 3 სოციალური სარგებელი (პენსია/სტიპენდია)
- 4 სხვა ადამიანების დახმარება (მეუღლე/ნათესავი/მეგობარი)
- 5 არალეგალური საქმიანობა
11. სხვა

**Q16.** მონიშნეთ რაც მოიხმარე ბოლო 14 დღის განმავლობაში ექიმის დანიშნულების გარეშე და მიუთითეთ უპირატესად რა გზით მოიხმარე

	1. ინექციით	2. ვსვამდი/ვყლაპავდი/ვჭამდი	3. მოწევი	4. ვაპორაიზებდი ვეწედი	5. შეყნოსვით	6. ინჰალაციით	7. ენაზე/ქვეშა დადებით
1. ჰეროინი, სირეცი							
2. ოპიუმი, შავი							
3. ქუჩის მეთადონი							
4. მეთადონი პროგრამიდან გამოტანილი							
5. ქუჩის სუბუტექსი/სუბოქსონი							

6. სუბუტექსი/სუბოქსონი პროგრამიდან გამოტანილი							
7. კოკაინი, კრეკი							
8. ვინტი, ჯეფი, ეფედრას (წიწვის) ვინტი							
9. ამფეტამინი, მეტამფეტამინი (აბი, ფხვნილი, კრისტალი)							
10. კანაფი (მარიხუანა, ჰაშიში)							
11. ალკოჰოლი							
12. ექსტაზი, MDMA							
13. NBOMe, "ენბაუმი"							
14. კეტამინი							
15. LSD							
16. სხვა ჰალუცინოგენები (სოკოები, ფსილოციბინი, ბელადონა)							
17. აქროლადი გამხსნელები (წებო, ბენზინი, ლაქის გამხსნელი, რასტვარიტელი)							
18. ფსიქოტროპული მიორელაქსანტები (ლირიკა, გაბა-გამა, ბაკლოსანი, გაბაპენტინი, რივოტრილი)							
19. ფსიქოტროპულები, დამამშვიდებელი, სედაციური (ბენზოები, დიაზეპამი, რელანიუმი, ფენაზეპამი, ციკლოდოლი)							
20. ამტიჰისტამინურები ცალკე ან ნარევში (დიმედროლი, პიპოლფენი, სუპრასტინი))							
21. სინთეზური კანაბინოიდები							
22. სინთეზური კათინონები - აბაზანის მარილი, PVP, alpha-PVP, MDPV, Mephedrone							
23. სხვა							

Q17. მიუთითეთ უპირატესად რა გზით შოულობდი ბოლო 14 დღის მანძილზე (თუ გიჭირს ერთი ძირითადი შოვნის გზის არჩევა, მონიშნე მაქსიმუმ 2 შოვნის გზა) [display only substances checked in Q16]								
	1. ვიწერდი ინტერნეტით და ვიღებდი ფოსტით	2. ვყიდულობდი აპლიკაციებით და მიგზავნიდნენ დადებული მისამართების კოორდინატებს	3. ვიღებდი დილერისგან ხელზე	4. ვყიდულობდი შუამავლისგან/მეგობრისგან/ ნაცნობისგან	5. მჩუქნიდნენ მეგობრები/ ნაცნობები	6. ჩემით ვამზადებდი	7. ვყიდულობდი ფსიქოტროპულ აფთიაქში	8. სხვა
1. ჰეროინი, სირეცი								



2. ოპიუმი, შავი								
3. ქუჩის მეთადონი								
4. მეთადონი პროგრამიდან გამოტანილი								
5. ქუჩის სუბუტექსი/სუბოქსონი								
6. სუბუტექსი/სუბოქსონი პროგრამიდან გამოტანილი								
7. კოკაინი, კრეკი								
8. ვინტი, ჯეფი, ეფედრას (წიწვის) ვინტი								
9. ამფეტამინი, მეტამფეტამინი (აბი, ფხვნილი, კრისტალი)								
10. კანაფი (მარიხუანა, ჰაშიში)								
11. ალკოჰოლი								
12. ექსტაზი, MDMA								
13. NBOMe, "ენბაუმი"								
14. კეტამინი								
15. LSD								
16. სხვა ჰალუცინოგენები (სოკოები, ფსილოციბინი, ბელადონა)								
17. აქროლადი გამხსნელები (წებო, ბენზინი, ლაქის გამხსნელი, რასტვარიტელი)								
18. ფსიქოტროპული მიორელაქსანტები (ლირიკა, გაბა-გამა, ბაკლოსანი, გაბაპენტინი, რივოტრილი)								
19. ფსიქოტროპულები, დამამშვიდებელი, სედაციური (ბენზოები, დიაზეპამი, რელანიუმი, ფენაზეპამი, ციკლოდოლი)								
20. ამტიჰისტამინურები ცალკე ან ნარევეში (დიმედროლი, პიპოლფენი, სუპრასტინი))								
21. სინთეზური კანაბინოიდები								
22. სინთეზური კათინონები - აბაზანის მარილი, PVP, alpha-PVP, MDPV, Mephedrone								
23. სხვა								

	Q 18. (თუ იხდიდი ფულს ნარკოტიკში ან ინგრედიენტებში ნარკოტიკის დასამზადებლად) როგორც წესი, რამდენ ლარს იხდიდი შენს ერთჯერად დოზაში ბოლო 14 დღის მანძილზე
1. ჰეროინი, სირეცი	
2. ოპიუმი, შავი	
3. ქუჩის მეთადონი	
4. მეთადონი პროგრამიდან გამოტანილი	
5. ქუჩის სუბუტექსი/სუბოქსონი	
6. სუბუტექსი/სუბოქსონი პროგრამიდან გამოტანილი	
7. კოკაინი, კრეკი	
8. ვინტი, ჯეფი, ეფედრას (წიწვის) ვინტი	
9. ამფეტამინი, მეტამფეტამინი (აბი, ფხვნილი, კრისტალი)	
10. კანაფი (მარიხუანა, ჰაშიში)	
11. ალკოჰოლი	
12. ექსტაზი, MDMA	
13. NBOMe, "ენბაუმი"	
14. კეტამინი	
15. LSD	
16. სხვა ჰალუცინოგენები (სოკოები, ფსილოციბინი, ბელადონა)	
17. აქროლადი გამხსნელები (წებო, ბენზინი, ლაქის გამხსნელი, რასტვარიტელი)	
18. ფსიქოტროპული მიორელაქსანტები (ლირიკა, გაბა-გამა, ბაკლოსანი, გაბაპენტინი, რივოტრილი)	
19. ფსიქოტროპულები, დამამშვიდებელი, სედაციური (ბენზოები, დიაზეპამი, რელანიუმი, ფენაზეპამი, ციკლოდოლი)	
20. ამტიპსიტამინურები ცალკე ან ნარევში (დიმედროლი, პიპოლფენი, სუპრასტინი)	
21. სინთეზური კანაბინოიდები	
22. სინთეზური კათინონები - აბაზანის მარილი, PVP, alpha-PVP, MDPV, Mephedrone	
23. სხვა	

	Q19 როგორც წესი, დღეში რამდენჯერ მოიხმარდით ბოლო 14 დღის მანძილზე	Q20. როგორც წესი, კვირაში რამდენი დღე მოიხმარდით ბოლო 14 დღის მანძილზე
1. ჰეროინი, სირეცი		
2. ოპიუმი, შავი		
3. ქუჩის მეთადონი		
4. მეთადონი პროგრამიდან გამოტანილი		
5. ქუჩის სუბუტექსი/სუბოქსონი		
6. სუბუტექსი/სუბოქსონი პროგრამიდან გამოტანილი		
7. კოკაინი, კრეკი		
8. ვინტი, ჯეფი, ეფედრას (წიწვის) ვინტი		
9. ამფეტამინი, მეტამფეტამინი (აბი, ფხვნილი, კრისტალი)		
10. კანაფი (მარიხუანა, ჰაშიში)		

11. ალკოჰოლი		
12. ექსტაზი, MDMA		
13. NBOMe, "ენბაუმი"		
14. კეტამინი		
15. LSD		
16. სხვა ჰალუცინოგენები (სოკოები, ფსილოციბინი, ბელადონა)		
17. აქროლადი გამხსნელები (წებო, ბენზინი, ლაქის გამხსნელი, რასტვარიტელი)		
18. ფსიქოტროპული მთრელები (ლირიკა, გაბა-გამა, ბაკლოსანი, გაბაპენტინი, რივოტრილი)		
19. ფსიქოტროპული, დამამშვიდებელი, სედაციური (ბენზოები, დიაზეპამი, რელანიუმი, ფენაზეპამი, ციკლოდოლი)		
20. ამტივისტამინურები ცალკე ან ნარევში (დიმედროლი, პიპოლფენი, სუპრასტინი)		
21. სინთეზური კანაბინოიდები		
22. სინთეზური კათინონები - აბაზანის მარილი, PVP, alpha-PVP, MDPV, Mephedrone		
23. სხვა		

**Q21.** ბოლო 14 დღის მანძილზე რამდენჯერ გქონდათ ნარკოტიკული საშუალებით გამოწვეული ზედოზირება? [skip to Q23 if "0"]

**Q22.** ბოლო 14 დღის მანძილზე რომელმა ნარკოტიკულმა საშუალებამ გამოიწვია ზედოზირება? [display only substances checked in Q16]

**Q23.** თუ დაიწყეთ ან აგრძელებდით მკურნალობას ბოლო 14 დღის განმავლობაში, რა სახის მკურნალობა იყო? [skip to Q25 if "0"]

		ვარგძელები	დავიწყე
0	არ დამიწყია მკურნალობა		
1	ამბულატორიული დეტოქსიკაცია		
2	სტაციონარული დეტოქსიკაცია		
3	ამბულატორიული ჩანაცვლებითი თერაპია		
4	ამბულატორული რეაბილიტაცია		
5	სტაციონარული (რეზიდენტული) რეაბილიტაცია		
6	დღის სტაციონარი		
7	ფსიქიატრიული საავადმყოფო		
8	სხვა საავადმყოფო		
9	სხვა: მიუთითეთ		

**Q24.** ჩამოთვლილი მკურნალობის სერვისებიდან ბოლო 14 დღეში რამდენი დღე მიიღეთ მკურნალობის სერვისი?

	მიუთითეთ დღეების რაოდენობა
--	----------------------------

1	ამბულატორიული დეტექსიკაცია	
2	სტაციონარული დეტექსიკაცია	
3	ამბულატორიული ჩანაცვლებითი თერაპია	
4	ამბულატორული რეაბილიტაცია	
5	სტაციონარული (რეზიდენტული) რეაბილიტაცია	
6	დღის სტაციონარი	
7	ფსიქიატრიული საავადმყოფო	
8	სხვა საავადმყოფო	
9	სხვა: მიუთითეთ	

**Q25.** ბოლო 14 დღის მანძილზე როგორ შეიცვალა თქვენი ძირითადი ნარკოტიკის ფასი?

4. გაიზარდა
5. არ შეცვლილა
6. გაძვირდა

**Q26.** ბოლო 14 დღის მანძილზე როგორ შეიცვალა თქვენი ძირითადი ნარკოტიკის ხარისხი?

4. გაუმჯობესდა
5. არ შეცვლილა
6. გაუარესდა

**Q27.** ბოლო 14 დღის მანძილზე როგორ შეიცვალა თქვენი ძირითადი ნარკოტიკის ხელმისაწვდომობა?

4. გაიოლდა შოვნა
5. არ შეცვლილა
6. გართულდა შოვნა

**Q28.** ბოლო 14 დღის მანძილზე როგორ შეიცვალა ზიანის შემცირების სერვისების ხელმისაწვდომობა?

7. გამარტივდა სერვისის მიღება
8. არ შეცვლილა
9. გართულდა სერვისის მიღება
10. არ მისარგებლია ზიანის შემცირების სერვისით

**Q29.** ბოლო 14 დღის მანძილზე გაგიკეთებია თუ არა ინექცია შპრიცით ან ნემსით, რომელიც მანამდე სხამ გამოიყენა?

1. ყოველთვის
2. უმეტესად
3. დაახლოებით ნახევარ ჯერზე
4. ხანდახან
5. არასდროს
6. მე არ მიმიღია ნარკოტიკი ინექციით ბოლო 14 დღის მანძილზე [ამ შემთხვევაში კითხვარი გადადის Q36-ზე]

**Q30.** ბოლო 14 დღის მანძილზე მიგიღია/გიყიდა წინასწარ შევსებული შპრიცით გახსნილი წამალი (არ დაგინახავს, ვინ და როგორ აავსო შპრიცი ნარკოტიკით)?

1. კი
0. არა

**Q31.** ბოლო 14 დღის მანძილზე, როდესაც გაიკეთე ნარკოტიკის ინექცია, გამოგიყენებია თუ არა შპრიცი, რომელიც სხვამ აავსო სხვა/თავისი უკვე გამოყენებული ან საერთო შპრიციდან?

1. კი
0. არა

**Q32.** ბოლო 14 დღის მანძილზე ერთხელ მაინც თუ გამოგიყენებია საზიარო ინსტრუმენტები/მოწყობილებები (თასი, ჯამი, პუზირი)?

1. კი
0. არა

**Q33.** ბოლო 14 დღის მანძილზე ყოველი ინექციისთვის გქონდა თუ არა სტერილური შპრიცი/ნემსი?

1. ყოველთვის
2. უმეტესად
3. დაახლოებით ნახევარ ჯერზე
4. ხანდახან
5. არასდროს

**Q34.** ბოლო 14 დღის მანძილზე სად შოულობდი შპრიცს/ნემსს [მონიშნე ყველა შესაძლო სწორი პასუხი]

11. ვყიდულობდი აფთიაქში
12. ვიღებდი უფასოდ აფთიაქში
13. ვიღებდი შპრიცების გამცემი (სიგმა) აპარატიდან
14. ვიღებდი ზიანის შემცირების პროგრამის სოციალური მუშაკისაგან (შპრიცების გაცვლის პროგრამა, სხვა არასამთავრობო ორგანიზაცია)
15. ვიღებდი სტერილურს მეგობრისგან, პარტნიორისგან
16. ვიღებდი ნახმარს მეგობრისგან, პარტნიორისგან
17. მოვიხმარე ჩემს მიერ მანამდე ნახმარი შპრიცი/ნემსი
18. შევიძინე ნარკოტიკი წინასწარ შევსებული შპრიცით
19. ვიპოვე ნახმარი შპრიცი/ნემსი ქუჩაში
20. სხვა

**Q35.** ბოლო 14 დღის მანძილზე რა იყო იმის მიზეზი, რომ არ გქონდა საკმარისი სტერილური შპრიცი/ნემსი ყოველი ინექციისთვის [მონიშნე ყველა შესაძლო სწორი პასუხი]

8. მე მქონდა სტერილური შპრიცი/ნემსი ყოველი ინექციისას
9. აფთიაქები არ მუშაობდნენ ჩვეული რეჟიმით
10. ზიანის შემცირების პროგრამები არ მუშაობდნენ ჩვეული რეჟიმით
11. არ მქონდა საკმარისი ფული
12. ტრანსპორტი არ მუშაობდა
13. მე ვრჩებოდი სახლსი კარანტინის გამო

14. ვიყავი ავად
15. სხვა
16. არ მსურს პასუხის გაცემა

**Q36.** ბოლო 14 დღის მანძილზე ნარკოტიკის მიღებისას გაგიზიარებია თუ არა (შენ მოიხმარე სხვისი გამოყენებული ან სხვამ მოიხმარა შენ მიერ გამოყენებული) მოსაწევი მოწყობილობა ან ინსტრუმენტი (ვაპორაიზერი, ინჰალატორი, მილი, ჩიბუხი, მუნდშტუკი) სხვასთან?

1. ყოველთვის
2. უმეტესად
3. დაახლოებით ნახევარ ჯერზე
4. ხანდახან
5. არასდროს
6. ბოლო 14 დღის მანძილზე მე არ მომიწევია, არ შემისუნთქია ნარკოტიკი ვაპორაიზერის ან ინჰალატორის მეშვეობით

**Q37.** ძირითადად რა წყაროდან გქონდა შემოსავალი ბოლო 14 დღის მანძილზე [მონიშნე ყველა შესაძლო სწორი პასუხი]?

- 1 სრული დასაქმება/ნაწილობრივი დასაქმება
- 2 სეზონური/დროებითი სამუშაო
- 3 სოციალური სარგებელი (პენსია/სტიპენდია)
- 4 სხვა ადამიანების დახმარება (მეუღლე/ნათესავი/მეგობარი)
- 5 არალეგალური საქმიანობა
6. სხვა

**Q38.** ბოლო 14 დღის მანძილზე ჩაიტარე თუ არა ტესტირება COVID-ზე?

- 1 ჩავიტარე და პასუხი იყო უარყოფითი
- 2 ჩავიტარე და პასუხი იყო დადებითი
- 3 ჩავიტარე და პასუხს ველოდები
- 4 არა

**Q39.** ბოლო 14 დღის მანძილზე იყავი თუ არა ჰოსპიტალიზირებული, და რამდენი დღით?

- 1 ვიყავი ჰოსპიტალიზირებული COVID ინფექციის მიზეზით (#დღეები)
- 2 ვიყავი ჰოსპიტალიზირებული სხვა, არა COVID ინფექციის მიზეზით (#დღეები)
- 2 არა

### ***Annex 3. Interview guide for key informants (English)***

#### **Interview guide for key informants**

(individual interviews to be held once every month)

##### **1. Drug markets**

What is your perception of the changes in the availability of illicit drugs during the last 30 days? Do you think drugs have become easier or more difficult to get? Which ones? How do you know?

What about the price - have drugs got cheaper or more expensive? Which ones, and why do you think so?

How the quality of drugs available on a drug market has changed? Why do you think so? Which drugs do you mean? What are the reasons for those changes? What could be the consequences of such changes?

##### **2. Drug users' behavior – supply and use**

What is your perception of changes in drug users' behavior over the last 30 days?

Did people look for/explored and used alternative supply channels and sources for drugs?

How did the quarantine requirements and public transportation shutdown change access of drug users to stashes or drug dealers? With social distancing required and businesses closed, how did drug users' access to legal or illegal source of income change? What could be the consequences of the mentioned changes?

How drug consumption patterns have changed? Do you know about cases when people replaced one type of drug with another? Did people switch to new drugs or combinations? In which way might the drug doses change? On average, did people use drugs in higher or lower doses? On average, did they use drugs more frequently or less frequently?

Did people change the route of drug consumption? Why do you think so? What are the reasons for those changes? Did they started using psychotropic or over-the-counter medications to maintain their withdrawal? What are these drugs? What could be the consequences of the mentioned changes?

##### **3. Drug users' behavior – risk taking**

What is your perception of changes in risk-containing behavior of drug users over the last 30 days? Did people exercise riskier (or safer) behaviors? What do you mean by that? Can you give any example?

Are drug users under the higher (or lower) risk of infections due to sharing drug taking instruments? Did they use more (or less) harmful combinations, riskier (or safer) routes of administration? Did they consume more (or less) drugs of unknown composition and/or quality?

Why do you think so? What are the reasons for those changes? What could be the consequences of the mentioned changes?

#### 4. Availability and utilization of services

What is your perception of changes in the availability and accessibility of harm reduction, drug treatment and other health services for drug users over the last 30 days? Did any services closed (or opened)? Reduced (or increased) coverage? Reduced (or increased) working hours? Reduced (or increased) the variety of services provided?

How did the quarantine requirements and the ceased public transportation influence accessibility of services for drug users? Did more (or fewer) drug users seek and access services? Which specific services do you mean? Why do you think so? What are the reasons for those changes?

#### *Annex 4. Interview guide for key informants (Georgian)*

ინტერვიუს გაიდი საკვანძო ინფორმაციებისთვის  
(ინდივიდუალური ინტერვიუები ჩატარდება თვეში ერთხელ)

#### 5. ნარკობაზარი

თქვენი აზრით, როგორ შეიცვალა არალეგალური ნარკოტიკული საშუალებების ხელმისაწვდომობა ბოლო 30 დღის განმავლობაში? ფიქრობთ, რომ ნარკოტიკები გახდა უფრო მარტივად ან უფრო რთულად მოსაპოვებელი? რომელი? რას ეფუძნება თქვენი ეს მოსაზრება?

რაც შეეხება ფასს - ნარკოტიკები გაძვირდა თუ გაიაფდა? რომელი და რატომ ფიქრობთ ასე?

ნარკობაზარზე არსებული ნარკოტიკების ხარისხი როგორ შეიცვალა? რატომ ფიქრობთ ასე? რომელ ნარკოტიკებს გულისხმობთ? რა არის ამ ცვლილებების მიზეზი? რა შეიძლება მოჰყვეს ამ ცვლილებებს შედეგად?

#### 6. ნარკოტიკების მომხმარებელთა ქცევა - მიწოდება და მოხმარება

თქვენი აზრით/აღქმით, როგორ შეიცვალა ნარკომომხმარებელთა ქცევა ბოლო 30 დღის მანძილზე? დაიწყო მომხმარებლება ნარკოტიკების ალტერნატიული მიწოდების გზებისა და წყაროების ძიება?

როგორ იმოქმედა კარანტინმა და საზოგადოებრივი ტრანსპორტის მოძრაობის შეჩერებამ ნარკოტიკებზე მისაწვდომობასა ან ნარკოდოზირებთან მიღწევაზე? სოციალური დისტანცირების მოთხოვნებისა და სამსახურების დახურვის შედეგად, როგორ შეიცვალა ნარკოტიკების მომხმარებელთა ლეგალური ან



არალეგალური შემოსავლების წყაროები? რა შეიძლება იყოს ზემოთხსენებული ცვლილებების შედეგი?

როგორ შეიცვალა ნარკოტიკების მოხმარების პატერნები? იცით შემთხვევები, როდესაც მომხმარებლებმა ჩაანაცვლეს ერთი ტიპის ნარკოტიკი სხვა ტიპით? გადავიდნენ ახალ ნარკოტიკებზე ან კომბინაციებზე? როგორ შეიცვალა ნარკოტიკების დოზირება? საშუალოდ, მოიხმარენ უფრო მეტი დოზით თუ ნაკლებით? საშუალოდ, უფრო ხშირად მოიხმარენ თუ იშვიათად?

შეცვალეს ნარკოტიკების მოხმარების გზა? რატომ ფიქრობთ ასე? რა არის ამ ცვლილებების მიზეზი? დაიწყეს ფსიქოტროპული ან ურეცეპტოდ გასაცემი მედიკამენტების მოხმარება იმისათვის, რომ შეინარჩუნონ აბსტინენციის მდგომარეობა? რომელი ნარკოტიკებია ესენი? რა შეიძლება მოჰყვეს ამ ცვლილებებს შედეგად?

## 7. ნარკოტიკების მომხმარებელთა ქცევა - სარისკო ქცევა

თქვენი აზრით, როგორ შეიცვალა ნარკომომხმარებელთა რისკისშემცველი ქცევები ბოლო 30 დღის მანძილზე? ახორციელებენ მეტად სარისკო (თუ უფრო უსაფრთხო) ქცევას? რას გულისხმობთ? რამე მაგალითის მოყვანა შეგიძლიათ?

არიან ნარკოტიკების მომხმარებლები ინფექციების გადადების უფრო მაღალი (ან უფრო დაბალი) რისკის ქვეშ საინექციო ინსტრუმენტების გაზიარების გამო? იყენებენ ისინი უფრო მეტად (ან ნაკლებად) საზიანო კომბინაციებს, უფრო სარისკო (ან უსაფრთხო) მოხმარების გზებს? მოიხმარენ მეტად (ან ნაკლებად) უცნობი შემადგენლობის ან/და ხარისხის ნარკოტიკებს? რატომ ფიქრობთ ასე? რა არის ამ ცვლილებების მიზეზი? რა შეიძლება მოჰყვეს ამ ცვლილებებს შედეგად?

## 8. სერვისების ხელმისაწვდომობა და გამოყენება

თქვენი აზრით, როგორ შეიცვალა ზიანის შემცირების, წამალდამოკიდებულების სამკურნალო და ნარკოტიკების მომხმარებელთა ჯანმრთელობასთან დაკავშირებული სერვისების ხელმისაწვდომობა ბოლო 30 დღის განმავლობაში? დაიხურა (ან გაიხსნა) რომელიმე სერვისი? შეამცირეს (ან გაზარდეს) დაფარვა? შეამცირეს (ან გაზარდეს) სამუშაო საათები? შეამცირეს (ან გაზარდეს) მისაწოდებელი სერვისების სახეობა?

რა გავლენა იქონია კარანტინმა და საზოგადოებრივი ტრანსპორტის მოძრაობის შეჩერებამ ნარკოტიკების მომხმარებელთა მიერ სერვისების მისაწვდომობაზე? უფრო მეტი (ან ნაკლები) მომხმარებელი მიდის სერვისებში? რომელ კონკრეტულ სერვისებს გულისხმობთ? რატომ ფიქრობთ ასე? რა არის ამ ცვლილებების მიზეზი?