DRUG SITUATION IN GEORGIA

2010

OVERVIEW

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ABSTRACT

This review aims to summarise the main aspects of the drug situation in Georgia, and to describe its main characteristics, trends and developments. It also attempts to identify drug information gaps, as well as the adequacy of the system of responses to the drug problem in the country.

The structure is based on EMCDDA standards and involves the system of key and core indicators of drug epidemiology. Following the structured description of the main aspects of the drug situation in the Republic of Georgia, the principal elements of the national response to the drug problem are described. The review reflects the drug situation and related challenges as studied and perceived by the authors. The analysis is based on data from 2009 and 2010. In certain cases the 2008 data are referred to because of information gaps and difficulties in the collection/coordination of drug information in the country, which to date has no institutional base that can sustainably follow international standards.

The review shows that despite the positive developments in the field of drug demand reduction measures, which are mostly driven by international sponsors, there are still a number of problems in the country that require an immediate response from the national government and society: first of all, the lack of a structured and balanced drug strategy and corresponding drug action plans, and the subsequent: (i) lack of a coordination mechanism in the field of drug demand and supply reduction measures; (ii) absence of institutional mechanisms for primary and secondary prevention; (iii) insufficient drug legislation and underdeveloped legislative practices; (iv) one-sided development of treatment methods, with little or no attention being paid to non-drug-assisted comprehensive care, including social rehabilitation, and (v) absence of institutional mechanisms for the maintenance of a drug information system that would provide sound evidence for the planning of interventions.

Key words:
Georgia; Caucasus; drug information; drug use; problem drug use; treatment demand; drug-related infectious diseases; drug-related deaths and mortality of drug users; drug-related offences; drug policies; drug legislation; prevention; treatment; harm reduction.

INTRODUCTION

Georgia is a presidential republic located in the South Caucasus. The country consists of 9 regions and one autonomous republic. Two regions of the country – Abkhazia and South Ossetia – are cut off from the rest of the country as a result of internal conflicts since the early 'nineties and further after the war with the Russian Federation and the subsequent *de facto* Russian occupation of these Georgian territories in 2008. Approximately 288,000 persons are internally displaced in Georgia. Tbilisi is the capital of the country, with a population of 1,253,000. The principal towns are: Kutaisi (241,100), Rustavi (158,000), Batumi (137,100), Zugdidi (105,000), Chiatura (70,000), Gori (70,000), and Poti (50,900). The state language is Georgian, and, in the territory of Abkhazia, Georgian and Abkhazian. The main religion is Georgian Orthodox; other confessional groups include Shiite and Sunni Muslims (in the Pankisi Gorge), Armenian Gregorians (in the Javakheti region of Georgia), Catholics, Baptists, and Jews.

Figure 1: Schematic Map of Georgia

The Republic of Georgia has experienced rapid economic, political and social changes since gaining independence from the Soviet Union in 1991. With the relaxation of political, social and trade control since the fall of the dictatorship, the scale of the illicit drug market has increased, drug use has become more common, and the citizens' attitude towards drugs has diversified.

A number of factors contribute to the illegal drug trade in Georgia, three of which we tend to consider the most crucial ones:

- the Republic of Georgia and the whole South Caucasus is a natural trafficking corridor from Asia to Europe for different commodities, including drugs;
- the two unresolved inter-ethnic conflicts limit Georgia's capacity to control its own territory and borders;
- the heritage of the Soviet repression-based approach of organising public life and the related social inertia slows down and complicates efforts to create a balanced pragmatic drug strategy and, subsequently, a sustainable system of interventions and responses.

Table 1: Key figures (www.geostat.ge)

	Year	Georgia	Source
Population	2009	4.4 million	National Statistics Office of Georgia
GDP per capita in PPS (Purchasing Power Standards)[1]	2009	EUR 1759.7	National Statistics Office of Georgia
Inequality of income distribution[2]	N/A	N/A	N/A
Unemployment rate[3]	2009	16.9%	National Statistics Office of Georgia
Prison population	2009	21,075 persons	National Statistics Office of Georgia
Nominal Salary per person per month	2009	EUR 244.4	National Statistics Office of Georgia
Population below poverty line	2009	21%	National Statistics Office of Georgia

1 Gross domestic product (GDP) is a measure of economic activity. It is defined as the value of all goods and services produced minus the value of any goods or services used in their creation. The volume index of GDP per capita in Purchasing Power Standards (PPS) is expressed in relation to the European Union (EU-27) average set to equal 100. If the index of a country is higher than 100, this country's level of GDP per head is higher than the EU average and vice versa.

2 Inequality of income distribution is measured as the ratio of total income received by the 20% of the population with the highest incomes (the top quintile) to that received by the 20% of the population with the lowest incomes (the lowest quintile).

3 Unemployment rates represent unemployed persons as a percentage of the labour force. Unemployed persons comprise persons aged 15 to 74 who were: (a) without work during the reference week; (b) currently available for work; (c) actively seeking work.

DRUG USE IN THE GENERAL POPULATION AND YOUNG PEOPLE

There are currently no reliable data indicating the extent of different patterns of illegal drug use in Georgia, with some limited exceptions relating to injecting/problem drug use (see below). The figures that are occasionally found in the media are unrealistically high, suffer from ambiguous case definitions and are not based on transparent data or a sound estimation method.

So far, no survey on drug use has been conducted in the general Georgian population – neither nationwide, nor limited to some city or area.

The survey of young people in Georgia that consistently followed international standards was conducted by the National Centre for Disease Control (NCDC) in the framework of the Southern Caucasus Anti-Drug Programme (SCAD)[1] (Baramidze & Sturua, 2009). Using the ESPAD survey methodology and a questionnaire that was adjusted to Georgian terminology and the local cultural environment, the study found that in the capital city, Tbilisi, in February 2009, 17% of the adolescents who were surveyed reported having used marijuana at least once in their lifetime. After cannabis, ecstasy was the most available drug for the young people who were surveyed, its use at least once in their lifetime being reported by 7.5% of the respondents; the lifetime prevalence for amphetamine-type stimulants was about 2%. Lifetime experience with crack cocaine was reported by fewer respondents (1.1%) and the rate for heroin was still lower (1%). Lifetime powder cocaine experience was reported by 0.6% of the survey respondents. Just as few reported experience of GHB and anabolic steroids or drug use by intravenous administration. Of the sample that was representative for Tbilisi, the lifetime prevalence for any illegal drug was 20% in the study (33% of males; 8% of females) (Baramidze & Sturua, 2009). The statistical error (margin) for each of the reported figures is ±5%.

The survey of young people was implemented in Tbilisi and the results obtained reflect the situation that is characteristic of Tbilisi youngsters. Stemming from this fact, the study results could not be extrapolated to the whole Georgian youth population. However, in the spring of 2011 Georgia intends to join the regular ESPAD wave and, on the basis of this cooperation, to conduct a countrywide ESPAD survey.

PROBLEM DRUG USE

As was noted in the previous section, the numbers on the extent of (different patterns of) drug use appearing in public debates in Georgia have been extremely flawed, with no transparent methodology until very recently. The first attempt to avoid mere guessing and to arrive at an expert consensus on the number of injecting drug users in the country occurred with the Consensus Meeting of experts in the field of drug demand reduction that took place on April 21, 2009. The meeting, which was organised by the Country Coordinating Mechanism on HIV/AIDS (CCM) critically reviewed the results of the "Study Estimating the Prevalence of Injecting Drug Use in Georgia Using the Multiplier/Benchmark Method" (Sirbiladze, 2010) conducted within the framework of a programme funded by the EU and implemented by UNDP, "South Caucasus Anti Drug Programme" (SCAD). Combining different estimation methods, the Consensus Meeting agreed on the estimation of IDUs in the country being approximately 40,000 (95% CI: 39,000-41,000), i.e. 1.5% (1.48%-1.52%) of the population aged 15-64 (Sirbiladze, 2010). It is generally assumed that in Georgia, virtually all problem drug users are injectors (Sirbiladze, 2010).

Concerning injecting drug use, the most frequent primary drug is of the opioid group, and heroin was the leading drug until the early 2000s. Since 2004, buprenorphine, in the form of the medical drug Subutex®, has become commonly injected (Javakhishvili et al., 2006). Subutex® is widely used for the substitution therapy of opioid addiction in the European Union, United States, Australia, India, China and elsewhere. In Georgia, Subutex® entering the black market from abroad and competing with heroin.

According to data provided by addiction clinics, approximately one third of medically treated injecting drug users (IDUs) asked for treatment because of problems related to the non-medical use of Subutex® in 2007 (Otiashvili et al., 2008b; Vadachkoria, 2008). Since the end of 2008, field studies have suggested that the overall use of Subutex® is slowly decreasing and other, more readily available injecting

1 Data were collected during February 2009 and the target population was Tbilisi students in the 10th grade (93% born in 1992), with a mean age of 16.1 years at the time of the data collection.

drugs are taking over its market share – most commonly home-made stimulants prepared from cough medicines containing pseudo/ephedrine or phenylpropanolamine that are easily available from pharmacies without a prescription (Otiashvili et al., 2008; Kirtadze et al., 2010). The final (injectable) product of the preparation contains methamphetamine (street name "vint" or "boltushka": a long-acting stimulant prepared through the reduction of pseudo/ephedrine) or methcatinone (street name "jeff"; a short-acting stimulant prepared through the oxidation of pseudo/ephedrine). The use of cocaine and other amphetamines than the two mentioned above remains very low (Javakhishvili et al., 2009).

TREATMENT DEMAND

In 2009, five specialised addiction clinics operated in the country and provided short- and mid-term detoxification with little or no further medical or psychosocial support (Chikovani et al., 2010). The number of detoxified patients in 2009 was 584 (841 in 2008, and 1092 in 2007). The overwhelming majority of the detoxification patients were male in the age cohorts 25-39 years of age (402 out of 584 patients in 2009). Altogether, only 12 women were treated medically for drug addiction in 2009. Contrary to detoxifications, opioid substitution treatment (OST) has been growing in recent years, providing methadone treatment to 1200 patients in 2009. Since January 2010, substitution treatment with Suboxone® (a composite medical drug, containing buprenorphine and naloxone, intended to lower the risk of injecting use buprenorphine) has been provided to about 60 patients in Tbilisi.

Traditionally, the majority of patients who came to addiction clinics for treatment were opioid users, most of them heroin addicts. In 2008, there was an increase in the number of detoxification patients whose principal drug was home-made methamphetamine and mezhcathinone (Todadze et al., 2008). Most of the inpatient detoxifications (94.5% in 2009, 97.4% in 2008 and 93% in 2007) were provided in specialised clinics in Tbilisi, whereas only 5.5% (2.2% in 2008, 7% in 2007) were detoxified in the Adjara region.

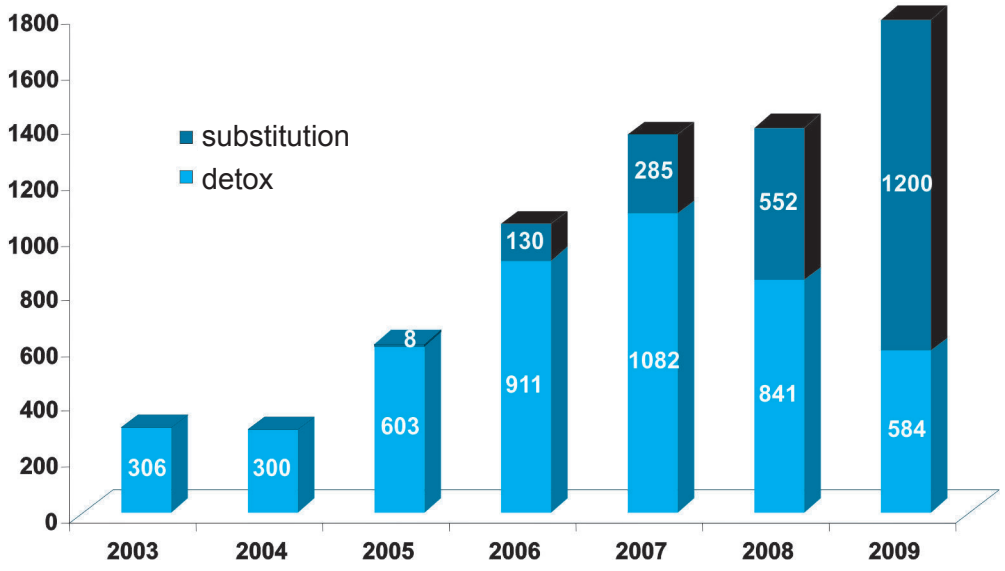

Figure 2: Patients treated by the narcological system in Georgia, 2003-2009 (Todadze K., 2009, Sturua L. 2010)

DRUG-RELATED INFECTIOUS DISEASES

By 18 August 2010, the Infectious Diseases, AIDS and Clinical Immunology Research Centre (henceforth the AIDS Centre) had registered 2497 cases of HIV, including 1849 men (75%) and 648 women (25%). Most patients (60%) were 29 to 40 years of age at the time of diagnosis. Altogether, 1369 reached the AIDS stage of the infection, and 583 of them died. Injecting drug use is the most frequent route of HIV transmission among all registered people living with HIV (58.4%). Other transmission routes

include heterosexual transmission (35%), mother to child (2.3%), homosexual transmission (2.7%), undetermined (1.0%), and blood transmission (0.6%). According to the data from AIDS Centre, two thirds of the patients infected via heterosexual contact are sexual partners of injecting drug users (AIDS Centre, 2010).

Among IDUs, HIV prevalence rates range from 1.5% to 4.5%, depending on the locality (Chikovani et al., 2010).

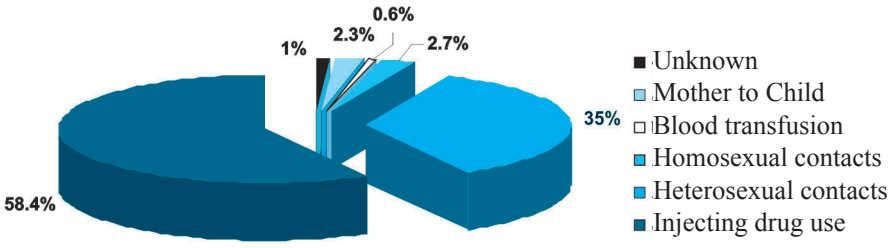

Figure 3: Infection transmission routes in HIV+ cases in Georgia (AIDS Centre, 2010)

According to a recent study, the prevalence of the hepatitis C virus (HCV) among HIV positive patients is as high as 48.6 %. In the study, HIV+ men were more likely to be co-infected with HCV than HIV+ women (60.8% and 18.0%, respectively). The prevalence of HCV among HIV+ injecting drug users was 73.4%. The odds of being HCV infected were 3.25 (95% CI; CL--1.89-5.26; p<0.01) for HIV+ injecting drug users (IDUs) compared to non-IDUs. The prevalence of viral hepatitis B antibodies (anti-HBV) among HIV positive people was 43.42% (76/175) in the study, and the prevalence of chronic HBV infection (HBsAg positive) was 6.86% (12/175). The prevalence rate of HBsAg was 8.51% in IDUs and 5.26% in non-IDUs. Triple infection (HIV, hepatitis C and chronic hepatitis B) was found in 9 patients (5.14%). Infections were associated with injecting drug use (88.88%) and were mainly related to the sharing of needles/syringes and other injecting medical paraphernalia (Badridze N. et al., 2008).

In 2009, out of the 2077 IDU clients of harm reduction programmes tested for HIV and HCV in Voluntary Counselling and Testing (VCT) centres, 23 people were found to be HIV+ (1.1%) and 999 were found to be hepatitis C positive (48%) (Otiashvili, 2010a).

DRUG-RELATED DEATHS

No data on drug-related deaths were recorded in Georgia from the 1990s till 2007.

In 2004, the Forensic Expertise Bureau was established within the Ministry of Justice, which re-started to register drug-related deaths - so far, only for the capital city, Tbilisi. In 2009, altogether 19 cases (0.8% of all cases of unnatural deaths) investigated by the Tbilisi Forensic Expertise Bureau were identified as drug overdose deaths (28 in 2008, 39 in 2007). Though the data do not cover the country and the data gathering system does not allow identification of the type of drug/s that caused the overdose, it is the first time that the data on deaths related to illegal drugs have been officially reported in independent Georgia, and the system needs only to be improved in terms of both data quality and coverage.

In 2004, the SCAD Programme set up a task force to conduct a special drug-related mortality study based on crossing the historic register of narcology patients and the register of the general population/general mortality register. The study was conducted by the Georgian Research Institute on Addiction. According to the results of the study, mortality among men aged 18-54 that had a record of any drug use in Georgia in 2003 was twice as high as the mortality rate among men of the same age with no such record (Javakhishvili et al., 2006).

PREVENTION

Since1995, the first specific primary drug prevention interventions started in the country, implemented by non-governmental sector. The Ministry of Labour, Health and Social Affairs (MoLHSA) of Georgia has played a key role in what was defined as governmental prevention activities for years; however, the focus of the governmental programmes was on drug testing of people suspected by the police of being drug users.

From the early 1990s until now, drug demand reduction efforts by the Georgian government and international donors have paid little attention to primary drug prevention. The period was often

marked by sporadic activities, insufficient funding, limited projects and beneficiaries, and a lack of quality control mechanisms (in 2005: 100 direct beneficiaries, budget — EUR 10,000; in 2006: 30 direct beneficiaries, budget — EUR 20,000; in 2007: no programmes at all; in 2008: 300 direct beneficiaries, budget — up to EUR 100,000; in 2009 – 60 direct beneficiaries, EUR 10,000).

There are no drug education curricula in the country: for the moment, none of the existing higher schools provide drug education for future teachers, journalists, psychologists, social workers and other professionals who should play a key role in primary (and secondary) drug prevention. A new initiative of the Centre for Addictology of Charles University, the Georgian NGO Alternative Georgia and IB Caucasian University plans to address this gap and to develop drug education curricula for higher schools.

TREATMENT RESPONSES

After the collapse of the Soviet system, the first two narcological clinics providing residential treatment of addiction emerged in the early 1990s, although both had very limited capacities: the Georgian Research Institute for Addiction's clinic with 25 beds, and the Bemoni clinic with 6 beds. Since then, treatment capacity has increased in the country: there are presently five clinics with 60 beds and the capacity to detoxify more than 1000 patients in one year while offering both in- and out-patient treatment.

Treatment is usually limited to a 2-week detoxification (either pharmacologically assisted or completely drug-free), followed by discharge to individual and group outpatient therapy that is provided for 1-6 months. Till now treatment approach follows the heritage of Soviet biomedical narcology, stressing the patients' control, with little attention being paid to the psychological, behavioural, social and spiritual dimensions of addiction and ignoring the phenomena of non-addictive use.

Most patients drop out of treatment during the first month since they believe the mere detoxification is sufficient for them, and because the cost of the outpatient therapy is extremely high: on average 2000 GEL per month (4 times the average salary in the country). As a result, the abstinence-oriented treatment as provided in Georgia has a very limited and short-term impact; it does not support the recovery process, and the rate of relapse is high.

Almost all treatment procedures provided by the narcological clinics are paid for by patients directly and are prohibitively expensive, with the cost ranging from about $1000-1500 per detoxification period. In 2009, the state budget covered the treatment of only 78 patients (Chikovani et al., 2010)

Opioid substitution treatment (OST) was introduced in 2005, fully funded by a grant of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM); given the grant support, it was the only addiction treatment that was provided free to the patients. Acknowledging the importance and positive impact of this treatment modality, the Georgian government started to co-fund OST in 2008.In the governmentally supported programmes, the cost of the methadone is covered by the state and patients only pay for the services of the staff; the cost of such treatment is 150 GEL per month. This has resulted in a rapid expansion and increased availability of the treatment; as of 1st January 2010, there were 14 programmes operating throughout 8 regions of the country (and one OST was established in a penitentiary institution – strict regimen prison No. 8, providing treatment to 1200 patients (see above). About 800 patients receive treatment in state co-funded programmes and 400 receive it in GFATM-funded programmes.

Currently, GFATM maintains OST programmes in Tbilisi, in Gori, and in one prison; all of the GFATM-funded programmes are provided free of charge. The governmental programmes are operating in Tbilisi and in seven regions of the country providing treatment for 150 GEL.

The psychotherapeutic services are underdeveloped in the country: there is a lack of trained experts in the field, and a lack of institutional mechanisms to deliver (and enforce) proper relevant training in evidence-based methods as recommended by United Nations (UN) agencies (e.g. WHO, UNODS & UNAIDS, 2008). Consequently, there are no licensing mechanisms for psychotherapists.

Similarly, the quality assurance mechanisms for addiction treatment are lacking in Georgia. Given the limited number of treatment modalities, with no quality assurance and excessive costs, there are no mechanisms to match the treatment with patients' needs, and to match patients' satisfaction with treatment goals. In most of the treatment institutions in Georgia, abstinence from illegal drugs is the only treatment goal, with no sequencing. According to the research

(Todadze et al., 2008; Chirikashvili et al., 2008), addiction clinics' physicians consider length of abstinence the main indicator of the effectiveness of treatment, while for the patients the most important indicator is their quality of life.

HARM REDUCTION INTERVENTIONS

Harm reduction is a relatively well-developed strategy in the field of drug demand reduction in the country. This has happened as a result of the attention of international donors (Global Fund, other UN agencies, the European Union and its Member States, the Open Society Institute and other private donors), reflecting the threat of HIV/AIDS quickly spreading in the post-Soviet region in the last two decades, with its disastrous epidemics in the Russian Federation, Ukraine, and several other countries (UNAIDS 2008). The technical and investment support of the international donors is reflected in the increasing number of NGOs active in the field of harm reduction. However, neither the Georgian government nor other public bodies have ever supported organisations providing HR services and, so far, no strategy to do so in the future exists. This clearly threatens the sustainability of the prevention of HIV and other blood-borne infections in the country.

In 2009, the harm reduction programmes served a total of about 4000 clients, providing information and education, distributing sterile injecting paraphernalia, condoms, and naloxone (as a means of prevention of death by overdose), and offering voluntary counselling and testing for HIV, HCV and HBV (Kirtadze, 2010a).

In 2006, 7 NGOs active in the field had created the Georgian Harm Reduction Network (GHRN). For the beginning of 2010 Georgian Harm Reduction Network united 15 NGOs. In the last two years, harm reduction organisations have increased the scope of their activities; in addition to needle exchange and distribution projects, they routinely involve voluntary counselling for their clients, and enter the public debates on drug policy development, provide advocacy, and perform awareness raising that should secure the sustainability and further development of HR interventions and programmes.

DRUG MARKET AND DRUG-RELATED OFFENCES

Traditionally, Georgia has not been considered a drug-producing country, given that the majority of narcotic drugs with plant precursors (with the exception of marijuana) are not produced domestically.

Traditionally, concerns exist over the potential for Georgia and the South Caucasus in general becoming a transit route for Afghan opiates heading to Europe. However, such a "massive-volumes route" has never been identified and the seizures of opiates and other drugs are rather small in both numbers and volumes (see Table 2):

	2006	2007	2008	2009
Heroin	8.592 k g	16.157 kg	12.12 kg	2.3 kg
Opium	229.1 g	185.89 g	53.6 g	37.2 g
Marijuana	23.958 kg	23.647 kg	28.3 kg	4.7 kg
Tramadol	70.850 g	100.3 g	739.2 g	79.0 g
Subutex	10,958 tablets	16,232 tablets	13,757 tablets	5072 tablets
Cannabis plants	123.336 kg	64.860 kg	41.563 kg	No data available
Methadone	23.057 g	213.9 g	328.27 g	73.8 g
Morphine	3.33 g	4.455 g	38.049 g	3.57 g
Codeine	5.1 g 102 pills	--------	1.675 g	0.535 g
Cannabis resin	8.242 g	--------	88.230 g	9.63 g
Poppy	---------	1388 g	-------	--------
Cocaine	3.224 g	0.558 g	1.375 g	0.78 g
Methamphetamine	2.418 g	0.472 g	2.907 g	0.03 g
Dypheniloxidate	--------	--------	0.7 g	---------

Table 2: Drug-related seizures 2006-2009

The drugs with the largest presence on the domestic black market include heroin, opium, and marijuana, recently supplemented by pharmaceutical buprenorphine (Subutex®) that is smuggled from EU countries into Georgia (Todadze et al.., 2008, Todadze 2009, Kirtadze, I., 2008, Vadachkoria et al., 2008).

Drugs – and opioid drugs in particular – are extremely costly in Georgia, especially when compared with the average income (see Table 1): According to the information provided by the Georgian Ministry of Internal Affairs (MoIA), the street prices were EUR 338-460 per gram of heroin, opium EUR 20-33 per gram, marijuana EUR 2-3.35 per gram, morphine EUR 20 (per 1-mg ampoule), and Subutex ® EUR 200-215 (per 8 mg pill). Though some of these prices do not fully correspond with those reported by the physicians, street workers and their drug-using clients, the prices provided by official and non-official sources are more or less the same: the price of heroin, reported from these sources, is EUR 100-140 (1 pack, i.e. 0.2-0.3 grams approximately), opium EUR 100 (1 pack, i.e. 0.5 grams approximately), marijuana EUR 2.4-3.2 (per gram), morphine EUR 10 (per ampoule), Subutex ® EUR 200 (per 8-mg tablet).

According to the MoIA and the Supreme Court, 6051 persons were convicted of drug-related crimes in 2009, including 3663 (60.5%) for the mere consumption of controlled substances[2] (Supreme Court, 2010), Additionally, 7106 persons were subjected to drug-related administrative charges in the same year (MoIA, 2010).

2 Article 273 of the Criminal Code of Georgia imposes a fine of at least 2000 GEL or imprisonment for up to one year for repeated consumption of controlled substances; liability is determined on the basis of the results of a rapid toxicological urine test.

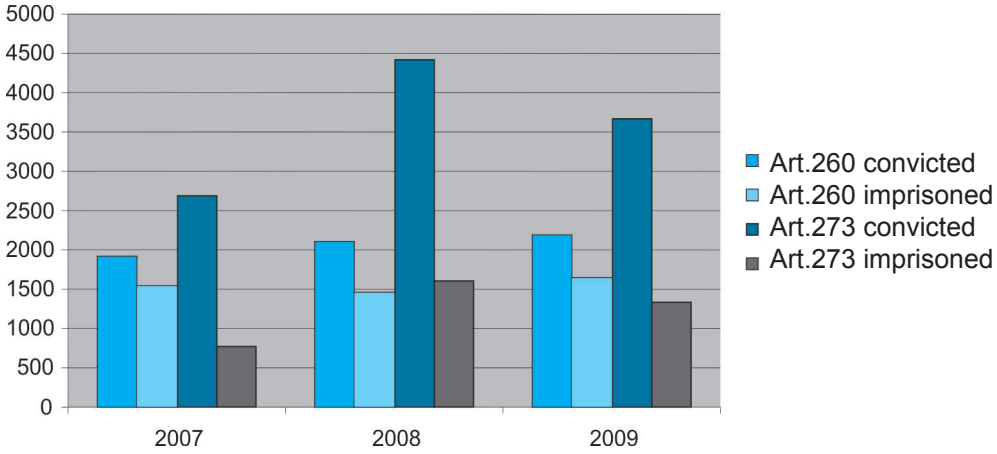

Figure 4: Dynamics of drug-related convictions and imprisonment (Article 260[3] and Article 273 of the Criminal code of Georgia)

3 Art. 260 of the Penal Code of Georgia - illicit preparation, production, purchase, possession, transportation or transfer or dealing in drugs, their analogues or precursors; in small quantities – imprisonment for up to 11 years; **in large quantities** - imprisonment for from 7 to 14 years.

NATIONAL DRUG LAWS

According to existing Georgian legislation, drug use is an administrative offence with a mandatory penalty of GEL 500 (approximately EUR 220). However, the same person apprehended as a drug user for a second time within one year after his/her first drug use offence bears criminal responsibility. In this case, the punishment may be either imprisonment or a fine of at least GEL 2000. Given that the maximum fine is not defined by the criminal code, the decision is at the discretion of the judge. As a result of this 'rubber law', there are cases of fines as high as GEL 4000 (approximately EUR 1800) imposed by courts for a positive urine test for inactive metabolites of illegal drugs.

The Criminal Code of Georgia does not differentiate between the illicit manufacture, production, purchase, storage, transportation, reselling and market sale of narcotic drugs or their analogues or precursors. All those criminal activities are defined under one paragraph/ definition of crime, which makes it impossible to employ a differentiated approach to different drug offences.

On the basis of Article 45 of the Administrative Code of Georgia, the Minister of Internal Affairs and the Minister of Labour, Health and Social Affairs of Georgia issued Joint Decree No 1049–233/n in 2006. According to the decree, 'in case of 'reasonable suspicion' (which is not specified/defined and thus again allows for vague interpretation) 'that a person is in a state of inebriation caused by narcotic drugs or/and psychotropic substances, and/or has consumed a narcotic drug, law enforcement officers can demand that the person undergo a test that should determine if the person used drugs or alcohol. At the same time, along with an increase in the drug-related administrative fine (from 80 to 500 GEL), the supervision of forensic laboratories of drug testing was assigned to a department newly established solely for this purpose under the MoIA. These changes created a powerful incentive for individual police officers and the police as a body, and resulted in a rapid increase in the number of people forced to undergo urine drug testing in the country; in 2007, the number of tests was 10 times higher than in 2005, with positive findings as low as 30%. This trend achieved its pick in 2007, since then it started to decrease but never achieved the previous level (Otiashvili et al., 2007; Alternative Georgia, 2010):

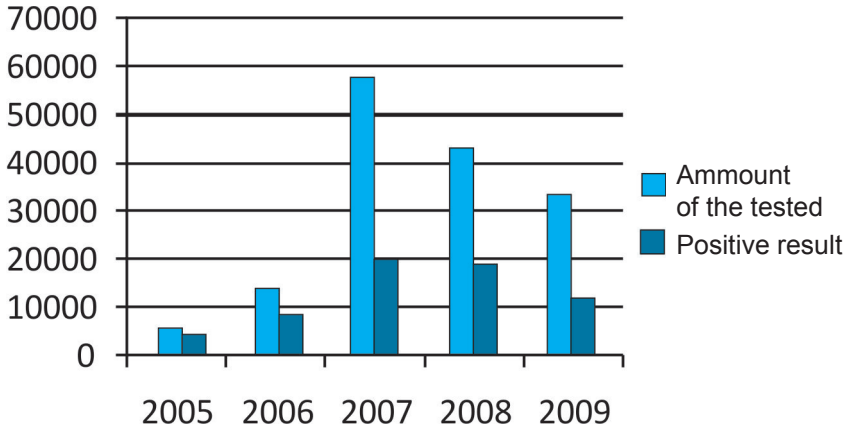

Figure 5: Dynamics of drug-testing in the country (Otiashvili et al, 2007; Alternative Georgia, 2010)

In 2008-2009, important activities and initiatives proposing amendments to the drug law occurred. This included advocating the revocation of criminal responsibility for drug use, and the creation of institutional mechanisms for the implementation of drug legislation (i.e. an interagency governmental body coordinating the system of responses in the country). Two packages of legislative changes entered the Parliament of Georgia for consideration (one prepared by a Global Fund-facilitated group (GFATM, 2008), the other one by the Georgian Harm Reduction Network (http://ziani.ge), but neither of them has yet been discussed in the parliament.

NATIONAL DRUG STRATEGY

Since 2005, intensive drug policy discussions have started in Georgia. In 2006, the State Drug Policy Council, established by the Ministry of Labour, Health and Social Affairs of Georgia, was appointed to draft a National Anti-Drug Strategy by the Ministry (Sirbiladze et al., 2006). The Georgian Parliament debated the strategy in February 2007 and approved its main priorities (Parliament of Georgia, 2007), which are: treatment and rehabilitation, prevention, harm reduction, staff capacity building, informing the public, etc. The elaboration of action plans according to the approved priorities and main aims was delegated to the relevant ministries, but never took place. The same year, the non-governmental organisation (NGO) Alternative Georgia drafted an alternative proposal for an anti-drug strategy, as well as an action plan, with the support of the Open Society Georgia Foundation. In the end, none of the documents was adopted by the Government or Parliament of Georgia as a normative act, rendering the documents non-legally binding and barred from implementation (Skhvitaridze, 2008).

Given the absence of a strategy and the absence of proper budget monitoring tools, the domestic funding provided for supply reduction activities is not known in Georgia, and the funding of demand reduction activities is rather chaotic, as is shown in Figure 6.

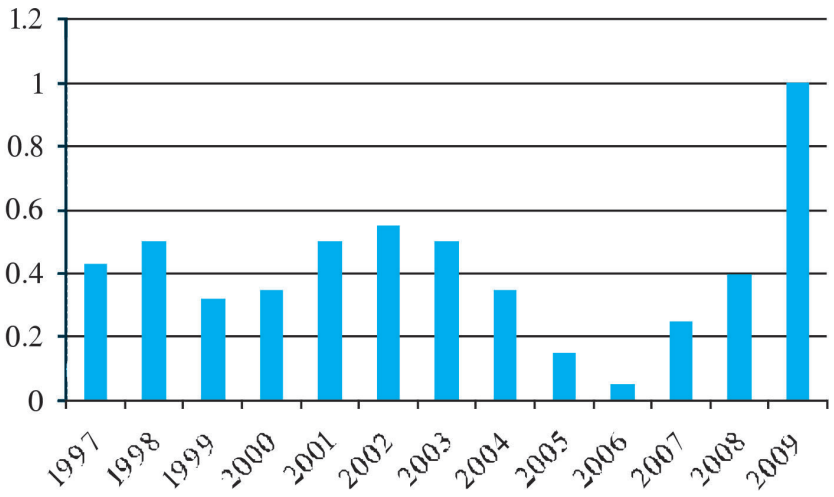

Figure 6: Funding of drug demand reduction measures by the MoLHSA (Otiashvili, Zabransky, Kirtadze, 2010b)

Despite a nominal increase in funding since its dramatic fall in 2006 (Javakhishvili et al., 2006), the inflation of the Georgian currency (called the Lari) over the last 10 years should be taken into account (see Figure 6). The "inflation-cleaned" evaluation of the budget is further supported by the fact that the percentage of drug demand reduction lines in the total budget of the Ministry of Health remains substantially lower than in 2000-03 (Javakhishvili & Sturua, 2009).

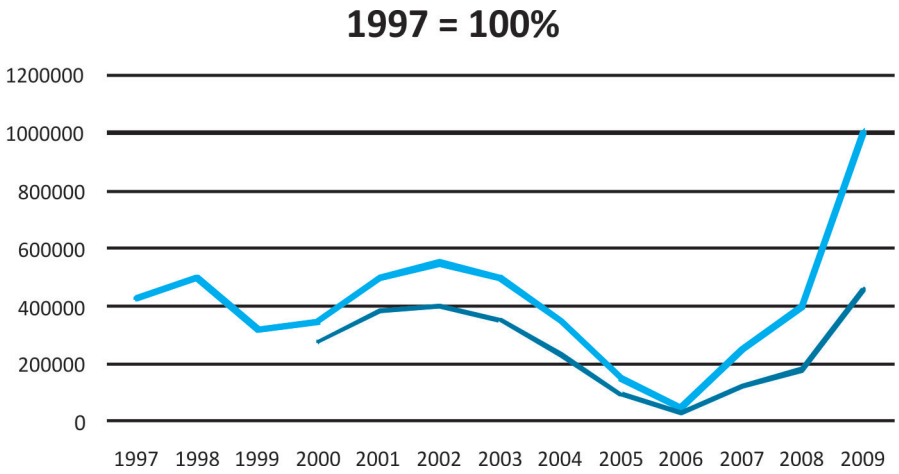

Figure 7: Impact of GEL inflation on the funding of demand reduction measures: blue line = financing in nominal figures, red line = financing in "1997 Lari" (Alternative Georgia, 2010)

COORDINATION

Since there is no anti-drug strategy in Georgia, accordingly there is no public administration or political body/institution responsible for implementing the strategy, and neither is there any responsible institution for the evaluation of the interventions undertaken in the drugs field.

However, the non-governmental sector is utilising networking and coordination to achieve harmony and synergy in the efforts; since 2003, facilitated by the SCAD programme, the Georgian Anti-Drug Coalition has been formed, uniting key non-governmental organisations in the field of drug demand reduction; in 2006, the National Harm Reduction network was established under the organisational guidance of the Open Society Georgia Foundation, uniting 15 organisations working in the field of harm reduction in 2009.

CONCLUSIONS (on the existed needs)

There is an urgent need for a balanced, budgeted, feasible and measurable drug strategy and corresponding action plan in the country; adoption of National Drug Strategy will create necessary condition for accomplishing all the efforts made in drug policy field since 2005 in the country;

Once National Drug Strategy is adopted and corresponding action plan is elaborated and approved, it is necessary to establish national interagency coordinating mechanism to assure the following: a. proper implementation of the adopted Strategy./action plan; b. monitoring of its implementation as well as adjustment to the rapidly changing environment in the country;

To achieve correspondence of Georgian drug legislation with the International Conventions and relevant international standards it is necessary to speed up the process of consideration and adoption of the drug legislation amendments prepared by the experts (Global Fund Group, Georgian Harm Reduction network, South Caucasus Anti Drug Program);

Especially urgent are issues of revocation of criminal responsibility for drug use, decreasing drug fines thus not to make it a source/cause/matter of human rights violations for those who undergo drug intoxication examination, and to create the best possible environment for implementation of drug demand reduction measures in the country;

The emerging trend of using home-made stimulants, prepared through chemical refinement of medicines used to treat respiratory disorders and available from drugstores without any prescription, should be responded to with the corresponding demand reduction measures (including rising awareness on its harm) to avoid further spread of this pattern/subculture;

Mechanisms of collection of the information on drug related death and mortality should be further developed to assess the scope of the problem in the country;

Treatment capacity should be developed and treatment methods should be diversified while treatment accessibility should be increased to respond to drug treatment demand in the country; psychotherapeutic capacity should be built and relevant human resources trained in evidence based methods (like Cognitive behavioral therapy (CBT), Motivational Interview (MI), Relapse Prevention (RP), etc.);

Harm reduction programs should be further developed, especially Methadone maintenance and VCT services, to contribute to decreasing the speed of the HIV epidemic in the country;

Prevention strategy should be elaborated and adopted by the Ministry of Education and Science in coordination with the other relevant agencies (MoLHSA, Ministry of Culture and Sports, etc.) to provide a systemic multidisciplinary strategic approach, based on participation of all the stakeholders of the school environment (students, teachers, parents);

University curricula on drug prevention should be elaborated and implemented to provide institutional mechanisms of teachers' and social workers' education in drug prevention;

Social reintegration mechanisms (especially social services) should be built to assure continuity in the chain of treatment of drug addicts;

Research on drug related costs should be conducted to make visible the pragmatism of investing into building a system of responses to the drug problem in the country for decision makers;

A Drug Information System corresponding to the EMCDDA Standards should further develop in the country and receive State support (in terms of state budget and ideological support from the side of decision makers) to assure an institutional mechanism for informing drug policy and strategy in the country.

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