POLICY BRIEF

Opioid Agonist Therapy and Harm Reduction in Georgia:

From Regional Success to Crisis

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ehra
Eurasian Harm Reduction Association

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EXECUTIVE SUMMARY

For two decades, Georgia built one of the most successful opioid agonist therapy (OAT) and harm reduction programmes in Eastern Europe and Central Asia (EECA). By the early 2020s, the programme was serving more than 16,000 people in state-run and private clinics, contributing substantially to the stabilisation of HIV among people who inject drugs (PWID), accelerating hepatitis C elimination, and improving the health and social outcomes of thousands of people with opioid dependence.

Since late 2024, Georgia has undergone rapid and mutually reinforcing changes in drug policy, civic space, and OAT provision that threaten to dismantle this hard-won achievement. In April 2025, sweeping drug law amendments introduced court-ordered treatment and criminal penalties for evasion of drug testing. In July 2025, Parliament enacted an emergency ban on all private OAT clinics, forcibly transferring approximately 3,600 patients from buprenorphine/naloxone-based care to state-run methadone programmes without adequate clinical assessment or informed consent. Of these, only approximately 1,800 have transferred to state-controlled clinics — leaving roughly 1,800 patients unaccounted for, with early data documenting a rapid increase in fatal and non-fatal overdoses.

70% reduction in HIV prevalence among PWID, 2012–2022	**67%** reduction in chronic HCV prevalence in the general population, 2015–2021	**~1,800** OAT patients unaccounted for after July 2025 private-clinic ban

> The danger lies not in any single policy change but in their combined and reinforcing effects. These policies represent a structural shift from a prevention-first public health model to one centred on deterrence and coercion — with predictable and rapid consequences for HIV and hepatitis C control, overdose prevention, and the health and dignity of thousands of people with opioid dependence.

1. Introduction

1.1 Context and purpose

Georgia stands at a critical juncture. The decisions made in the coming months about opioid agonist therapy and harm reduction will determine whether the country sustains one of the region's most important public health programmes — or whether decades of investment and advocacy are rapidly dismantled.

This brief is based on analyses of Georgia's OAT programme conducted by international and regional harm reduction networks, national tripartite dialogue reports, case studies of OAT transitions and integration, peer-reviewed literature, and recent programme data documenting the effects of 2024–2026 policy changes.

> **A note on terminology.** This brief uses OAT (opioid agonist therapy) as the standard term throughout. OST (opioid substitution therapy), MMT (methadone maintenance treatment), and MST (methadone substitution treatment) appear in quoted materials and cited sources: all refer to the same class of treatment. MMT and MST are more specific, referring only to methadone-based treatment.

2. The scale and epidemiology of opioid use in Georgia

Injection drug use (IDU) remains a substantial public health challenge in Georgia. Based on data from the 2022 Integrated Bio-Behavioural Surveillance Survey (IBBS) conducted across seven Georgian cities, the combined population size estimate for PWID in Georgia is 54,342 people, corresponding to a prevalence of 1.4% across all age groups and 2.4% among adults aged 18–64. Geographic variation is significant: estimated IDU prevalence is highest in Kutaisi (4.3–4.4%) and lowest in Batumi (1.3–1.4%). The predominant drugs injected are heroin and buprenorphine.

IBBS surveys conducted since 2002 document a compelling narrative of epidemiological progress. HIV prevalence among PWID decreased from 3.0% in 2012 to 0.9% in 2022 — a 70% relative reduction over a decade. In 2023, approximately 9,100 adults in Georgia were estimated to be living with HIV.

Georgia's nationally led hepatitis C elimination programme, launched in 2015 with support from the US CDC, Gilead Sciences, and WHO, achieved a 67% reduction in chronic HCV prevalence in the

general population between 2015 and 2021 (from 5.4% to 1.8%). Per-protocol sustained virologic response (SVR) reached 99.0% in 2024.

PWID remain disproportionately affected. In the 2022 IBBS, 58.1% of PWID tested positive for HCV antibodies and 32.1% had active HCV RNA. HCV seropositivity was significantly higher among PWID with a history of incarceration compared with those who had never been imprisoned (68.1% vs 46.8%).

Among methadone-based OAT patients analysed in the Stvilia et al. (2021) retrospective cohort from 2015 to 2018, 85.6% tested positive for HCV antibodies and 96.3% of those had confirmed chronic HCV infection. Crucially, more than 75% initiated treatment, 94.3% completed it, and the cure rate was 96.1% — demonstrating that OAT patients may become the first micro-elimination target population in which hepatitis C elimination is achieved in Georgia.

At the same time, HCV reinfection among PWID who completed treatment remains a challenge. A 2025 study found a reinfection rate of 13% among PWID who had previously received HCV treatment, with high injection frequency, public injecting, and young age as key risk factors.

3. Georgia's OAT programme: evidence of success

3.1 Programme history and scale

Methadone maintenance treatment (MMT) in Georgia began in 2005, funded entirely by the Global Fund. A fundamental transition occurred in July 2017, when Georgia removed financial barriers for patients and transferred full programme ownership to the government. In 2020, take-home doses were extended to stable patients for up to five days — a patient-centred policy associated with improved retention, since progressively reversed, with delivery now restricted to one day in cases of acute illness from January 2024.

The Giorgobiani et al. (2025) cohort analysis covering all patients registered between 2008 and 2024 confirms that the 2017 removal of financial barriers was associated with improved retention; that the introduction of five-day take-home doses in 2020 further improved retention stability; and that multiple treatment episodes over a lifetime are normal and should be accommodated within a patient-centred system.

In 2021, 16,291 individuals received OAT services in the treatment facilities of the Centre for Mental Health and Prevention of Drug Addiction (16,192 men and 99 women), with 17,969 treatment episodes recorded.

Systematic reviews and meta-analyses consistently demonstrate that all-cause mortality among OAT patients is 50–70% lower than among people using illicit opioids outside treatment, and that mortality risk rises sharply immediately following OAT discontinuation. This is the most direct mechanism by which Georgia's current treatment disruption translates into preventable deaths: the thousands of

patients who have left treatment since July 2025 face substantially elevated overdose and mortality risk now.

3.2 OAT in prison settings

As described in the Global Fund Funding Request Form for January 2026–December 2028, maintenance OST is unavailable in Georgian prisons — only methadone detoxification of up to six months in two facilities. The Prioritized Above Allocation Request (PAAR) includes support for a pilot of maintenance OST in two prisons, especially for women, with state takeover of funding from 2028.

3.3 Women who use drugs and OAT: compounding vulnerabilities

Women who use drugs in Georgia are structurally excluded from harm reduction and OAT. The Global Fund funding request records that women represent less than 1% of OAT patients across Georgia's 22 state methadone clinics — a figure attributed explicitly to stigma against female drug users. Women comprised only 1.4% of the estimated 54,000 PWID population, a figure likely reflecting under-enumeration given the structural factors that push women's drug use underground.

The EWNA gender assessment (2023) documents the mechanisms that produce this exclusion: routine stigma and coercion in healthcare settings; use of drug-use status in obstetric settings to justify denial of care, involuntary procedures, and punitive reporting to child protection authorities; breaches of medical confidentiality; and intimate partner violence and economic dependence constraining independent healthcare decisions. The EWNA obstetric violence study (2025) documents these patterns as consistent across the region, with Georgia among the countries where punitive drug policies and weak confidentiality protections compound their severity.

> The mental health and addiction database, mandated by December 2025 amendments, operationalises the confidentiality breach that the EWNA research identifies as a primary driver of women's disengagement from health services. For women who use drugs, it is a retrievable state record that can be consulted in child custody proceedings and employment screening.

3.4 Georgia's OAT delivery model before 2025

The core of Georgia's system was an integrated network of state OAT sites, primarily administered through the Centre for Mental Health and Prevention of Drug Addiction in Tbilisi and associated regional facilities. By the early 2020s, state centres were providing methadone-based treatment to more than 60–70% of all people in OAT. In parallel, private clinics provided buprenorphine or buprenorphine/naloxone-based therapy to an estimated 3,600 patients — being the de facto sole provider of this medication option, with four of the only five Georgian clinics offering buprenorphine/naloxone being privately run.

3.5 Georgia's OAT delivery model after 2025

On 25 June 2025, Prime Minister Irakli Kobakhidze announced a complete ban on private OAT provision, arguing that private providers were effectively 'legally supplying narcotic substances.' In

July 2025, Parliament passed urgent legislative amendments centralising all OAT under exclusive state control.

> This decision directly affected approximately 3,600 patients — of whom only approximately 1,800 have transferred to state-controlled clinics (Kirtadze et al., *Lancet HIV*, 2026). The remaining ~1,800 are unaccounted for, and this large-scale treatment disruption has already resulted in a rapid increase in fatal and non-fatal overdoses.

Reports from service providers, patients, and community organisations document serious problems:

- Many patients were transitioned from buprenorphine to methadone without clinical indication and without genuine informed consent; some experienced withdrawal symptoms and medication complications as a result.
- In some regions, state authorities could not identify suitable OAT facilities for transferred patients; people were directed to clinics in distant cities, making regular attendance extremely difficult.
- By September 2025, private clinics were reporting sharp declines in patient numbers, with five or more discharge requests in a single week documented in late July 2025.
- There is a credible risk of further restrictions on OAT within the state system, including expansion of the compulsory treatment model at the expense of voluntary OAT.

4. Mental health and addiction database

In December 2025, Parliament passed amendments to fifteen laws, including the Law on Mental Health, requiring the Ministry of Health to establish a 'unified information database of persons with mental health problems, alcoholism, drug addiction and/or toxicomania' by 1 March 2026, with the Interior Ministry 'actively involved' in its creation and management.

The database creates severe and specific risks:

- Anyone diagnosed with 'drug addiction' — a category that could encompass anyone enrolled in OAT — will be entered into a permanent state database accessible to the Interior Ministry.
- Fear of permanent registration in a law enforcement-accessible database will deter people from seeking voluntary addiction treatment or harm reduction services.
- The database fundamentally undermines the doctor–patient relationship by transforming healthcare providers into data-collection agents for law enforcement.

> Psychiatrist Nino Okribelashvili observed: "If someone ends up in the registry once, they remain there not as a person, but as a category, which leads to stigma, control, and restrictions on rights."

5. Outlawing 'LGBT propaganda', banning trans healthcare, and removing 'gender' from legislation

In September 2024, prior to the drug-law measures described above, Parliament enacted a legislative package comprising one primary law and 18 consequential amendments, with effects across healthcare, education, media, employment, and public assembly. Key provisions include: a prohibition on publications or demonstrations deemed to constitute 'LGBT propaganda'; a ban on all gender-affirming healthcare including hormone therapy for transgender people; and restrictions on the depiction of same-sex relationships in educational and media contexts. The legislation was condemned by the Council of Europe Commissioner for Human Rights, the European Parliament, and UN human rights mandate-holders as incompatible with Georgia's obligations under the European Convention on Human Rights and the International Covenant on Civil and Political Rights.

In April 2025, Parliament passed legislation removing the word "gender" and the term 'gender equality' from Georgian legislation in their entirety, requiring the systematic deletion of both terms from all existing legal instruments. A separate amendment, passed in 2024, repealed gender quotas in parliamentary election lists.

> Together, these measures remove both the legal vocabulary and the institutional mechanisms through which gender-specific barriers to harm-reduction services had previously been recognised and addressed. Georgian law no longer contains a statutory basis for gender-sensitive service mandates, funding obligations targeting women, or non-discrimination provisions applicable to transgender people seeking healthcare.

6. Drug policy: legislative changes and implementation

6.1 Drug law amendments (April 2025)

On 16 April 2025, Parliament passed urgent amendments to Georgia's drug legislation, representing a fundamental shift from a health-based to a punitive approach:

- Compulsory treatment: individuals diagnosed with substance use disorder may be subjected by court to mandatory treatment for up to two years through newly established state-run facilities.
- Mandatory drug testing: first refusal results in administrative liability; repeated refusal may lead to criminal charges. People who test positive or refuse may be barred from employment in state institutions and certain professions for up to five years and lose driving privileges for up to five years.
- Prison sentences and fines for drug possession and distribution substantially increased, including up to 20 years for certain distribution offences.

The Georgian Association of Addictologists (GAA) responded that 'the authors of the reform view coercion as a solution — a stance that reflects outdated and harmful practices rooted in Soviet-era ideology... Effective and sustainable treatment must be based on the patient's consent, trust, and motivation — not on control and repression.'

6.2 Compulsory treatment: the evidence

Research consistently demonstrates that compulsory treatment for addiction is generally ineffective, often retraumatising, and may constitute torture or cruel, inhuman, or degrading treatment under international human rights law. The UN Special Rapporteur has documented that state policies subjecting people to coercion in the name of abstinence represent a complete disregard for the chronic nature of dependency. Twelve UN agencies have called for the closure of compulsory detention centres and their replacement with voluntary, evidence-informed, rights-based services.

7. The narrowing civic space: legislative changes and implications

7.1 The Foreign Influence Transparency Law

In June 2024, Parliament adopted the Law 'On Transparency of Foreign Influence', enacted on 4 August 2024. Article 2 defines non-commercial legal entities, broadcasters, and media organisations whose annual revenue includes more than 20% from international donors as 'organisations acting on behalf of foreign powers.' The OSCE/ODIHR noted that Parliament failed to provide an evidence-based assessment of specific risks posed by Georgian civil society, and that European courts require evidence of imminent threats to democracy before such restrictions can be justified.

The HERA XXI assessment found that the law produced a significant chilling effect even before its formal entry into force: staff outflows, psychological burnout, and reduced community engagement with NGOs were documented. As one Tbilisi participant noted: "Who would like to be labelled an agent and live with that title in their own country?"

7.2 The Grants Law

In April 2025, Parliament required all international donors to obtain prior government approval before issuing grants to Georgian organisations, with receipt of unapproved grants punishable by an administrative fine equal to double the grant amount.

In March 2026, Parliament passed a further package of amendments to five laws. The package dramatically broadened the definition of a 'foreign grant' to encompass any monetary or in-kind transfer from a foreign donor — including individual foreign citizens — aimed at influencing the Georgian government, public authorities, or any segment of society on matters of domestic or foreign policy. The expanded definition explicitly covers technical assistance, translation and interpretation services, pro bono expertise, and funds transferred by a foreign organisation to its own Georgian branch or subdivision. Prior approval is now required even of organisations registered abroad whose activities substantially relate to Georgia. Retroactive application is provided for.

> **The criminal consequences are severe.** A new Article 319 of the Criminal Code introduces up to six years' imprisonment for receiving an unapproved foreign grant connected to political activity. Money laundering for the purpose of political activity is defined as a separate offence under Article 194, punishable by nine to twelve years — sentences comparable to those for serious violent crime. Individuals who have received income from any organisation deriving

> more than 20% of its income from foreign sources are barred from political party membership for eight years after leaving that employment.

Amnesty International characterised these amendments as 'highly damaging measures that signify Georgia's further expansion of authoritarian practices to silence and criminalise dissent.' The International Federation for Human Rights (FIDH) called for their repeal.

The implications for harm reduction and OAT organisations are direct and severe. According to local lawyers, any organisation that receives international funding and engages in any policy dialogue, advocacy, or documentation of human rights violations may now face criminal prosecution. Even receiving pro bono expert advice or specialised training from an international partner without prior government approval could fall under the expanded definition of a foreign grant.

8. RECOMMENDATIONS

8.1 For Georgian authorities

Immediate

- Announce a moratorium on further OAT restrictions until the cumulative impact of the 2025 changes has been independently assessed.
- Issue a binding ministerial order confirming that OAT enrolment does not trigger administrative penalties, driving-licence revocation, employment bans, or child protection sanctions under the April 2025 drug-law amendments, and that OAT and NSP patient data may not be shared with law enforcement without a court order.
- Halt the operationalisation of the addiction database pending an independent human rights impact assessment. Interior Ministry access to health records of people seeking addiction treatment is incompatible with voluntary care.
- Suspend the ban on private OAT provision and halt forced medication transitions. Any medication change must be based on individual clinical assessment and informed consent. No clinic may be closed or significantly downsized without six months' notice, a written patient transition plan, and a guarantee of treatment continuity.

Medium-term

- Repeal the compulsory treatment provisions of the April 2025 drug-law amendments. Compulsory treatment without consent lacks an evidence base, elevates post-discharge overdose risk, and violates the right to health under international law.
- Adopt clinical guidelines defining OAT as long-term maintenance therapy with no arbitrary duration limits, voluntary tapering only on patient request, and no forced switching between medications.
- Re-enable licensed non-state OAT provision under public financing and quality standards, with buprenorphine and buprenorphine/naloxone available alongside methadone. Restore extended take-home doses for stable patients.
- Publish quarterly OAT data disaggregated by site, region, medication, and reason for dropout, with women's enrolment as a mandatory sub-indicator. Establish a unified national OAT registry with privacy protections consistent with human rights standards. Define coverage floor at the 2023–2024 baseline of approximately 16,000 active patients; automatic policy review is triggered if enrolment falls below it.
- Establish a multi-stakeholder OAT working group — including patient council representatives, harm reduction NGOs, and legal experts — with a formal consultative mandate and quarterly reporting to Ministry of Health leadership.

- Issue prosecutorial guidance clarifying that harm reduction service delivery, community health monitoring, and documentation of patient rights violations do not constitute 'political activity' within the meaning of the Grants Law or Article 319 of the Criminal Code.

8.2 For international partners

- Embed OAT coverage, retention, medication diversity, HIV/HCV integration, and women's enrolment as binding indicators in all grant agreements. Make continued funding contingent on voluntary, rights-based OAT and transparent public outcome reporting.
- Establish a contingency channel — through a non-Georgian regional entity such as EHRA, ENPUD, or INPUD — for harm reduction functions that cannot legally flow through domestic sub-grants. Priority functions are community-led monitoring, REAct human-rights documentation, peer-led services for women who use drugs, and legal aid for OAT patients. Design and fund this channel in 2026, before criminal enforcement intensifies.
- Provide flexible grants covering legal fees, digital security, and where necessary relocation of at-risk staff. Support strategic litigation on foreign-agent laws and coercive drug policies before the ECtHR, UN treaty bodies, and Council of Europe mechanisms.
- Bring Georgia's pattern of legislative restrictions on civil society and harm reduction to the attention of all relevant international fora including the UPR, Committee Against Torture, CRPD Committee, CESCR, OSCE, Commission on Narcotic Drugs, UNAIDS PCB, and Council of Europe. Ensure Georgian civil society is resourced to participate in these processes and in EHRA and INPUD peer-exchange.

8.3 For civil society and community networks

- Use REAct as a monitoring mechanism to document patient attrition, forced transfers, overdose clusters, and rights violations, and share findings with international networks in identity-protecting formats.
- Conduct peer-led outreach to people who have left OAT since July 2025, with specific capacity for women with caregiving responsibilities and people released from detention. Produce regular short briefing notes for EHRA, ENPUD, INPUD, and IDPC.
- Maintain structured dialogue with any officials and clinicians willing to engage. Inform OAT patients of their legal rights, including data-sharing rights and the basis for any testing or employment consequences, within what is legally permissible.
- Implement organisational resilience measures now: diversify funding, secure digital infrastructure, build international partnerships, and document all enforcement actions systematically for use in domestic and international legal proceedings. Prepare contingency plans for transition to informal or externally hosted structures if domestic operations become legally untenable, prioritising the safety of staff, patients, and communities over institutional form.

Conclusion

Georgia's OAT programme represents one of the most significant public health achievements in the EECA region: a government-financed, mixed-model system that contributed to a 70% reduction in HIV incidence among PWID and a 67% decline in national HCV prevalence over a decade. The 17-year longitudinal evidence base, the 2022 IBBS data, and the HCV treatment cascade analyses all point to the same conclusion: Georgia's OAT programme worked, and it worked because it was voluntary, evidence-based, multifaceted in its medication offerings, and integrated with broader HIV, HCV, and harm reduction services.

The policies enacted between April 2025 and March 2026 reverse the principles that made this programme successful. Compulsory treatment, forced medication changes, the elimination of buprenorphine/naloxone access, permanent registration in state databases, and the criminalisation of the civil society organisations that supported, monitored, and advocated for this programme constitute a systematic dismantling of a functioning public health system in favour of a punitive model for which there is no credible evidence of effectiveness.

> The window for reversing this trajectory is narrowing. Every month of continued treatment disruption means more patients lost to follow-up, more overdose deaths, more hepatitis C reinfections, and a weakening of the institutional and community infrastructure — built over two decades — that cannot be quickly rebuilt.

APPENDIX I — International standards on OAT, harm reduction and human rights

A.1 WHO, UNAIDS and UNODC guidance

The World Health Organization, UNAIDS and UNODC jointly recommend that OAT be recognised as a vital, life-saving intervention for opioid dependence. Key principles include:

- OAT should be offered on a voluntary basis with informed consent. Forced or coerced OAT is ineffective and violates the right to liberty and security of the person.
- OAT is not a pathway to abstinence but a long-term medical treatment. Patients should be able to remain on OAT indefinitely if they and their clinician agree, provided their condition is stable.
- OAT is most effective when combined with needle and syringe programmes, regular HIV and HCV testing, access to ART and treatment for viral hepatitis, and psychosocial support.
- Patients should have access to methadone, buprenorphine and buprenorphine/naloxone, with the ability to switch between them based on clinical need and patient preference.

A.2 Human rights law

UN treaty bodies have consistently held that:

- Forced or coercive treatment for addiction violates the right to liberty and security, and may constitute torture or cruel, inhuman and degrading treatment.
- States have an obligation to provide access to evidence-based, voluntary treatment as part of the right to health.
- Criminalisation of drug use that impedes access to treatment violates the right to health.
- Discrimination against people who use drugs or who have substance use disorders violates the principle of non-discrimination and equal protection.

A.3 Evidence on effectiveness of OAT and harm reduction

Scientific literature consistently demonstrates that:

- OAT reduces illicit drug use, improves medication adherence, and reduces HIV and hepatitis C transmission by 50–80%.
- OAT improves employment, housing and social stability for the majority of patients.
- Even modest increases in OAT coverage (20–30%) lead to measurable reductions in HIV incidence and increases in life expectancy in populations with high opioid use.
- Forced detoxification and coercive treatment have high failure rates and are associated with overdose and death.
- Needle and syringe programmes are effective at preventing HIV and hepatitis C and are cost-effective compared to treatment of infections.

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