Opioid Agonist Therapy and Harm Reduction in Georgia: From Regional Success to Crisis

POLICY BRIEF — April 2026

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 the 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 for anyone the state deems to be 'addicted to drugs' and who is convicted of a drug-related crime under the Criminal Code, and criminal penalties for repeated evasion of drug testing. In July 2025, Parliament enacted an emergency ban on all private OAT clinics, forcibly transferring approximately 3,000 patients from buprenorphine/naloxone-based care to state-run methadone programmes without adequate clinical assessment or informed consent.

These policy shifts are occurring in parallel with a systematic dismantling of Georgia's civil society space. In August 2024, the law on foreign influence transparency came into force. In April 2025, the Grants Law was amended to require prior government approval for all foreign grants. In March 2026, Parliament passed a further legislative package criminalising the receipt of foreign grants connected to political activity, with sentences of up to six years' imprisonment.

The combined effect creates a real and imminent risk that Georgia will lose the OAT and harm reduction infrastructure that has taken decades to build, with serious 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. Readers will also encounter OST (opioid substitution therapy), MMT (methadone maintenance treatment), and MST (methadone substitution treatment) in quoted materials and cited sources. MMT and MST are more specific: both refer 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 in Georgia are heroin and buprenorphine; injection of stimulants such as methamphetamine or cocaine is relatively uncommon.

IBBS surveys conducted in Georgia 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. Since 2012, heterosexual transmission has become the major route of HIV transmission in Georgia. The proportion of new HIV cases attributed to injecting drug use decreased from 46.7% in 2010 to 33.3% in 2016. 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 Centers for Disease Control and Prevention (CDC), Gilead Sciences, and World Health Organisation (WHO), achieved a 67% reduction in chronic hepatitis C virus (HCV)

prevalence in the general population between 2015 and 2021 (from 5.4% to 1.8%). In Georgia's national HCV elimination programme, 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% of anti-HCV-positive individuals had active HCV ribonucleic acid (RNA). Regional variation was marked: the highest HCV antibody prevalence was in Zugdidi (76.0%) and the lowest in Kutaisi (46.0%). HCV seroprevalence was substantially higher among participants older than 35 years compared with younger PWID (68.4 % vs 20.7 %). In addition, 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 substitution treatment (MST) 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 were confirmed with chronic HCV infection. Crucially, more than 75% of HCV-infected MST patients initiated treatment, 94.3% completed it, and the cure rate was 96.1% — demonstrating that MST 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. Key risk factors for reinfection were high injection frequency, public injecting, and young age.

3. Georgia's OAT programme: Evidence of success

3.1 Programme history and scale

Methadone maintenance treatment (MMT) in Georgia began in 2005 with limited programmes funded entirely by the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund). Programme expansion followed a phased approach: a transition to partial government/patient co-payment funding occurred in 2008, and between 2008 and 2024, 22 specialised departments were established across Georgia.

A fundamental transition occurred in July 2017, when Georgia removed financial barriers for patients and transferred full programme ownership to the government, ending reliance on donor funding — a landmark in programme sustainability. In 2020, responding to COVID-19, take-home doses were extended to stable patients for up to five days, a patient-centred policy change associated with improved retention. (However, this policy was subsequently reversed: from January 2024, take-home delivery was restricted to only one day in cases of acute illness.)

The Giorgobiani et al. (2025) cohort analysis covering all patients registered between 2008 and 2024 provides evidence on long-term treatment patterns. Key findings include:

- The 2017 policy change — removing financial barriers and ensuring full state financing — was associated with improved retention indicators in subsequent cohorts, consistent with global evidence that cost is a significant barrier to OST retention;
- The introduction of five-day take-home doses in 2020 was associated with further improvements in retention stability for patients who had demonstrated adherence;
- Older age and higher methadone doses were associated with better retention;
- Multiple treatment episodes over a lifetime are normal and should be accommodated within a patient-centred system — evaluating effectiveness through total engagement duration, not only single-episode retention, is critical.

According to the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs of Georgia, in 2021, 16,291 individuals received MST services in the treatment facilities of the Center for Mental Health and Prevention of Drug Addiction (16,192 men and 99 women), and 17,969 treatment episodes were recorded (17,866 men and 103 women).

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 is substantially elevated in the period immediately following OAT discontinuation. The buprenorphine/naloxone combination available in private clinics provided an additional safety margin — reducing overdose risk even when other opioids are used concurrently.

3.2 OAT in prison settings

As described in the Funding Request Form for the Global Fund country grant for January 2026-December 2028, unavailability of opioid substitution therapy (OST) in the correctional sector represents a gap in services, as PWID cannot continue treatment after long-term methadone detoxification (up to 6 months) available in two prisons. The proposed Prioritized Above Allocation Request (PAAR) intervention includes support for OAT in two prisons, especially for women. The Global Fund grant support will include procurement of equipment (such as video observation cameras, safes, etc.) for selected sites, staff training,

and support for a pilot project in 2027. From 2028, the Government will take over the funding of OST units in prisons.

3.3 Women who use drugs and OAT: compounding vulnerabilities

Women who use drugs in Georgia are structurally excluded from the harm reduction and OAT programmes. The Global Fund funding request records that women represent less than 1% of OAT patients across Georgia's 22 state methadone clinics — a figure the document attributes explicitly to stigma against female drug users. The same document notes that although some OAT sites opened separate entrances for female patients with Global Fund support, this had no measurable effect on female enrolment. Women comprised only 1.4% of the estimated 54,000 PWID population captured in the 2022 population size estimate — a figure likely reflecting under-enumeration of women rather than their genuine absence from the drug-using population, given the structural factors that push women's drug use underground.

The Eurasian Women's Network on AIDS (EWNA) gender assessment (2023), drawing on community-led research across the EECA region, identifies the mechanisms that produce this exclusion. Women who use drugs experience stigma and coercion as routine rather than exceptional features of their contact with health institutions. In obstetric settings specifically, drug-use status is used to justify denial of care, involuntary procedures, and punitive reporting to child protection authorities — making pregnancy and childbirth a moment of acute institutional risk for women who use drugs rather than a point of engagement with the health system. Breaches of medical confidentiality are documented as common, occurring both within clinical settings and through disclosure to family members, employers, and authorities. Intimate partner violence and economic dependence constrain women's ability to make independent decisions about healthcare attendance and disclosure. The EWNA research documents these patterns as consistent across the region, with Georgia among the countries where punitive drug policies and weak confidentiality protections compound their severity.

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. The 2017 transition to full state financing removed financial barriers, centralised procurement, and enabled multi-year planning. It was widely regarded as one of the most important policy achievements in Georgia's drug policy history.

State OAT clinics were progressively extended to Batumi, Kutaisi, Zugdidi, Gori, and smaller urban centres. In several sites, OAT was co-located or closely linked with HIV, tuberculosis (TB), and hepatitis services. The type of facility providing HCV screening significantly affected treatment uptake: MST patients screened at centres with integrated HCV treatment services had significantly higher treatment initiation rates than those screened elsewhere.

In parallel, private OAT clinics provided buprenorphine or buprenorphine/naloxone-based therapy to an estimated 2,500–3,000 patients. With four of the only five Georgian clinics offering buprenorphine/naloxone being privately run, private clinics were the de facto sole provider of this medication option.

The combination of state-run methadone programmes and private buprenorphine-based clinics constituted a mixed OAT model widely regarded as a regional good practice. The Eurasian Harm Reduction Association (EHRA) study visit to Tbilisi in the early 2020s showed that Georgia's system represented a comprehensive approach to harm reduction and OAT that merits wider dissemination in the region.

3.5 Georgia's OAT delivery model after 2025

On 25 June 2025, Prime Minister Irakli Kobakhidze announced a complete ban on private entities operating substitution therapy programmes, arguing that private providers were effectively “legally supplying narcotic substances” and were driven by profit motives rather than patient recovery”. In July 2025, Parliament passed urgent legislative amendments prohibiting private clinics from providing OAT services and centralising all opioid agonist therapy under exclusive state control.

This decision directly affected approximately 2,500–3,000 patients receiving treatment in private buprenorphine-based clinics. The ban effectively eliminated buprenorphine/naloxone as a treatment option for the vast majority of patients. By August 2025, Georgia had brought OAT fully under state control.

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

- Many patients were transitioned from buprenorphine to methadone — the only medication available in state facilities — without clinical indication and

without genuine informed consent. Some patients experienced withdrawal symptoms and medication complications as a result;

- In some regions, state authorities could not identify suitable OAT facilities to accommodate transferred patients; people were directed to clinics in distant cities, making regular attendance extremely difficult;
- Already by September 2025, private clinics were reporting sharp declines in patient numbers. Programme data documented five or more patient discharge requests in a single week 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. The Interior Ministry was to be "actively involved" in the creation and management of this database.

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." Psychologist Elene Koridze noted the state is "reverting to old mechanisms of control deeply rooted in the Soviet past."

5. Outlawing “LGBT propaganda”, banning trans healthcare and removing the word “gender” from legislation

In September 2024, prior to the drug-law measures described above, Parliament enacted a further legislative package restricting the rights of lesbian, gay, bisexual, and transgender people. The package comprised one primary law and 18 consequential amendments to existing legislation, with effects across healthcare, education, media, employment, and public assembly.

Key provisions include: a prohibition on the publication or distribution of content deemed by the authorities to constitute "LGBT propaganda"; a ban on public assemblies or demonstrations in support of LGBT rights; a prohibition on all gender-affirming healthcare, including the provision of hormone therapy to transgender people; and restrictions on the depiction or discussion of same-sex relationships in educational settings, broadcast media, and commercial advertising.

The legislation was condemned by the Council of Europe Commissioner for Human Rights, the European Parliament, and multiple 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 particular the rights to privacy, health, freedom of expression, and freedom of assembly.

In April 2025, Parliament passed legislation — introduced by a group of 19 members from Georgian Dream and its satellite party People's Power — removing the word "gender" and the term "gender equality" from Georgian legislation in their entirety. The law requires the systematic deletion of both terms from all existing legal instruments in which they appear.

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. Key provisions include:

- 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, including for small quantities, increased substantially — including sentences of 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. This approach contradicts human rights and modern medical ethics. Effective and sustainable treatment must be based on the patient's consent, trust, and motivation — not on control and repression."

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. Talking Drugs columnist from Georgia characterised the measures as a policy that "treats addiction as a moral failing rather than a health condition, forcing people into treatment against their will."

7. The narrowing civic space: Legislative changes and implications

7.1 The foreign influence transparency law

In June 2024, the Parliament of Georgia adopted the law "On Transparency of Foreign Influence", which was enacted on August 4, 2024. According to the HERA XXI Association report "Assessment of the Needs and Attitudes of Women, Youth, and Local Civil Society Organizations in the Context of the New Political and Legislative Environment", it resulted in the public stigmatization of civil society organizations in the country, increased government surveillance over them, and led to the imposition of reporting requirements and other obligations that significantly hinder the activities of these organizations. Article 2 of the law defines non-commercial legal entities, broadcasters, and media organizations whose annual revenue sources include more than 20% from international donors as "organizations acting on behalf of foreign powers".

The HERA XXI study also found that the law produced a significant chilling effect even before 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?"

The OSCE Office for Democratic Institutions and Human Rights (ODIHIR) 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.

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, introduced by Georgian Dream in January 2026. 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: grant agreements and technical assistance arrangements concluded before the amendments but not yet fully implemented require government approval for the use of remaining funds; an interpretation is available under which agreements concluded before April 2025 are similarly caught.

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, using an approved grant for purposes other than those sanctioned, providing technical assistance to a foreign donor for political activities without approval, or concluding a sham transaction whose true nature constitutes a grant agreement. Transferring funds or property to a foreign person or entity in exchange for political engagement carries three to six years' imprisonment. 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. Because funds received in violation of the

Grants Law may be classified as illegal property, their use for any political activity is susceptible to recharacterisation as laundering of illegal income.

Two further provisions extend the reach of the legislation beyond organisations into individuals and the private sector. Business entities that publicly engage in political activities unrelated to their primary operations face administrative fines of GEL 20,000 (6,355 EUR), doubling on each repeated violation, with criminal liability triggered for persistent offenders. Any natural or legal person whose activities are deemed substantially similar to those of a political party — regardless of formal registration — may be assigned the status of "entity with a declared party-political objective." 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 the local lawyers, any organisation that receives international funding from donors such as UNAIDS, the EU, or international harm reduction networks, 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. The threat of imprisonment may deter organisations from engaging in policy reform, documentation of harms, or public criticism of government health policies. These are activities that could be construed as attempting to "influence" public authorities.

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

needle and syringe programs (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 — including by private clinics — 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 the Ministry of Health (MoH) 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 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, Eurasian Network of People who Use Drugs (ENPUD), or International Network of People who Use Drugs (INPUD) — for harm reduction functions that cannot legally flow through domestic sub-grants. Priority functions are community-led monitoring, including through REAct (Rights–Evidence–Actions) 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 European Court on Human Rights (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 Universal Periodic Review (UPR), Committee Against Torture, Convention on the Rights of Persons with Disabilities (CRPD) Committee, the UN Committee on Economic, Social and Cultural Rights (CESCR), the Organization for Security and Co-operation in Europe (OSCE), Commission on Narcotic Drugs, UNAIDS Programme Coordinating Board (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 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 International Drug Policy Consortium (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 reduction of HIV incidence among PWID by 70% and a 67% decline in national HCV prevalence over a decade, respectively. The 17-year longitudinal evidence base, the 2022 IBBS epidemiological 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 the United Nations Office on Drugs and Crime 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 antiretroviral therapy 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. Council of Europe Standards

The Council of Europe's Pompidou Group has issued guidance on Bringing Human Rights to the Heart of Drug and Addiction Policies affirming that:

— Substance use should be treated as a health condition, not primarily as a criminal matter;

— States have a duty to provide evidence-based, voluntary treatment and care;

— Drug policy must respect the right to privacy, freedom from torture and inhuman treatment, and the right to health;

— Criminalisation of use and simple possession is incompatible with human rights and public health;

— Civil society and people with lived experience of drug use must participate meaningfully in policy development and monitoring.

A.3. UN Human Rights Standards

UN treaty bodies monitoring human rights (the Human Rights Committee, the Committee on Economic, Social and Cultural Rights, the Committee Against Torture) 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.4. 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 (e.g., 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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