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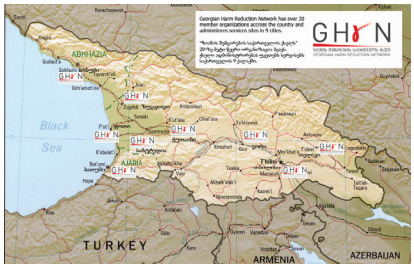
Uniting to Build HIV Prevention for Drug Users

The Georgian Harm Reduction Network



Georgian Harm Reduction Network

The Georgian Harm Reduction Network has over 20 member organizations across the country and administers service sites in nince cities.

The patient at the private clinic in Gori, Georgia, looked very tired. Committed to receiving treatment for his drug addiction, he sat in the office of the clinic director, asking for help. It had been difficult for him to get a job or integrate into society because of his addiction, and it had been impossible to find effective methadone treatment in the region where he lives. In Georgia, methadone must be dispensed daily at a clinic—it cannot be taken at home—but the closest methadone clinic was more than 60 kilometers away in Tbilisi.

Because this clinic is a member organization of the Georgian Harm Reduction Network (GHRN), a solution was quickly found. The director—aware of treatment options offered by other network members—picked up the phone to refer the patient to a small clinical trial of buprenorphine, an alternative to methadone that can be prescribed and taken home. Enrolling in the trial would allow this patient to receive effective substitution therapy without traveling great distances every day. This

The Georgian Harm Reduction Network coordinates the nongovernmental response to meeting the treatment and care needs of the country's drug users. Its human rights-centered, evidence-based approach has successfully supported effective treatment and prevention services and advocated for legal and policy change in Georgia.

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WHAT IS HARM REDUCTION?

For decades, the term "harm reduction" has defined a combination approach that flexibly uses multiple intervention strategies, policy advocacy, and legal change to both support drug users at risk of HIV and change the risk environment that surrounds them (Rhodes and Hedrich 2010).

Harm reduction interventions seek to reduce the harms of drug use, prevent HIV and other infectious diseases, and improve the health of drug users. Working toward cessation of drug use through treatment is a major component of human reduction, as is the interruption of blood-borne HIV transmission by providing sterile injection equipment, sexual risk reduction materials and education, counseling, peer outreach, and opioid substitution therapy.

simple act could improve the likelihood that he will be able to reduce the harms of drug use in his life and lower his risk for HIV.

One lesson of the global HIV epidemic has been that HIV prevention among people who inject drugs (PWID) is built from numerous points of entry, lower thresholds and fewer requirements for engagement with programs, and multiple levels of structural interventions and advocacy. Like drops of water, each combines with others to wear away the structural, legal, and individual barriers to treatment and care. At the heart of GHRN is a shared commitment to a harm reduction approach based on human rights and evidence-based interventions to prevent HIV transmission for drug users.

Founded in 2006, GHRN is a well-organized network of 21 organizations that operates both to reduce individual risk of HIV and to act on policy, regulatory, legal, and other structural-environmental factors influencing the health of drug users. Almost all groups in Georgia that offer services for drug users are members.

The Risk Environment for PWID

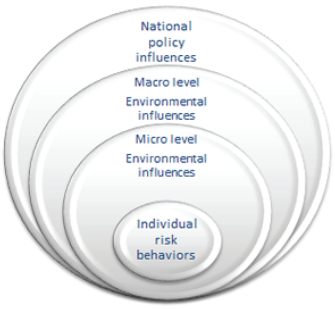
To effectively lower vulnerability to HIV infection through sexual and injection risk behaviors, any intervention must take into account the risk environment as well as the behavior of the drug user, and then respond at multiple levels. Using its established advocacy and communications capacity, GHRN organizations provide a wide range of strategic approaches to risk reduction that engage drug users at different stages of change with simultaneous availability of outreach activities, HIV testing, harm reduction services, biomedical treatment, and structural interventions that respond to local realities.

Injection drug use and associated HIV and infectious disease risk do not occur in a vacuum; risk is not merely a result of an individual behavior, and the reduction of risk behaviors on the part of individuals, while necessary, is insufficient. As conceptualized by Rhodes and colleagues (1999), vulnerability to HIV among drug users is firmly contextualized in the "risk environment" and is a product of the interaction between individual behaviors (such as using blood-contaminated syringes and injection equipment), the environment, and policy and legal structural elements. There are differing influences of micro- and macro-level factors in the risk environment in which individual risk behavior takes place. Micro-level environmental factors include issues that directly affect the drug user, such as targeted policing practices and restrictive

policies regarding access to drug treatment. Macro-level or overall structural factors include national drug possession enforcement policies, legal frameworks that enhance punishment and diminish treatment, and national budgets that do not contain sufficient funding for their citizens affected by drug dependence or HIV (Rhodes et al. 1999).

What makes GHRN an effective model for others is that the network acts at multiple levels of the risk environment. Acting collaboratively in a strategic and organized way on both the micro and macro levels of the risk environment creates a combination intervention with the potential to slow the emergence of the HIV epidemic in Georgia (see Figure 1).

FIGURE 1. RISK ENVIRONMENT MODEL (BASED ON RHODES ET AL. 1999)



Examples:	Micro level	Macro level
Physical	Prisons	Punitive laws promoting incarceration
Social	Local police practice	Stigma and discrimination
Policy	Pharmacists do not sell syringes	Laws restricting access to drug treatment
Economic	Expensive drug treatment	National budget does not contain sufficient Funds for HIV prevention

Injection Drug Use in Georgia

By any estimate, prevalence of injection drug use in Georgia—1.5 to 4.1 percent of the adult population—is one of the highest in the region (Coffin, Sherman, and Curtis 2010; Sirbiladze et al. 2009). There are few reliable data about the size of the population of PWID in Georgia; official records are either poorly kept or unavailable. Some researchers estimate that there were approximately 127,800 (range: 14,400 to 241,266) adult PWID in Georgia in 2008, with an estimated population prevalence of 4.1 percent among 15- to 64-year-olds (Mathers et al. 2008). However, the most reliable estimate of the number of PWID in Georgia comes from a 2009 study conducted by the South Caucasus Anti-Drug Programme using established statistical methods to estimate numbers. The study produced a national estimate of between 1.46 to 1.53 percent of the population and an estimated number of between 39,152 and 41,062 PWID (Sirbiladze et al. 2009).

Despite high prevalence of injection drug use in Georgia, HIV prevalence is relatively low—about 2 percent—among PWID (Chikovani et al. 2011a). But mounting evidence suggests a strong potential for an injection-related, blood-borne HIV outbreak, given the high rates of hepatitis C virus (HCV) infection—also blood-borne—among PWID in Georgia (Research Institute on Addiction 2007). Other countries in the region, such as Ukraine, have already experienced severe injection-related HIV outbreaks.

HIV among PWID: Georgia is considered a low-prevalence country, with HIV prevalence of about 0.1 percent among adults aged 15 to 49 (United Nations General Assembly Special Session on HIV/AIDS 2010). Within the country, HIV is largely an injection-driven phenomenon, with 70 percent of HIV cases in 2009 attributable to injection, either directly through injected drug use or indirectly through sexual contact with PWID (European Centre for Disease Prevention and Control/ WHO Regional Office for Europe 2010). In a study of 1,108 PWID, 2 percent tested HIV-positive, and PWID in large urban areas, in prison, or in places of transition, such as conflict zones and ports, were found to be at higher risk of HIV infection. Thus, it is unsurprising that in this study HIV prevalence among PWID is highest in Tbilisi (2.3 percent) and in the port city of Batumi (4.4 percent) (Chikovani et al. 2011a).

Globally, HIV infection among PWID is not static. Between 2004 and 2009, the number of newly diagnosed HIV infections among PWID increased by 76 percent (European Centre for Disease Prevention and Control/WHO Regional Office for Europe 2010). Rates of HIV testing are quite low among PWID, which may result in underestimates of HIV prevalence within this population. In 2009, only 5.7 percent of PWID reported receiving an HIV test in the last 12 months and knowing the result (United Nations General Assembly Special Session on HIV/AIDS 2010).

HCV among PWID: In contrast to HIV, HCV infection among PWID in Georgia is the highest in the region, with prevalence of 69 percent (Shapatava et al. 2006). Among HIV-positive patients in Georgia, almost half (48.6 percent) are co-infected with HCV (Badridze et al. 2008). HCV infection in Georgia has been strongly associated with a high number of syringe-sharing partners (Kuniholm et al. 2008). Few HIV-positive women admit to injection drug use, yet 17 percent are co-infected with HCV (Chikovani et al. 2011a). While official data are either limited or unreliable, studies of blood donors have shown that this is an injection-driven, blood-borne epidemic that has resulted in very high HCV rates among blood donors, a group similar to the general population. Two reported HCV rates of 6.7 percent (Sharvadze et al. 2008) and 7.8 percent (Zaller et al. 2004) among blood donors are much higher than rates in neighboring countries.

Data on women and drug use: There are few women drug users represented in surveillance data, reports, and programs. For example, one large opioid substitution therapy (OST) program has 250 clients, but only 2.4 percent are women. All member organizations of GHRN report that women PWID are "out there" but are not accessing services, for reasons that include women's felt stigma, discomfort with attending gender-mixed programs, or isolation. GHRN member organizations do not believe that women avoid services because of institutional discrimination but say that women drug users are more stigmatized within Georgian culture and by male drug users.

A qualitative assessment conducted in 2008 among 39 women PWID found that women reported three factors that put them at risk: 1) being the second in line when sharing needles, 2) little direct access to services, and 3) gender-related barriers that impede access to detoxification, rehabilitation, or OST services (Burns 2009). Men were cited as being particularly disapproving of women receiving help, and other barriers were reported, such as lack of childcare. In Georgia, there are methadone programs in men's prisons, but there are none in women's prisons (Burns 2009). In 2011, two GHRN member organizations implemented programs specifically for women.

Legal and policy environment: Under Georgian law, there is little distinction between selling, possession, and consumption of drugs, and status as a drug user. In addition, possession of a used syringe (with drug traces) is illegal, regardless of whether one is a drug user or a syringe exchange worker. Police may forcibly test citizens' urine "on suspicion" of drug use. If the urine is found to be positive for illegal drugs, the police may impose high fines that can cause considerable financial distress to citizens.

The legal environment emphasizes punishment rather than the health or human rights—the right to privacy, self-determination, respect, and autonomy—of individuals affected by drug use. In 2008, GHRN was instrumental in developing amendments to the drug law and relevant articles of the Criminal Code. Within eight weeks, GHRN gathered 58,000 signatures in a petition of support for the bill. As of 2011, the initiative remains stalled in the Georgian Parliament.

Implementation

GHRN was founded by a dozen organizations providing HIV services or involved in advocacy activities to promote programming for PWID. One structural issue that drove these groups to unite as a network was the difficult legal environment in which they struggled to do their work, according to Dr. David

Otiashvili, Director of the Addiction Research Center at Alternative Georgia and a long-time GHRN leader.

"At that time, people who were working in the NGO sector in the field of drugs and HIV realized that one of the major barriers to delivering effective services was that criminalization and punitive policies were keeping people from seeking help for their health and addiction," he said. "We realized that there was an obvious need to work with decision makers and push for change, and that we'd be more effective working together."

Today, GHRN has grown to include 21 member organizations spread across nine Georgian cities: Tbilisi, Telavi, and Gori in the east, and in the west, Batumi, Kutaisi, Samtredia, Zugdidi, Poti, and Sukhumi. Two are at the borders of conflict zones within Georgia: Gori, near the South Ossetia conflict zone, and Sukhumi in west Georgia, which is the capital of the disputed region of Abkhazia. In addition to PWID from the immediate community, these organizations also serve PWID internally displaced due to conflict.

In 2011, GHRN member organizations reached 3,200 people, about 8 percent of the estimated 40,000 PWID in Georgia. The network has since grown, and there are now 10 service sites covering most of the country except for remote regions. By the end of 2012, GHRN member organizations expect to reach a much greater percentage of PWID in Georgia.

Network Operations

The stated purpose of the GHRN and the shared mission of its member organizations are to:

- Advance harm reduction strategies to prevent HIV
- Support reduction of drug use
- Facilitate prevention of HIV
- Improve public health, reduce stigma, and protect the rights of the marginalized
- Facilitate drug users' inclusion in social life.

GHRN accomplishes these goals as a network by improving coordination between member organizations and facilitating cross-referral. GHRN also conducts training for members and supports sharing of experiences and information through regular online and in-person meetings. Members are engaged in debate and discussion in an effort to align goals and objectives and to flexibly develop new strategies. Perhaps the most important function of the network is combining the individual organizations into a whole that is greater than the sum of its parts for national advocacy and change.

In the past, GHRN was supported by an all-volunteer staff. Recently, the network obtained funding to hire core staff, such as an executive director, to support network activities, extend the advocacy efforts, offer fundraising assistance to member organizations, provide technical assistance to increase quality of services, and strengthen network-wide advocacy efforts. GHRN is supported by the European Union; the Global Fund for AIDS, Tuberculosis and Malaria (GFATM); and the Open Society Foundations/Open Society Georgia Foundation.

GHRN holds meetings with representatives of all member organizations on a monthly basis and uses social media, including a GHRN Google group, to further connect members, especially those in more outlying areas. All decisions are posted online, which can lead to lively online discussions on policy positions and advocacy strategies. GHRN also conducts training on topics of interest to the group.

GHRN is open to new member organizations, following an interview process to confirm that the applicant organization supports the network's core

principles. Member organizations pay dues of about U.S.$73.00 a year to support the network's efforts.

Activities of Member Organizations

Member organizations provide services along a spectrum of prevention, from low-threshold harm reduction efforts to drug treatment programs using methadone and buprenorphine. While individual organizations provide specific services, organizations collaborate to refer drug users to other appropriate services.

HIV counseling and testing: During HIV counseling and testing, drug users receive information about their HIV status as well as counseling about how to either remain HIV-negative or—for individuals who test positive—how to change their behavior to avoid infecting others. Members of the network conduct HIV counseling and testing with difficult-to-reach populations using outreach workers, mobile testing vans, or satellite operations in prisons.

Behavioral HIV interventions: Strategies include targeted harm reduction initiatives for PWID, including supplying such materials as sterile syringes and condoms, and offering brief counseling techniques about HIV prevention and harm reduction from drug use.

Biomedical prevention activities: Medical care, including traditional drug treatment and the stabilization of opiate users through the use of OST (methadone and buprenorphine) is available within the network. OST has been shown to be effective at preventing HIV among PWID, with reduced HIV incidence rates as a result of less drug use, fewer injections, and stabilization of PWID (Corsi, Lehman, and Booth 2009; Schaub et al. 2010; Suntharasamai et al. 2009). For both HIV-positive and HIV-negative PWID, OST leads to reduced drug use, which reduces the number of injections and leads to reduced sharing of needles and syringes. HIV-positive PWID on OST are also more likely to adhere to antiretroviral therapy, thus reducing their viral load and their likelihood of transmitting HIV to sexual partners in Georgia. Thanks to the advocacy efforts of GHRN, OST is now available in prisons.

National advocacy: At the network level, GHRN conducts activities to address structural factors limiting effective public health responses to the drivers of the HIV epidemic in Georgia. In one case, GHRN recently successfully advocated for one-time amnesty for incarcerated drug offenders with the objective of more successful social reintegration. Social reintegration of drug users into their communities is an important element of drug control strategies to reduce risky drug use, and it also serves as an HIV prevention strategy. Twenty-one European countries have specific policies regarding social reintegration as part of their national drug control policy (European Monitoring Centre for Drugs and Drug Addiction 2011). Advocating for measures that remove barriers to social reintegration for drug users is one of GHRN's successes.

Research and surveillance: One member organization, Union Alternative Georgia, leads efforts in conducting clinical and behavioral HIV surveillance, designs and tests interventions, and collaborates with U.S.-based and European researchers in intervention research. These activities provide a strong evidence base for the activities of the network. For example, Union Alternative Georgia is able to rapidly assess and

validate anecdotal reports from GHRN members about potential emerging HIV risk patterns, new drug trends, and associated HIV risks. GHRN members are then positioned to develop and test interventions rapidly.

What Has Worked Well

National and municipal advocacy for legal change: In 2008, GHRN advanced a bill to improve drug laws—a package of legislation that includes revocation of criminal responsibility for simple drug use—and to create an interagency governmental body to coordinate drug policy in the country. The constitutional right of citizens to initiate changes in legislation was used to lobby for this bill, when GHRN submitted 58,000 citizen signatures collected in 40 days to support the drug policy reform initiative—an impressive number, given that Georgia's population is only 4.6 million people. In May 2012, the parliament adopted some minor intermediate changes to drug policy that had little potential to improve the legal environment for drug users.

Despite the slowness of the parliamentary response, organizing Georgian citizens in support of drug policy reform has changed both public opinion and the policy environment. GHRN has also successfully advocated for increased governmental funding for drug treatment and prevention services and for the relaxation of some OST regulations, and has maintained a constant presence at the highest levels of national policy.

Engaging gatekeepers: GHRN members have used engagement of gatekeepers and policymakers as a network strategy for change. By conducting workshops and site visits for narcotics experts, legislators, and others who may resist the principles of harm reduction, GHRN members demonstrate through example. Other forms of engagement take place at the level of international and regional drug policy developments, where GHRN forms close collaborative relationships with international agencies. Members of GHRN sit on steering committees for major international drug policy consortiums, such as the International Drug Policy Consortium and the Eurasian Harm Reduction Network.

Education and training: Within Georgia, GHRN has disseminated information about state-of-the-art harm reduction approaches throughout the network and other health care systems in the country. In just one example, in 2010, an overdose prevention initiative started in Georgia, which included the training of drug users and distribution of naloxone—a medication to counter opioid overdose—through member organizations of the GHRN (Coffin, Sherman, and Curtis 2010). All members of GHRN were trained by Irma Kirtadze, a GHRN member, using a "training the trainers" model in the use of naloxone. The Georgian Red Cross Society, a member organization of GHRN, is not funded to disseminate harm reduction information but on a volunteer basis conducted 94 seminars for 4,340 participants on overdose prevention harm reduction and on safe injecting methods. The Georgian Red Cross Society also conducted a series of workshops on HIV and AIDS within the framework of harm reduction for 9,586 young people (average age 23) through 217 workshops conducted by 140 trained volunteers (Georgian Red Cross Society 2011).

GHRN is also conducting training and promoting its network model throughout the region. For example, GHRN is providing harm reduction training to the Romanian Harm Reduction Network and disseminating information about the network's operations in the region.

Challenges

Challenges to GHRN's work are primarily structural, making collaborative advocacy for policy change a critical task for the network. Among these structural challenges are punitive law enforcement practices, legal barriers to drug treatment, restrictions on harm reduction program development, and funding gaps.

Law enforcement practices: These remain a significant obstacle to programs working to improve the health of drug users and reduce transmission of HIV. Policing practices have led to continual harassment of PWID, who receive fines or imprisonment instead of treatment and care to reduce HIV infection, HCV infection, overdose, and addiction. Unlike other countries, drug use in Georgia—in addition to possession or selling—is a criminal offense (Article 45 of the Georgia Criminal Code). First offenders must pay an administrative fine of approximately U.S.$304; a second offense can lead to a prison sentence of up to a year or a fine of U.S.$1,219 or more.

In 2007, member organizations of the GHRN mobilized to educate the public about new changes in the law allowing the police to forcibly conduct urine tests on persons "in the case of reasonable suspicion," which led to a ten-fold increase in forcible testing—with no increase in efficiency for identifying drug users. First, GHRN reported that the program violated the Georgian Constitution and explained how to legally refuse the test. The parliament then passed a new law stipulating that refusing a test may be admitted as evidence of drug use. A GHRN organizational member, Union Alternative Georgia, conducted a survey of drug users in 2008 to assess the effectiveness of forced testing in persuading drug users to stop using drugs. Union Alternative Georgia concluded that forced drug testing is ineffective in deterring drug users, or in addressing drug use and associated HIV risks among drug users. They argued that the law diverts attention and, even more important, economic resources away from evidence-based and effective interventions that do work to prevent HIV, such as drug treatment.

Furthermore, increased HIV risk may arise as a result of forced drug testing. Multiple studies globally have documented the negative effect of law enforcement and policing practices at the macro and micro levels in accelerating HIV outbreaks and limiting the ability of PWID to reduce their drug-related risk (Rhodes et al. 2003). For example, forced urine testing leads to more incarceration, which is associated with increased HIV risk for PWID because drugs are widely available in prison but sterile syringes are not (Gunchenko and Kozhan 1999; Rhodes et al. 2006; Suntharasamai et al. 2009).

Legal barriers to drug treatment: Methadone treatment has been successfully rolled out in Georgia, and with GFATM support, there is now free treatment available, as well as methadone programs in prison. Program directors attribute this success to funding from the GFATM; to the influence of Sandra Saakashvili-Roelofs, the Dutch-born First Lady of Georgia, who has supported free methadone programs; and to the advocacy efforts of GHRN.

Nevertheless, methadone is highly regulated in Georgia, as it is worldwide. Drug users must be 25 years old to join a methadone program, which contradicts the principle that early treatment, before a PWID becomes infected with HCV or HIV, is good clinical practice. Furthermore, patients cannot take methadone home; it must be dispensed at a clinic. Promoting the social integration of former drug users into society is challenging because they spend so much time daily at the methadone clinic. GHRN as a network has advocated for change in methadone regulations, and this remains an ongoing challenge.

Restrictions on harm reduction program development: These limit the expansion of this critical element in HIV prevention work. One primary benefit of needle exchange is the removal of unsterile needles from the environment. While needle distribution is legal in Georgia, there is no exemption to Article 273 of the Georgian legal code for possession of a contaminated syringe for needle exchange program workers. Possession of drug-contaminated syringes obtained from drug users for disposal has put workers in GHRN member organizations at risk of arrest.

Further inhibiting harm reduction efforts is the confusing status of the drug naloxone, an opiate antagonist that reverses respiratory failure associated with opiate overdose and is included on the World Health Organization 2011 Model List of Essential Medicines (World Health Organization 2011). Training drug users to act as "first responders" in the event of an opiate overdose and equipping them with naloxone is a remarkably simple intervention that can substantively reduce the mortality of drug users (Doe-Simkins et al. 2009; Lagu, Anderson, and Stein 2006; Saucier 2011; Strang et al. 2008). Some program directors have reported that naloxone can no longer be legally imported into the country and is no longer available, but others report that it is still a registered drug available at pharmacies.

The emergence of new drugs: Street drugs are very expensive in Georgia, which has led to a proliferation of homemade drugs. Some of the emerging drugs have been linked to increased HIV risk behaviors among users. For example, in a study of 1,127 PWID in Georgia, only 9.1 percent of PWID reported injecting ephedrine, and 81 percent of ephedrine injectors reported unsafe injecting at last injection (Chikovani et al. 2011b). Similarly, in a cohort of 583 PWID from three cities in Georgia, those injecting homemade drugs and opium most frequently reported elevated rates of HIV-related risk behaviors (Shapatava et al. 2006).

In addition to the risk of HIV and HCV infection, some homemade drugs are severely toxic, with long-term cognitive, mobility, and speech effects. Some homemade stimulants, principally methcathinone (*jeff*), have led to an outbreak of severe manganese poisoning and Parkinsonism among users. In just one clinic in Tbilisi, there were more than 70 patients with manganese toxicity; a physician member of GHRN reported encountering 150 cases in the previous three years. There is little effective treatment available.

Other drugs and homemade opiates are a cause for great concern in Georgia, such as the use of diverted Coaxil (tianeptine) reported in the South Caucasus Anti-Drug Programme Assessment Mission Report in 2008 (Ives 2008) and the Georgia Medical News in 2009 (Vadachkoria et al. 2009). An emerging drug, crocodile, is a homemade opiate made with codeine-based medications, red phosphorous, and iodine. Early local knowledge about crocodile was disseminated by GHRN to network members (Onlinenews.ge 2011; Shuster 2011). While GHRN members are seeking to address this transition to homemade drugs, the rapid increase in use has outstripped the capacity of some organizations to target jeff, crocodile, and Coaxil users.

Funding gaps: Altogether, governmental and GFATM funding to support the health of drug users, including drug treatment, is quite low, ranging from only U.S.$30,000 in 2006 to U.S.$595,000 in 2009 (Javakhishvili et al. 2011). Despite marginal increases in governmental funding for drug treatment and prevention, the contribution of the Georgian government is so small relative to the need that GHRN members are dependent on nongovernmental funding sources. This has resulted in service gaps. For example, some member organizations had to close offices and prison HIV counseling and testing programs as they awaited the results of Round 10

GFATM proposals in 2011. GHRN is engaged in advocacy efforts to increase government funding and to achieve sustainability for HIV prevention initiatives.

Recommendations

Maintain a consistent focus on human rights: Drug users are marginalized and stigmatized as a population, and HIV prevention for them must go far beyond individual behavior change. At its core, problematic drug use, in the absence of access to appropriate care, can be seen as a symptom of the abuse of human rights. By maintaining a focus on the right of drug users to health through ending stigma, discrimination, and structural barriers to health, this symptom can be treated. Intervening in micro- and macro-level structural risks for HIV through legal and policy change is very challenging for a single organization, as opposed to participating in a network with strong shared values and principles that promotes a united rights-based approach to health.

Do not compromise on core principles: GHRN is a membership organization. Potential member organizations must apply, be interviewed, and agree to the core principles and theoretical perspective of GHRN before they can be accepted. Unlike other networks, in which agreements are based on a minimal consensus and thus are diffuse in network-level initiatives, GHRN has established robust principles about advocacy and change. Thus, instead of diffusion of initiative, there is a concentration of shared efforts. Networks that share a common vision are more effective in altering structural impediments to health. Elsewhere in the world, networks based on the "lowest common denominator" have largely been ineffective in altering the risk environment at the structural or policy level simply because network members may not be able to agree on policy approaches. The GHRN model facilitates successful evidence-based HIV interventions both at the level of individual organizations' service provision and in GHRN's ability to strongly advocate for change at multiple levels of the risk environment.

Use the reach of a network to advocate for national legal and policy change: GHRN has had great success in mobilizing Georgians to advocate for national law and policy changes to improve the risk environment at the micro and macro levels. Without alterations in policy and law, HIV prevention efforts will stall at the individual level. Networks with a strong common vision can effectively address risks and barriers that impede the health and human rights of drug users. Joining together in advocacy in large and diverse networks of organizations sharing a common human rights-based approach is far more effective in ensuring drug users' right to health and preventing the rapid spread of HIV.

Use the combined "local" knowledge of member organizations to respond with flexibility to emerging information: Within a network, timely and immediate information can be shared and a response crafted long before the information shows up in a report, surveillance data, or a publication. Within a national network, trends that emerge in one region can be addressed before reaching another region. Creating venues that facilitate dissemination of "on the ground" local knowledge, such as an online discussion group or through other forms of social media, is effective as an early warning system.

Be sure that member organizations have realistic expectations about what the network can give them: Networking can help groups face common external challenges and generate effective joint problem solving, but some new GHRN members also expected financial and administrative benefits that simply weren't available.

Expect differences of opinion: Different groups have different perspectives and different priorities, so some network decisions may not be

well received by all network members. For GHRN, this prompted the departure of one organization. Dr. Otiashvili feels that this is a normal part of the process and not necessarily a failure on the part of the network overall.

If possible, create paid administrative positions for the network: In the early years, GHRN depended on the volunteer efforts of network members to handle GHRN administrative work, which was extremely difficult, given their busy schedules serving clients and running their own organizations. Designating funding for these functions and creating a board has helped improve GHRN operations.

Future Programming

As GHRN transitions to a paid staff and adds new member organizations, it will continue to build on the strong network collaboration it has pioneered in the region. National advocacy for structural change to support the prevention of HIV among drug users continues as the foundation of the network's efforts. As a network, GHRN plans to focus its efforts in two directions: first, by participating in training and sharing experiences with other countries in the region to promote regional advocacy, and second, by working on a national bill to decriminalize drug use, to decrease imprisonment, and to increase treatment and care for drug users. In addition, GHRN is planning new initiatives to prevent the use of homemade drugs, prevent HIV transmission in the context of drug use, and explore new and creative ideas for the clinical treatment of dependence and toxicity associated with emergent drugs.

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