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# Identifying and Linking to Care and Treatment Persons With Hepatitis C Who Were Lost to Follow-Up, Georgia 2023–2024

**Vladimer Getia**[1], **Paata Imnadze**[1], **Eka Adamia**[1], **Maia Tsereteli**[1], **Maia Alkhazashvili**[1], **Sophia Surguladze**[2], **Irina Tskhomelidze Schumacher**[2], **Nancy Glass**[3], **Shaun Shadaker**[3], **Rania A. Tohme**[3]

[1] National Center for Disease Control and Public Health, Tbilisi, Georgia

[2] Task Force for Global Health, Tbilisi, Georgia

[3] Division of Viral Hepatitis, Centers for Disease Control and Prevention, Atlanta, Georgia, USA

## Abstract

In 2015, Georgia launched a hepatitis C elimination programme with free screening and treatment. However, a large number of persons were lost to follow up after screening for, or diagnosis with, hepatitis C virus (HCV) infection. During February 2023–September 2024, we conducted active outreach to reengage persons who were lost to follow-up in care and assess barriers to hepatitis C care and treatment through questionnaires covering pre- and post-outreach perceptions. Among 18,034 persons who tested HCV antibody (anti-HCV) reactive but were not tested for HCV viremia and had valid contact information, 14,252 (79%) could be reached, among whom 64% were unaware of their test result. After outreach, 4593 (32%) completed HCV viremia testing, among whom 2440 (53%) tested positive and 1577 (65%) initiated treatment. Main reasons for not seeking care after active outreach were having another chronic illness (33%) and being unaware they were screened for anti-HCV (23%). Among 13,151 persons diagnosed with HCV infection who did not initiate treatment and had valid contact information, 6982 (53%) were reached, among whom 2267 (33%) initiated treatment. The main reason for not initiating treatment before outreach was lack of information (62%) and after outreach was distrust in the hepatitis C elimination programme (79%). Treatment initiation was more common among those first tested in recent years. Active outreach successfully identified new infections and nearly 40% of those diagnosed initiated treatment. Educating patients about their test results and promptly linking them to care and treatment is essential to achieve hepatitis C elimination.

**Correspondence:** Vladimer Getia (kh.getia@nccdc.ge).

Author Contributions

Vladimer Getia, Paata Imnadze, Eka Adamia, Maia Tsereteli, Maia Alkhazashvili, Irina Tskhomelidze Schumacher, Nancy Glass, Shaun Shadaker, Rania A. Tohme contributed to the study conception and design. Vladimer Getia, Maia Tsereteli and Maia Alkhazashvili contributed to the study implementation and data collection. Vladimer Getia, Irina Tskhomelidze Schumacher and Sophia Surguladze, Shaun Shadaker, Rania A. Tohme contributed to data analysis and interpretation. Vladimer Getia, Irina Tskhomelidze Schumacher, Sophia Surguladze, Shaun Shadaker, Nancy Glass and Rania A. Tohme drafted the manuscript. All authors reviewed and provided critical feedback and approved the final version of the manuscript.

Conflicts of Interest

The authors declare no conflicts of interest.

Disclosure

Disclaimer: The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the US Centers for Disease Control and Prevention.

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**Keywords**

Georgia; hepatitis C; linkage-to-care; lost to follow up; viral hepatitis

## 1 | Introduction

Hepatitis C remains a significant global health threat, with chronic hepatitis C virus (HCV) infection leading to severe liver complications such as cirrhosis and hepatocellular carcinoma [1]. The World Health Organization (WHO) estimates that approximately 50 million people worldwide live with chronic HCV infection, with one million new infections each year [1]. Hepatitis C-related liver disease accounts for almost 240,000 deaths annually [2].

In 2016, the World Health Assembly endorsed the global goal to eliminate hepatitis B and hepatitis C as public health threats by 2030, defined as a 90% reduction in incidence and a 65% reduction in mortality compared to 2015 levels [3]. In 2021, the updated Global Health Sector Strategies (GHSS) 2022–2030 integrated elimination goals for HIV, viral hepatitis and sexually transmitted infections, expanding the approach to elimination. It outlines absolute impact and programmatic targets for 2025 and 2030, serving as the foundation for country validation and elimination pathways [4]. These include diagnosing at least 90% of persons with chronic HCV infection and ensuring that at least 80% of those diagnosed initiate treatment. These targets are critical for strengthening linkage to care, reducing delays between diagnosis and treatment, and mitigating disease progression and preventing deaths. Achieving these goals requires efficient screening programmes, patient-centred approaches and improved healthcare accessibility.

In 2015, Georgia launched a national hepatitis C elimination programme aiming to reduce hepatitis C prevalence through implementation of widespread screening, enhanced linkage to care and provision of free antiviral treatment [5]. The elimination programme offers free rapid HCV antibody (anti-HCV) testing that is accessible throughout the country, and a national registry tracks the number of persons screened for hepatitis C and linked to care and treatment. In 2017, screening for hepatitis C expanded to hospitals, antenatal clinics, primary healthcare centres, blood banks, harm reduction sites and prisons. Although screening identified numerous persons with hepatitis C, robust linkage-to-care strategies, including patient navigation, are crucial for optimising treatment uptake and supporting elimination goals. As a result of the success of the hepatitis C elimination programme, the prevalence of chronic HCV infection in the Georgian population decreased by 67% in 2021 compared to 2015 [6]. As of April 2024, more than 2.5 million persons—nearly 89.3% of Georgia's adult population—had been screened for hepatitis C, and 86% of persons diagnosed with HCV infection initiated treatment [5].

Despite the progress in scaling up screening and treatment in Georgia, a large number of persons were lost to follow up after screening or diagnosis with HCV infection. The COVID-19 pandemic also compounded these challenges, disrupting healthcare services and causing significant delays in both diagnosis and treatment initiation [7].

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Recognising these issues, Georgia's hepatitis C elimination programme implemented a coordinated outreach initiative to bridge these gaps. This effort combined implementing active outreach to persons who were lost to follow-up in the hepatitis C care and treatment cascade, deploying mobile blood collection teams, patient navigators, and providing targeted communication efforts to improve linkage to care. Analysing the impact of this outreach programme helps identify effective strategies for improving patient retention and ensuring a smoother transition from diagnosis to treatment.

We evaluated the effectiveness of this initiative to reengage persons who were lost to follow-up after hepatitis C screening or diagnosis and identified barriers to linkage to care and treatment.

## 2 | Methods

### 2.1 | Study Population

During February 2023–September 2024, we conducted active outreach targeting adults (age ≥ 18 years) who did not seek hepatitis C care and treatment at least 3 months after a positive anti-HCV test result or positive HCV RNA or hepatitis C core antigen (HCVcAg) result (Figure 1). Persons lost to follow-up (LTFU) were categorised into two groups:

- Group 1: persons who tested positive for anti-HCV but had not completed viremia testing ($N$ = 20,467)
- Group 2: persons who had completed viremia testing and tested positive for HCV RNA or HCVcAg but had not initiated treatment ($N$ = 14,716)

### 2.2 | Intervention

The Georgia National Center for Disease Control and Public Health (NCDC) provided training to epidemiologists at both national and municipal levels, equipping them with information needed to actively track persons with suspected or confirmed HCV infection. This process was authorised under Georgian Law (Resolutions N169 and N693).

Trained navigators and epidemiologists at the NCDC attempted to contact each eligible person by phone, making up to two calls if the first attempt was unsuccessful. If a patient remained unlinked to testing or treatment after 1 month of being contacted by phone, their information was shared by NCDC with municipal epidemiologists. Each municipal public health centre designated at least one trained epidemiologist to serve as a patient navigator, assisting persons in navigating the care cascade and conducting door-to-door visits for those who remained unlinked to care after expressing willingness during the initial phone call. To address geographic and logistical barriers in rural areas, mobile teams from municipal public health centres were deployed to collect blood samples for HCV RNA testing. This strategy ensured that those facing difficulties accessing healthcare facilities had access to essential testing services. During in-person visits, public health workers informed persons of their positive test results and encouraged them to complete HCV RNA or HCVcAg testing and/or initiate treatment.

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### 2.3 | Data Sources

We used multiple data sources to maximise the ability to reach persons lost to follow-u p from the hepatitis C care and treatment cascade. Primary data on persons lost to follow-up was obtained from the 'Stop-C' and 'Elim C' databases, which are integral to Georgia's hepatitis C elimination programme [8]. These databases consolidate all national screening and treatment data, covering the entire cascade of care from initial screening for, and diagnosis of, hepatitis C to treatment initiation and outcomes. The Georgian Personal Identification Number, which is a unique identifier, allows for accurate linkage of persons across these databases, ensuring consistency and completeness of the data used in the analysis.

In addition to these core databases, we incorporated supplementary data sources to enhance the accuracy and completeness of contact information (phone number and address) of persons LTFU to be able to reach them by phone or in-person visits. The additional databases included the national immunisation database, COVID-19 vaccination registries and the COVID-19 mobile application database—which provided updated and more extensive contact information. Furthermore, records from the Ministry of Internal Affairs and the Ministry of Justice were accessed to supplement missing contact information and improve tracking of persons who were LFTU.

By cross-referencing these sources with the actual list of persons identified as LFTU in the hepatitis C programme databases using personal IDs, we ensured a more comprehensive approach to outreach efforts.

### 2.4 | Data Collection

When reaching out to participants by phone, epidemiologists and trained patient navigators at the NCDC administered questionnaires to identify barriers to HCV viremia (HCV RNA or HCVcAg) testing and treatment initiation. All participants were asked if they were aware of their status, reasons for not being linked to care, willingness to be linked to care, and reasons for refusing if they were not willing to be tested or treated. Questions related to testing and treatment barriers were open-ended and subsequently categorised by the investigators. All participants in both groups were informed of their status and provided with information on where and how to access hepatitis C testing and treatment. Patient navigators worked to ensure these persons were informed of their treatment options and assessed specific barriers, such as transportation difficulties, stigma and lack of awareness.

NCDC tracked the completion of HCV RNA or HCVcAg testing and initiation of hepatitis C treatment for everyone that was contacted by monitoring the hepatitis C screening and treatment databases.

Navigators' salaries were incentive-based, with 5 Georgian Lari (GEL; approximately $1.80 US dollars) awarded for each person who was reached successfully by phone, 10 GEL ($3.60 US dollars) for each person who completed HCV viremia testing (HCV RNA or HCVcAg) after outreach and an additional 10 GEL ($3.60 US dollars) for each person with confirmed chronic HCV infection who initiated treatment, defined as the person taking their first dose after active outreach.

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### 2.5 | Data Analysis

For both Group 1 (persons who were positive for anti-HCV but did not have further viremia testing) and Group 2 (persons who tested positive for HCV RNA or HCVcAg but had not initiated treatment), we analysed the completion of the cascade of care for hepatitis C after being contacted by NCDC or municipal epidemiologists. We also compared the demographic characteristics of persons who were not successfully linked to care and treatment to those who were successfully linked to care and treatment after implementation of the active outreach interventions. In addition, we conducted a descriptive analysis of the reasons for loss to follow-up provided by the participants both before and after the active outreach.

This activity was conducted as part of the national hepatitis elimination programme, which was determined by the National Center for Disease Control and Public Health of Georgia to be a public health programme activity. This activity was reviewed by CDC, deemed not research, and was conducted consistent with applicable federal law and CDC policy.

## 3 | Results

### 3.1 | Group 1—Persons Who Tested Anti-HCV Positive but Were Not Linked to Viremia Testing

Of the 20,467 persons with reactive anti-HCV tests who were LTFU, 18,034 (88.1%) had valid contact information. Men (67.3%) and those aged 40–59 years (44.1%) represented the highest proportion of anti-HCV reactive persons that were not linked to care. Nearly half (49.0%) of persons who were LTFU after testing anti-HCV positive were screened early in the hepatitis C elimination programme (2015–2017) (Table 1).

Among 18,034 persons with contact information, 14,252 (79.0%) were successfully reached by phone. Persons aged ≥ 60 years had the highest percentage reached (87.6%), while those aged 25–39 years had the lowest (72.3%). Of the 14,252 who could be reached by phone, 14,177 (99.5%) agreed to be interviewed to understand barriers to hepatitis C care and treatment. The majority (63.6%) reported not being told of their screening status or reported not knowing that they were screened. Of the 36.4% ($n$ = 5160) who reported being told of their screening status, 69.6% ($n$ = 3591) knew they were anti-HCV positive, 28.3% ($n$ = 1460) reported screening negative and 2.1% ($n$ = 109) could not recall their test result.

Among the 3591 respondents who were aware that they were anti-HCV positive, the main reasons for not undergoing HCV viremia (HCV RNA or HCVcAg) testing were either not being aware of the need to get tested for HCV viremia (27%), feeling healthy and not seeing the need to get further tests (27%), or not having enough information on where to go to get tested (14%) (Figure 2).

Of the 14,177 respondents, 9513 (67.1%) reported that they will get tested for HCV viremia after the outreach. Among 4664 persons who were not willing to get viremia testing, 395 (9.3%) gave a reason for their decision. The main reported reasons were the presence of other severe chronic illnesses that were of a higher priority (33%), belief that they were

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never screened and thus could not be positive for anti-HCV (23%), and the belief they did not require further testing because they felt healthy (19%) (Figure 2).

By September 2024, of the 14,252 persons who were successfully contacted by phone, 4593 (32.2%) were tested for HCV RNA or HCVcAg, among whom 1386 required home visits for blood collection. The majority of those tested ($n$ = 2440; 53.1%) were positive, indicating current HCV infection and of them 1577 (64.6%) initiated HCV treatment (Figure 3).

There were notable differences in HCV testing and treatment initiation by age group, sex and year of initial reactive anti-HCV test result. The proportion of respondents who were tested for HCV RNA or HCVcAg was highest among those aged 25–59 years (33.7%) and in males (33.8%) compared to females (29.3%). In addition, persons who were diagnosed to be anti-HCV positive in 2021–2023 had the highest proportion of initiating HCV RNA or HCVcAg (49.5%) testing than those tested in 2015–2020. The highest proportion positive for HCV viremia was among those aged 40–59 years (57.3%). Females had a lower proportion of HCV viremia positivity compared to males (40.3% vs. 58.9%) (Table 1). Additionally, among persons who were tested for HCV RNA or HCVcAg after active outreach, persons whose anti-HCV test was conducted in 2018–2023 (56.6%) had a higher proportion of HCV RNA or HCVcAg positivity than those whose anti-HCV test was done in 2015–2017 (48.9%). Among those who had current HCV infection, older persons (≥ 60 years) had a lower proportion of treatment initiation (50.0%), while persons aged 18–24 years had highest proportion of treatment initiation (72.5%). Once initiated, treatment completion rates were consistently high across all groups, exceeding 99%. Sustained virologic response (SVR) was also high, with over 97% of those tested achieving cure, though SVR testing coverage varied by subgroup (on average 63.1%) (Table 1).

### 3.2 | Group 2—Persons Who Tested Positive for HCV RNA or HCV Core Antigen but Had Not Initiated Treatment

Of the initial 14,716 persons who tested positive for HCV RNA or HCVcAg but had not initiated treatment, 13,151 (89.4%) had valid contact information. Men (73.0%) and those aged 40–59 years (48.2%) represented the highest proportion of those who were confirmed positive for HCV RNA or HCVcAg and who did not initiate treatment. Almost 70% of persons who were positive for HCV RNA or HCVcAg test who were not linked to treatment were confirmed to have chronic HCV infection in 2018–2020 (Table 1).

Among 13,151 persons with contact information, 6982 (53.1%) answered the phone. Persons aged ≥ 60 years (55.4%) and females (54.6%) had the highest response rates to phone calls. Of the 6982 persons who could be reached, 6768 (96.9%) agreed to be interviewed to identify barriers to initiation of treatment. The majority were men ($n$ = 4873, 72.0%) and aged ≥ 60 years ($n$ = 2843, 42.0%). Of the 6768 respondents, 61.7% were aware of their chronic HCV infection status, while 15.8% reported being unaware and 22.5% refused to provide an answer. Of the 4176 respondents who were aware of their HCV infection status, 2944 (70.5%) provided a reason for not initiating treatment. The main reason for not initiating treatment was lack of information on the next steps needed after diagnosis (62.0%) (Figure 4).

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Of the 6768 interviewed respondents, 59.5% ($n$ = 4026) expressed a willingness to initiate treatment in the future, whereas 37.6% were unwilling to be treated and 2.9% refused to answer. Of the 2544 participants who refused to initiate HCV treatment in the future, 1211 (47.6%) provided a reason for their refusal, with the most common reason cited as distrust of medications used in the hepatitis C elimination programme (79.0%) (Figure 4).

By September 2024, of 6982 persons who were reached by phone, 2267 (32.5%) subsequently initiated HCV treatment (Figure 5). Persons aged 18–39 years (40.2%) had the highest proportion of treatment initiation while those aged ≥ 60 years (20.1%) had the lowest. Males had a higher percentage linked to care (34.3%) than females (27.7%). Additionally, persons who were diagnosed with HCV infection in 2021–2023 had a much higher proportion of treatment initiation (65.2%) compared to those diagnosed in previous years. Among those who initiated therapy, treatment completion was nearly universal (> 99%). SVR testing coverage ranged from about 64% to 74% across subgroups, with females showing slightly higher coverage. Among those tested, SVR rates were consistently high, with > 98% achieving cure (Table 1).

## 4 | Discussion

This project demonstrated the effectiveness of active outreach interventions in re-engaging persons lost to follow-up with hepatitis C care and treatment in Georgia. Among more than 14,000 persons contacted who had been LTFU after testing anti-HCV positive, 32.2% underwent HCV RNA or HCVcAg testing. Among them, just over half were confirmed to have chronic HCV infection, and 64.6% subsequently began treatment. Additionally, of nearly 7000 contacted persons who were LTFU after previously testing positive for HCV infection, 32.4% subsequently initiated treatment. Altogether, among 9422 adults with chronic HCV infection who were contacted as part of this initiative, 3848 (41.8%) initiated treatment. Identification of persons with HCV infection and linking them to care and treatment are essential for the success of Georgia’s hepatitis C elimination programme [5, 9].

Our analysis found that nearly two-thirds of persons who were LTFU after testing anti-HCV positive were either unaware of their screening results or did not recall being tested. Even among those aware of their infection status, 62% cited a lack of knowledge about the next steps after diagnosis as a key reason for not initiating treatment. This is similar to a study among persons who inject drugs (PWID) in Georgia, which showed that PWID were not sufficiently informed about the necessary steps after a positive HCV antibody test result [10]. In addition, some persons in this analysis reported distrust of medications as a barrier to initiating treatment. To address the above-mentioned concerns, it is important to ensure that healthcare workers are trained to inform patients of their test results and the need to seek further testing and treatment as necessary. Also, having patient navigators in hospitals could help to improve patient knowledge of the seriousness of HCV infection and its repercussions on their health [11, 12], as well as educating them on the efficacy and safety of direct-acting antiviral treatment to build trust in the hepatitis C elimination programme in Georgia. In addition, implementation of immediate reflex testing for HCV RNA by collecting specimens to test for anti-HCV and HCV RNA during the same visit could facilitate linkage to care.

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If the person tests positive for anti-HCV, the duplicate specimen would be automatically tested for HCV RNA. Hence, the patient would receive the final diagnosis with no need for another visit to the healthcare system, which could help decrease the number of persons lost to follow-up from the hepatitis C care cascade [13].

Testing for HCV viremia (Group 1) and treatment initiation for HCV infection (Group 2) was highest among those tested and diagnosed in recent years (2021–2023). Almost half of the persons who tested positive for anti-HCV in 2021–2023 and could be contacted had an HCV viremia test conducted after the active outreach, compared to less than a third of those first tested in 2015–2020. Similarly, almost two-thirds of persons diagnosed with HCV infection in 2021–2023 who were contacted initiated treatment compared to < 30% of those diagnosed in 2015–2020. These findings highlight the importance of contacting persons promptly after testing if they have not initiated care and treatment to avoid loss to follow-up [ 14–16].

Young adults aged 18–24 years demonstrated the highest treatment initiation rates in both groups, while persons aged 60 years and older had the lowest rates of getting tested for viremia and initiating treatment. Older adults may not have been linked to care and treatment due to competing chronic health problems, mobility, or inability to access health care [17]. More urgent health conditions may have been prioritised over hepatitis C treatment [18]. Several respondents reported older age as a barrier to seeking hepatitis C care and treatment, and a third of those who declined testing after outreach cited other chronic illnesses. Deployment of mobile teams that could provide hepatitis C screening and treatment to older persons could resolve loss to follow-up among older adults and ensure they get cured of HCV infection [19].

Men constituted the majority of persons lost to follow-up from the hepatitis C care cascade, which correlates with the higher prevalence of HCV infection among males (3.1%) compared to females (0.6%) in Georgia [6]. Although men in Group 1 had a slightly higher proportion of having an HCV viremia test compared to women, treatment initiation in Group 1 was similar. On the other hand, the proportion of men who initiated treatment in Group 2 was higher than that of women. These findings might indicate potential barriers to seeking further care that are specific to women, such as financial barriers, being busy caring for other family members, anticipated negative reactions and stigma [20, 21]. In addition, injection drug use is one of the leading factors for HCV infection in Georgia [22, 23]. Studies have shown that women who inject drugs had lower uptake of hepatitis C testing and treatment than men in some settings [24–26]. Hence, addressing drug use stigma in women and ensuring that further follow-u p and support are provided to women to ensure their linkage to hepatitis C care and treatment, such as providing sex-specific peer support, might need to be considered and evaluated in Georgia.

## 5 | Strengths and Limitations

This study’s strengths include its large sample size as we attempted to contact all persons who were lost to follow-up, and the comprehensive approach to identify barriers to seeking hepatitis C care and treatment. Limitations include potential selection bias, as persons who

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could be successfully reached may differ from those who could not be reached. Social desirability bias may also have led to underreporting of some barriers such as competing illnesses or distrust in the programme. In addition, recall error might have impacted some responses to the potential barriers to seeking hepatitis C care and treatment as most persons who were lost to follow-up were first tested or diagnosed more than 5 years prior to the interview.

## 6 | Conclusions

Georgia's active outreach initiative successfully re-engaged a substantial proportion of persons who were lost to follow-up from the hepatitis C care cascade and led to an increase in treatment initiation rates, especially among those diagnosed during the past 3 years. In addition, we identified barriers to engagement in hepatitis C care, which were mainly due to lack of awareness of test results or lack of information about HCV infection and the care and treatment process. Addressing these challenges through patient education, tailored interventions and sustained outreach efforts within a year of loss to follow-u p remains critical to achieving hepatitis C elimination in Georgia.

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## Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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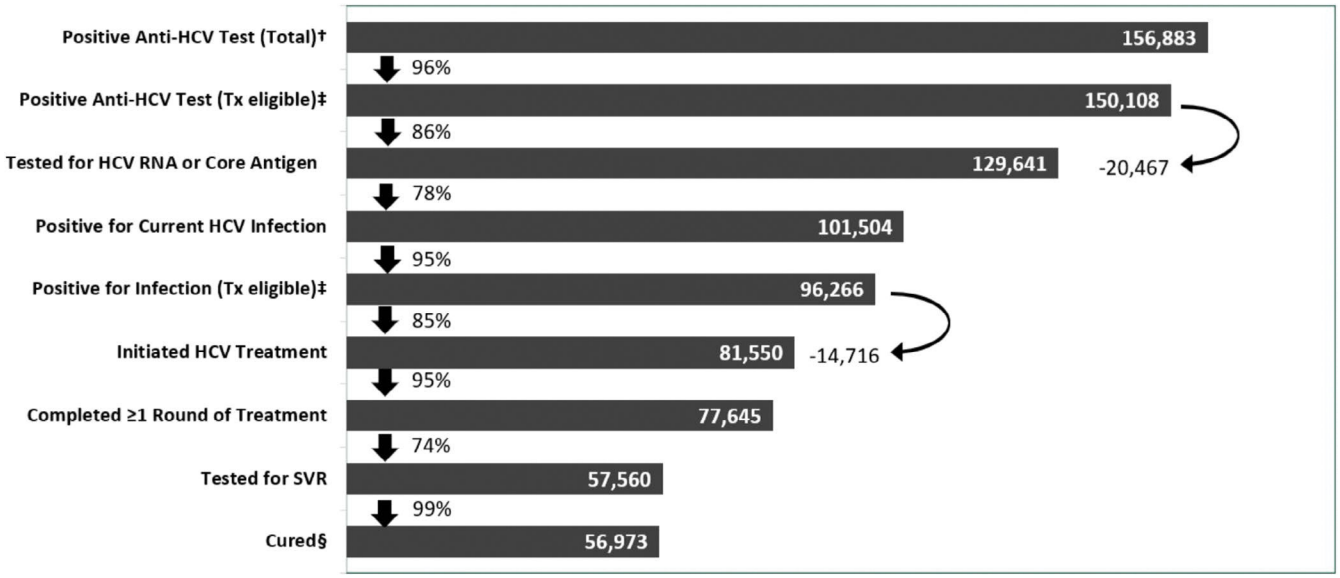
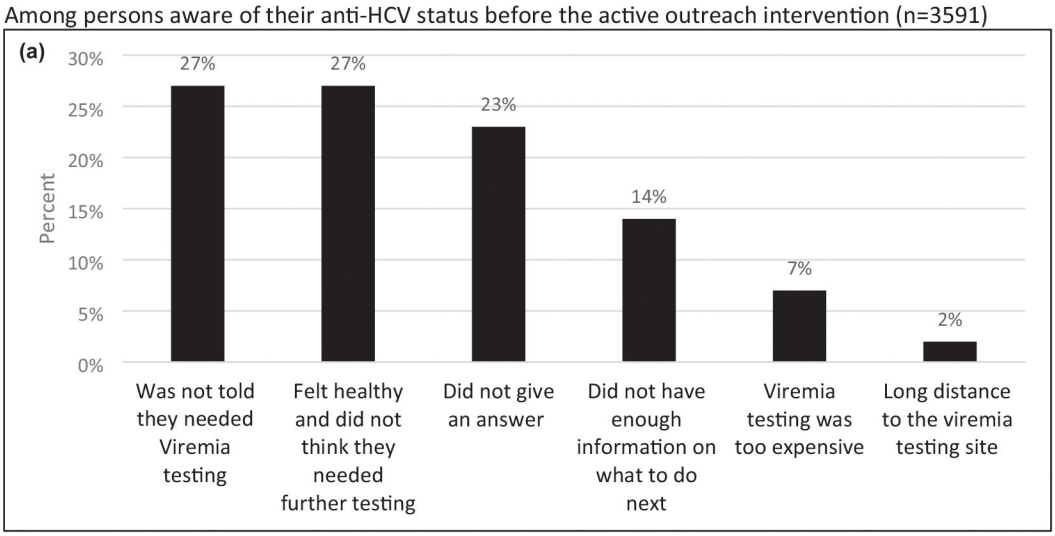


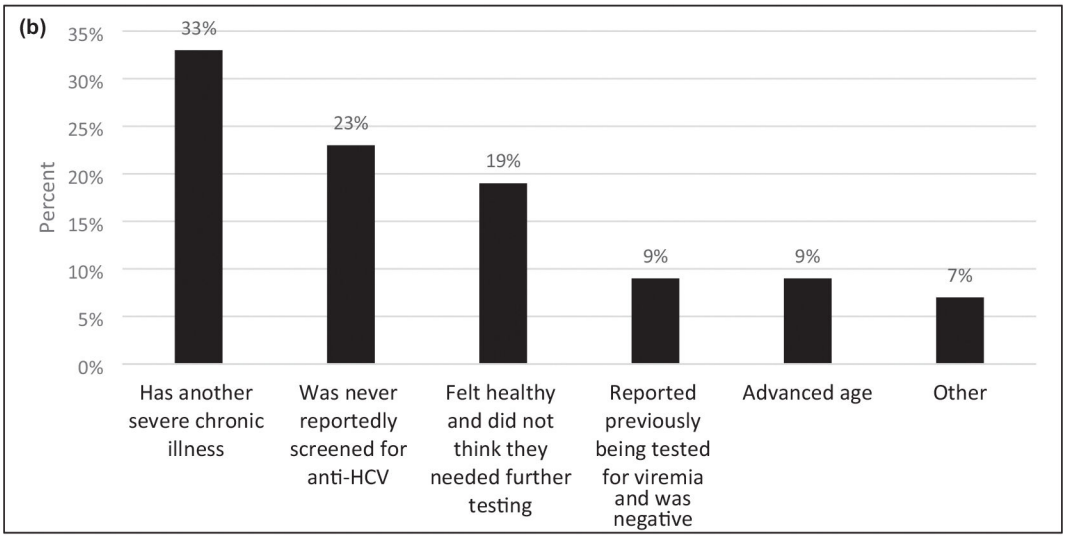

**FIGURE 1 |.**

Georgia hepatitis C Elimination Program Care Cascade, 28 April 2015–28 February 2023. † Among persons with national ID number. ‡ No mortality data prior to progressing in cascade. § Per-protocol, includes retreatments. This cascade presents the progression of individuals through the national HCV care continuum, from initial antibody screening to documented cure. Percentages represent retention at each stage relative to the immediately preceding tier, and numbers in arrows indicate attrition between tiers. anti-HCV, HCV antibodies; HCV, hepatitis C virus; SVR, sustained virologic response; tx, treatment.

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Note: response options are not mutually exclusive




Note: response options are not mutually exclusive; Other responses included a lack of trust in the elimination program, a willingness to undergo viremia testing only if visited at home, and having already received HCV treatment.

**FIGURE 2 |.**

Reasons for loss to follow-up among respondents who tested anti-HCV positive but not tested for HCV RNA or HCV core antigen. (a) Reasons reported by respondents who were aware of their anti-HCV–positive status before the active outreach intervention ($n$ = 3591). (b) Reasons reported by respondents who declined HCV RNA or HCV core antigen testing after the active outreach intervention ($n$ = 395). anti-HCV, HCV antibodies; HCV, hepatitis C virus.

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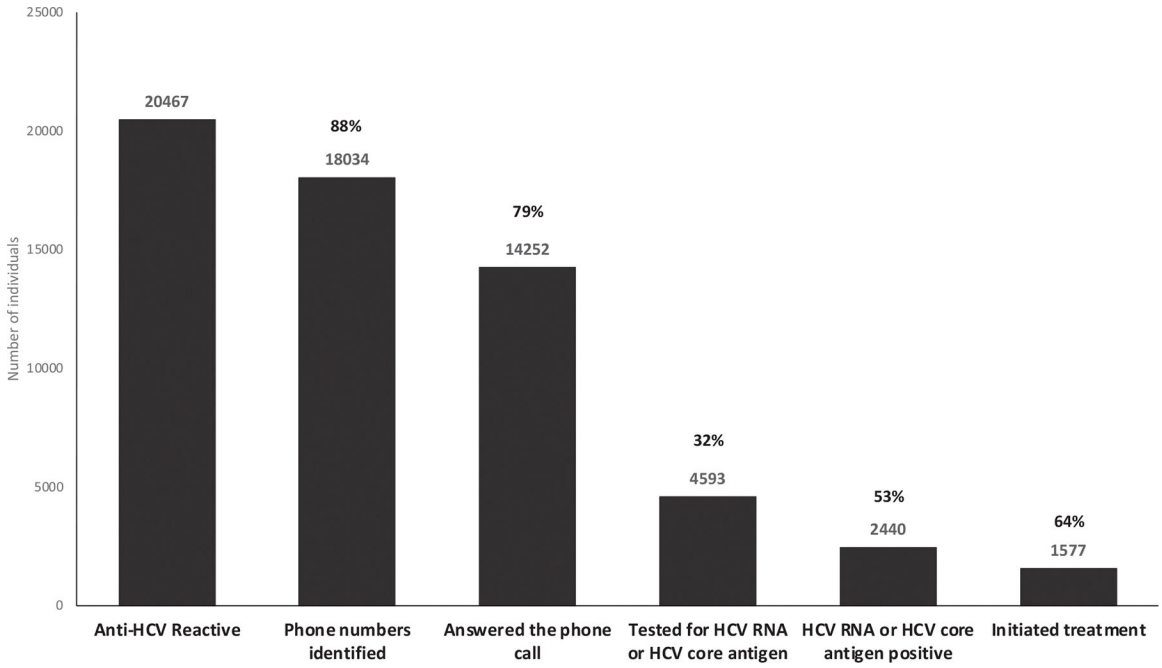


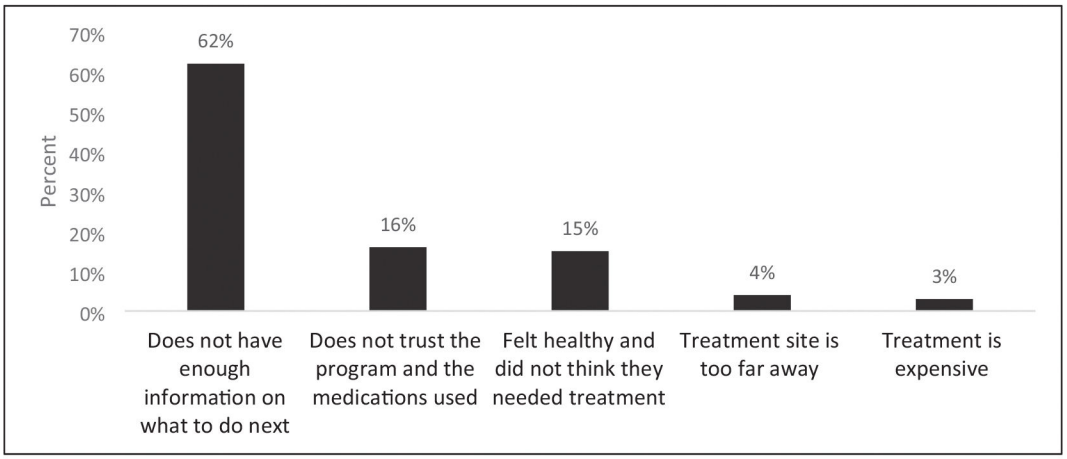

**FIGURE 3 |.**

Linkage to hepatitis C care and treatment through active outreach among anti-HCV reactive persons who had been lost to follow-up, Georgia, February 2023–September 2024. Percentages are the percent retained from the previous tier. anti-HCV, HCV antibodies; HCV, hepatitis C virus.

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**(a)**

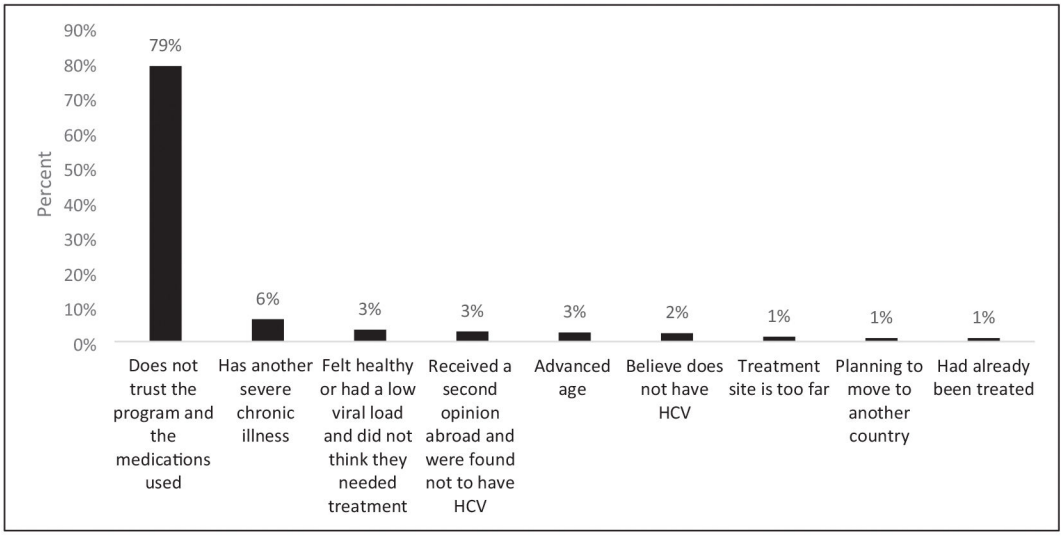
Among persons aware of their HCV infection before the active outreach intervention (n=2944)




Note: responses are mutually exclusive

**(b)**

Among persons who refused treatment initiation after the active outreach intervention (n=1211)




Note: responses are mutually exclusive

**FIGURE 4 |.**

Reasons provided by respondents who were positive for HCV RNA or HCV core antigen result but had not initiated treatment. (a) Reasons for not initiating treatment among respondents who were aware of their HCV infection status before the active outreach intervention ($n$ = 2944). (b) Reasons for refusing treatment initiation after the active outreach intervention ($n$ = 1211). HCV, hepatitis C virus.

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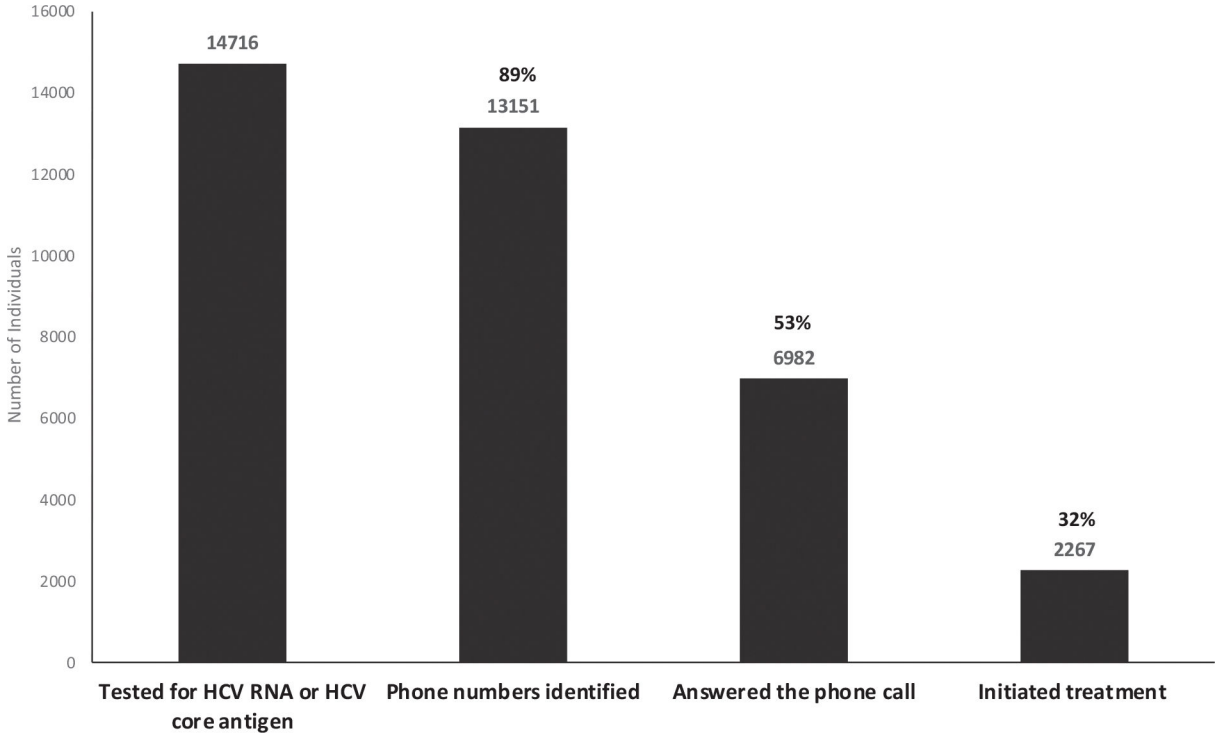



**FIGURE 5 |.**

Linkage to hepatitis C treatment through active outreach initiatives among persons with chronic HCV infection who had been lost to follow-up, Georgia, February 2023–September 2024. Percentages are the percent retained from the previous tier. HCV, hepatitis C virus.

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**TABLE 1 |**

Cascade of care and linkage to hepatitis C care by age, sex and time period, Georgia, 2015–2023.

| | Group 1 (persons positive for anti-HCV who were not tested for viremia) | | | | | | | | Group 2 (persons with HCV infection who did not initiate treatment) | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Anti-HCV positive, not tested for viremia, *n* (column %) | Answered the phone call, *n* (% of previous column) | Received HCV RNA or HCV core antigen testing, *n* (% of previous column) | Confirmed positive for HCV RNA or HCV core antigen testing, *n* (% of previous column) | Initiated treatment, *n* (% of previous column) | Treatment ended (% of previous column) | SVR checked (% of previous column) | SVR achieved (% of previous column) | HCV RNA or HCV core antigen positive, not treated, *n* (column %) | Answered the phone call, *n* (% of previous column) | Initiated treatment, *n* (% of previous column) | Treatment ended (% of previous column) | SVR checked (% of previous column) | SVR achieved (% of previous column) |
| **Age group (years)** | | | | | | | | | | | | | | |
| 18–24 | 979 (5.4%) | 761 (77.7%) | 211 (27.7%) | 51 (24.2%) | 37 (72.5%) | 37 (100%) | 24 (64.9%) | 24 (100%) | 172 (1.3%) | 95 (55.2%) | 39 (41.1%) | 39 (100%) | 25 (64.1%) | 25 (100%) |
| 25–39 | 5354 (29.7%) | 3873 (72.3%) | 1316 (34.0%) | 657 (49.9%) | 442 (67.3%) | 442 (100%) | 238 (53.8%) | 230 (96.6%) | 3173 (25.1%) | 1535 (48.4%) | 616 (40.1%) | 616 (100%) | 357 (57.9%) | 345 (96.6%) |
| 40–59 | 7954 (44.1%) | 6334 (79.6%) | 2119 (33.5%) | 1214 (57.3%) | 839 (69.1%) | 839 (100%) | 545 (64.9%) | 534 (97.9) | 6344 (48.2%) | 3433 (54.1%) | 1226 (35.7%) | 1224 (99.84%) | 800 (65.3%) | 793 (99.1%) |
| ≥60 | 3747 (20.8%) | 3284 (87.6%) | 947 (28.8%) | 518 (54.6%) | 259 (50.0%) | 259 (100%) | 188 (72.5%) | 187 (99.47%) | 3462 (26.4%) | 1919 (55.4%) | 386 (20.1%) | 385 (99.74%) | 279 (72.5%) | 277 (99.3%) |
| **Sex** | | | | | | | | | | | | | | |
| Male | 12,128 (67.3%) | 9382 (77.4%) | 3168 (33.8%) | 1866 (58.9%) | 1215 (65.1%) | 1215 (100%) | 722 (59.4%) | 705 (97.5%) | 9598 (73.0%) | 5042 (52.5%) | 1729 (34.3%) | 1729 (100%) | 1066 (61.6%) | 1048 (98.3%) |
| Female | 5906 (32.7%) | 4870 (82.4%) | 1425 (29.3%) | 574 (40.3%) | 362 (63.1%) | 362 (100%) | 273 (75.4%) | 270 (98.9%) | 3553 (27.0%) | 1940 (54.6%) | 538 (27.7%) | 537 (99.8%) | 395 (73.6%) | 393 (99.5%) |
| **The time of the initial positive anti-HCV test** | | | | | | | | | **The time of the initial positive HCV RNA/HCVcAg** | | | | | |
| 2015–2017 | 8837 (49.0%) | 6700 (75.8%) | 2052 (30.6%) | 1003 (48.9%) | 644 (64.2%) | 644 (100%) | 394 (61.2%) | 385 (97.7%) | 1930 (14.7%) | 1209 (62.6%) | 269 (22.2%) | 269 (100%) | 178 (66.2%) | 173 (97.2%) |
| 2018–2020 | 6890 (38.2%) | 5894 (85.5%) | 1721 (29.2%) | 980 (56.9%) | 630 (64.3%) | 630 (100%) | 393 (62.4%) | 383 (97.5%) | 9138 (69.5%) | 4916 (53.8%) | 1439 (29.3%) | 1436 (99.8%) | 915 (63.7%) | 902 (98.6%) |
| 2021–2023 | 2307 (12.8%) | 1658 (71.9%) | 820 (49.5%) | 457 (55.7%) | 303 (66.3%) | 303 (100%) | 208 (68.6%) | 207 (99.5%) | 2083 (15.8%) | 857 (41.1%) | 559 (65.2%) | 559 (100%) | 368 (65.8%) | 365 (99.2%) |
| Total | 18,034 | 14,252 (79.0%) | 4593 (32.2%) | 2440 (53.1%) | 1577 (64.6%) | 1577 (100%) | 995 (63.1%) | 975 (97.9%) | 13,151 | 6982 (53.1%) | 2267 (32.5%) | 2264 (99.9%) | 1461 (64.5%) | 1440 (98.6%) |

Abbreviations: anti-HCV, HCV antibodies; HCV, hepatitis C virus; HCVcAg, HCV core antigen.