HEPATITIS C TREATMENT AND DIAGNOSTICS ADVOCACY IN GEORGIA

WORKSHOP SUMMARY REPORT

HOTEL ZP PALACE

TBILISI, GEORGIA

13-15 MAY 2019

Georgian Harm Reduction Network (GHRN) prepared the workshop summary report for public dissemination. The workshop organizers were GHRN, in partnership with Foundation for Innovative New Diagnostics (FIND), Treatment Action Group (TAG), and the Georgia Community Advisory Board (GeCAB). The views and opinions expressed in this report are those of the workshop participants and do not necessarily reflect the official policy or position of the convening organizations. This report was written by Maka Gogia and Irma Kirtadze.

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INTRODUCTION

Georgia is among the countries with a high hepatitis C virus (HCV) prevalence, with +7.7% HCV antibody and HCV ribonucleic acid (RNA) +5.4%. The reasons for the high disease burden have not been studied sufficiently. People who inject drugs (PWID) did not have widespread access to sterile injecting equipment, especially in the early 1990s, following the dissolution of the Soviet Union, which contributed to the spread of HCV in the general population.

Until 2014 HCV diagnostics and treatment were neither financed by the state nor private insurance schemes. Due to enormous pressure from civil society and affected communities, in 2015 the Georgian Government took action and initiated the National HCV Elimination Program[1]. The program target intended to achieve targets in that 90%-95%-95% of all Georgian citizens would be diagnosed, receive treatment, and care for HCV by 2020.

After four years, we see limitations of the program. The PWID community still faces challenges for inclusion and accessing treatment and affordable diagnostics in the national treatment program. For 15 years, GHRN has been a strong advocate for accessible, affordable diagnostics, prevention, treatment, and drug policy changes at the country level. Based on patients' needs, it creates advocacy and educational platforms for identifying problems and convening stakeholders to find solutions.

During 13-15 May, 2019, the GHRN, in partnership with FIND, TAG, and the Georgia Community Advisory Board—comprised of medical and other healthcare providers and affected community members—convened an advocacy workshop to focus on strategies to overcome barriers to diagnostics and the overall services in the national elimination plan, held at Hotel ZP Palace, in Tbilisi, Georgia. There were a total of 34 participants, including two medical providers, 24 resource persons from international organizations, national NGOs, and academia, and eight community members from the HIV, HCV, LGBTQ+, and harm reduction communities. Participants included members of the GeCAB, other healthcare providers, and human rights, healthcare, and drug policy reform advocates from around the country. It was important to ensure medical expertise was paired with community experiences and knowledge, and to understand how we could build a broad, intersectional healthcare advocacy network that complements existing advocacy platforms.

Workshop objectives were to:

- Increase knowledge of treatment advocates on HCV prevention, diagnostics and treatment and harm reduction basics to overcome existing myths about treatment among people who inject drugs;
- Define existing barriers within HCV elimination program and to set effective strategies/ways to solve;
- Share good practices, lessons and tools for activists.

Anticipated Outcomes were to ensure treatment activists strengthened their technical knowledge and received quality information and educational materials on current HCV prevention, diagnostics and treatment options. The workshop also anticipated that participants would effectively use the information and lessons exchanged to formulate

[1] Ministry of Health. Strategic Plan for the Elimination of the Hepatitis C Virus in Georgia, 2016-2020. https://www.moh.gov.ge/uploads/files/2017/akordeoni/failebi/Georgia_HCV_Elimination_Strategy_2016-2020.pdf (Accessed 9 July, 2019).

short and long-term advocacy strategies for better treatment coverage and treatment outcomes.

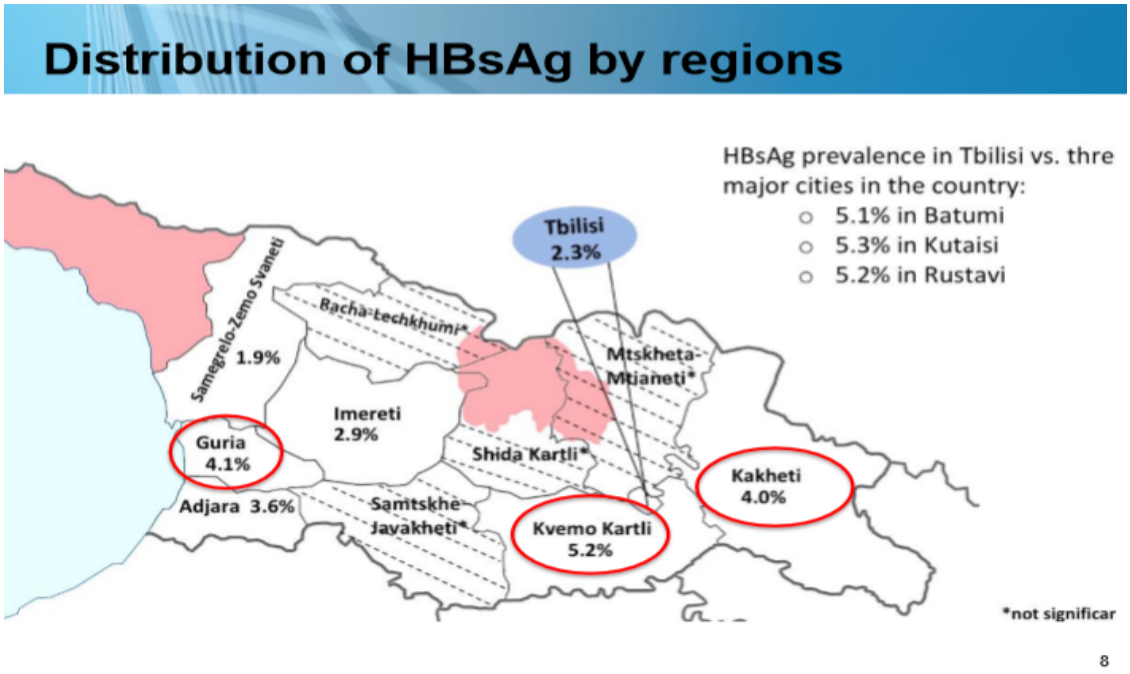
See agenda (**Annex 1**) and list of participants (**Annex 2**).

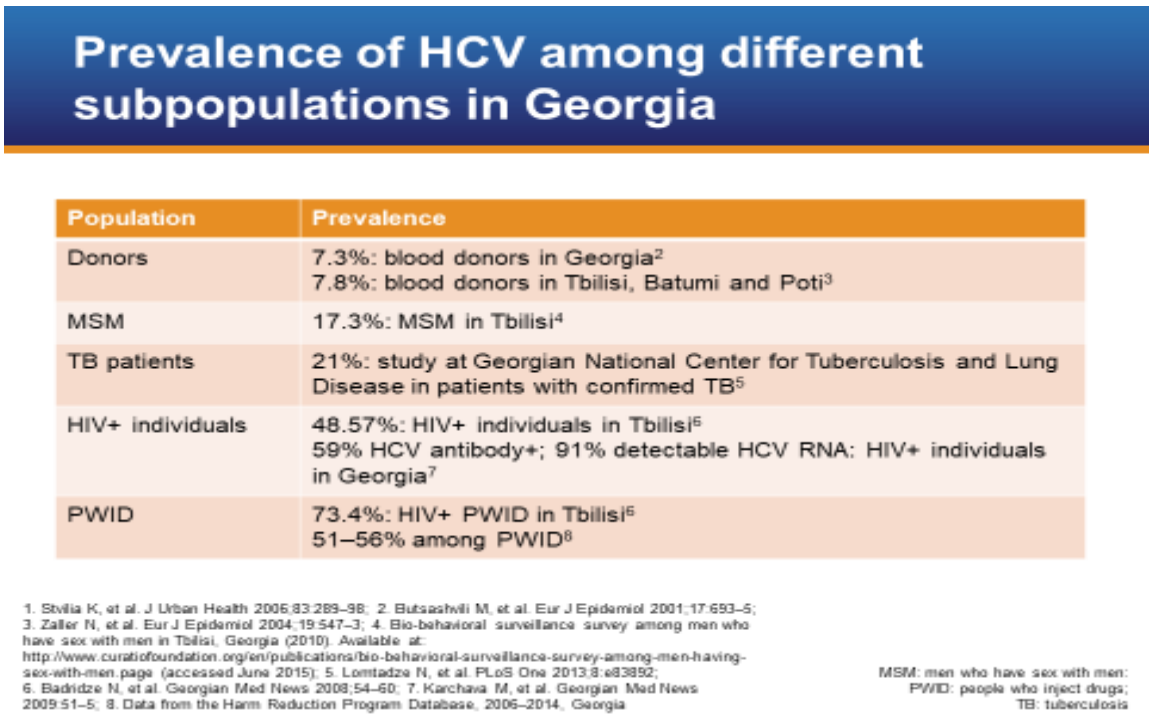
DAY 1 SUMMARY: Strengthening Relationships & Building Momentum to Catalyze Diagnostics Advocacy

Following introductory remarks, we reviewed the objectives of the meeting and participants took time to respond to the learning evaluation form (**Annex 5**).

The Georgian HBV and HCV epidemic, national targets, current care cascade and routes of transmission in the country were covered to ensure all meeting participants had the same basic knowledge on both diseases and were aware of the latest National HCV Elimination Program results.

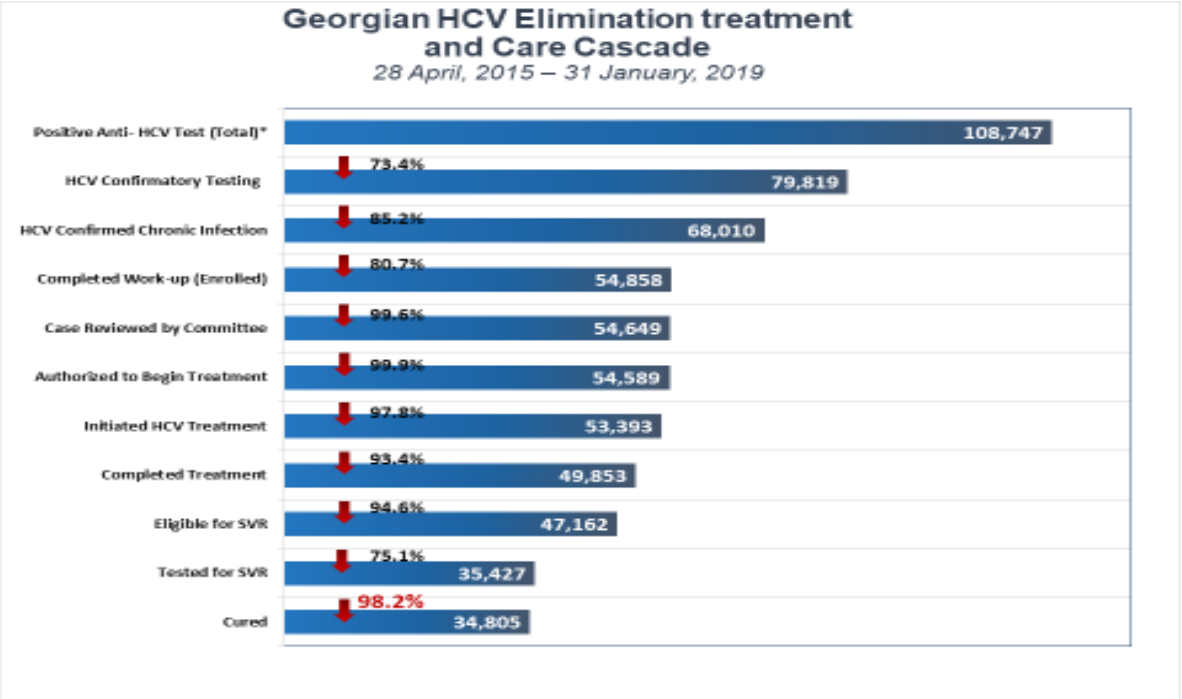
The following figures show the HBV prevalence in different regions and the different groups with high prevalence of HCV:





The Extension for Community Healthcare Outcomes (ECHO) Model in Georgia was discussed as an effective model in linking and retaining patients in care, and how this model is used for harm reduction program in Georgia. Participants reviewed HCV prevention and harm reduction principles to ensure that all participants including those who are members of the GeCAB have an equal understanding of harm reduction and HIV/HCV prevention related to injection and sexual practices.

A range of available treatment options beyond Gilead's direct-acting antivirals exist and participants reviewed the HCV Treatment Landscape (in the pan-genotypic era). It's important to compare existing treatment regimens in Georgia across all the available, optimal regimens, particularly when treating compensated cirrhosis, decompensated cirrhosis, HIV co-infected persons, chronic kidney disease, children and adolescents, and treatment considerations for key populations, including people who inject drugs, men who have sex with men, sex workers, and incarcerated people. The remaining challenges globally and in Georgia to HCV treatment access were also outlined. Direct-acting antivirals (DAAs) are just as safe, tolerable, and effective for people who actively or formerly inject drugs as for the non-drug using population. We need to debunk the myths surrounded treatment among PWID – there is no scientific evidence to deny treatment to PWID!



Participants reviewed the basic concepts and terminology for HCV diagnostics, the updated WHO Testing Guidelines on HCV and HBV, and the existing testing algorithm in Georgia. Participants reviewed the WHO recommendations on existing practices for HBV vaccination in community settings, as the integration of HBV vaccinations in harm reduction settings is increasingly a priority in Georgia. In strengthening advocates' technical knowledge, the WHO Essential Diagnostics List and ways to simplify the diagnostics algorithm, such as removing genotype testing if using pan-genotypic regimens and eliminating viral load adherence checks, were discussed. It is important that governments validate tests' quality and ensure that providers/NGOs in Georgia use high quality test-kits, particularly those that are WHO pre-qualified and/or CE-marked by a stringent regulatory authority (SRA).

At the end of the day the workshop participants were divided in 4 working groups to identify problems in HCV and HBV screening in the country, which is the focus for developing advocacy strategies (**Annex 4: Working Group Results**).

DAY 2 SUMMARY: Practices in Georgia & Barriers to Diagnostics

The facilitator opened the second day of the workshop. Following a brief summary of Day 1, participants were reminded of the topics on which to focus in the break out groups. Each break out group exchanged ideas on how to make HCV testing more available in their communities and considered the recommendations of the external Technical Advisory Group (TAG) that had been previously presented to the Georgian government and Ministry of Health (MoH) in November 2018. Yet, providers and advocates have not seen much progress or accountability by the government in implementing the recommendations. As a result, the four groups compiled the list of treatment barriers to overcome, including:

1. Quality tests (to ensure zero false negative results).
2. Lack of information about the available services.
3. Myths and stereotypes about hepatitis and key populations.
4. Low motivation of the community members to seek services.

5. Low geographical access.
6. Some clinics offer to pay for screening; the disproportionate coverage of services costs; no universal coverage of diagnostics.
7. Purposeful discredit of the national hepatitis program, attributed to misinformation and HIV/HCV/biomedical treatment denialism.
8. Stigma towards patients, particularly from key populations, by the medical personnel.
9. Internalized stigma by patients.
10. HBV-testing is not offered to MSM and sex-workers.
11. Low testing of the sexual partners and peers of people who use drugs.
12. Lack of anonymity and confidentiality by medical providers.

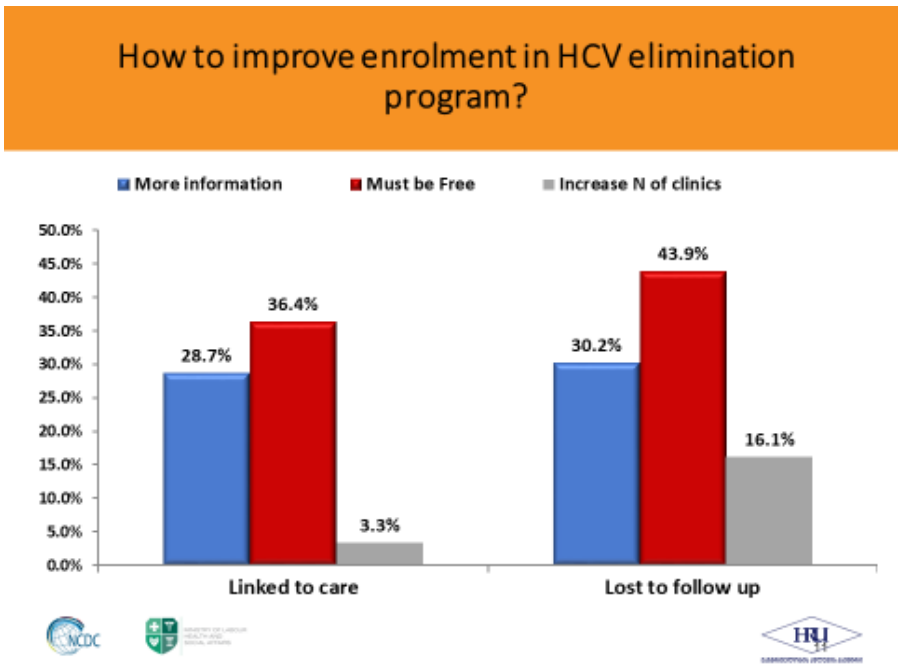
Participants came to an agreement that this list covers the primary, most important barriers for scaling up screening and treatment programs.

Characteristics of the “ideal test” in HCV diagnostics, the existing technologies, and several diagnostics that are under research and development were presented. Key advocacy points about the need to scale up number of people diagnosed and linked to treatment and care were highlighted to frame the current diagnostics barriers in Georgia.

Georgia’s strict drug policy and its impact on the treatment access and provision of healthcare for PWID was presented. We need to advocate for drug policy reforms if we are to make significant progress in the national elimination program. Again, the evidence on the efficacy, safety, and adherence of DAAs for PWID was discussed. Key advocacy points were presented on how public health interventions, including substance use disorder and mental health programs, for PWID are less costly than the criminalization and incarceration of people who use drugs. National budgets could save money if funds are shifted from criminal justice and prisons to public health programs that include responses to infectious diseases.

GHRN presented preliminary study results on the barriers for people who inject drugs and people who use harm reduction services to participate in the national hepatitis C program. One major barrier is the lack of information about HCV testing and treatment among this population as well as other affected communities.

More, accurate, quality information and full coverage of the HCV package of services are seen by PWID survey respondents as the best ways to improve enrolment in the HCV elimination program:



The social determinants of health including stigma and discrimination were outlined, with respect to the definitions by the World Health Organization Rio de Janeiro Declaration. Several practical examples in Georgia demonstrated that the community lacks awareness on the HIV/AIDS law, the legal protections against discrimination, and how claimants do not utilize the role of the ombudsmen or other legal mechanisms for the purposes of advocacy due to stigma and not wanting to be public about some of these claims.

Participants reviewed a brief history of HCV advocacy activities since 2010 to present, specifically the access to DAAs. Community engagement in advocacy activities is vitally important to spread information about available services, such as hepatitis C treatment and about the advantages of providing "one-stop-shop" services, in range of healthcare services can be accessed in one visit at one site. One example from HCV treatment advocacy in Georgia was a Flash Mob during World Hepatitis Day in 2013 (WORLD HEPATITIS DAY 2013, FLASH MOB-ZUGDIDI, GEORGIA).

Participants were introduced to how intellectual property plays a role in access to anti-retroviral (ARVs) and DAA medications. Access to medicines advocates need to be aware about the potential of using international policy mechanisms, such as those enshrined in the Doha Declaration on Public Health, and the policy flexibilities under the Trade Related Aspects of Intellectual Property Rights (TRIPS) Agreement, such patent oppositions, voluntary and compulsory licensing, and strengthening patentability criteria, in order to expand affordable generic treatment access.

A range of other issues that pharmaceutical companies could address include that patients lack information about the medications and package inserts need to be translated into Georgian. It is difficult for the patients to understand the medical guidelines with lots of medical terms and there is a need to create community-friendly ARV guidelines, written with simple language for patients and community members. Moreover, patients need to receive written, informed consent forms when taking medications (that treatment is voluntary) and we need to avoid centralized procedures currently in place to distribute medications to patients. We need to decentralize HIV

and HCV services, so that patients are more comfortable seeking treatment and care. Advocates and community members taking ARVs are currently circulating a petition to decentralize ARVs. Workshop participants were called to support the petition.

Following the technical and knowledge-building presentations, the four break out groups reformed to focus on the following specific strategies to address key questions:

1. **Increase HBV/HCV screening in the community by way of decentralization** – Which methods can be used and which activities can be realized to increase screening coverage and thus, to boost the indicators of engagement in the treatment for the hepatitis C elimination program? How can screening and treatment services be decentralized? What will contribute to better indicators for screening and treatment?
2. **Integrate HBV vaccination in low-threshold harm reduction settings** – What are the possible ways and current needs for realizing such integration today?
3. **Public awareness campaigns/capacity building of hepatitis C** – What kinds of campaigns will promote the dissemination of information about hepatitis C among the general population? What are the best ways to engage key populations, particularly PWID and their sexual partners and peers? What types of cooperation and community engagement is needed with the National Center for Disease Control and Public Health to exchange, monitor and inquire about the data?
4. **Activities aimed at high level, national policy reforms** – What kind of changes are needed to achieve all types of drug decriminalization. How can we better support people's reintegration and support for their harm reduction strategies after they leave prison? How do we protect the confidentiality and anonymity of patients taking DAAs, given the challenges with the national surveillance and reporting system?

Participants needed to self-select the break out groups in which they could bring their strengths, expertise, and skills. Each group chose a group facilitator and a rapporteur to present on the strategies and action plans.

DAY 3 SUMMARY: Advocacy Strategies for Overcoming Diagnostics Barriers

Preliminary results of the FIND project in Georgia were presented to compare costs and efficiency among different decentralized diagnostics pathways using RNA and core antigen platforms and the current standard of care in Georgia. Whether to initiate the FIND study at Xenon and Hepa Plus clinics was considered.

One tool, **mapCrowd**, that community advocates can use in their advocacy and to monitor the HCV epidemiology, policies, treatment and diagnostics access and availability in their countries and in comparison with other countries/regions is the free, open-sourced database: (https://mapcrowd.org/). It is available in four languages, including Russian. Advocates are encouraged to use the data tool when governments are negotiating drug prices and weighing policy and programs in the HCV response.

Then break out groups reformed to identify:

- Activities to implement for their strategies;
- Timeframe and resources available to implement the activities;
- Persons responsible for the implementation and to carry out the actions/tasks;
- Additional resources and support needed.

Participants were asked to formulate their plans according to SMART criteria:

- Specific – objective should be specific and sensitive.
- Measurable – objective should be measurable, for example the %, ratio, quantitative and qualitative – with relevant context.
- Achievable – objective should be achievable; the data can be collected and are safe.
- Relevant – objective should be relevant/realistic; the degree of relevance of the link between the reason and the outcome with this indicator.
- Time bound - objective should be time bound; accomplishable in time, when the reform is expected.

In addition, a brief summary about the community and who is considered a community member: A community is a form of self-organization of a group of people with one or several signs, which is the unity of people living in nearby locations, which fosters relations between them, and the sharing of culture and values within the scope of such relations. Consequently, a community can be formed as a unity of three necessary elements: people, location and relationship.

Element	Example
People	Values, beliefs, behaviors, size, membership, demographic properties, social and economic status, feeling of strong influence, feeling of property
Location	Geography, frames/borders, house, industry, air, water, ground, virtual existence
Relationship	Communication, familial, education, religion-based, political, recreational, virtual.

CONCLUSION

Participants committed to following up on the action plans. Participants shared their impressions over the three days and proposed useful topics for future trainings. For example, advocates would like to participate in a budget advocacy training focused on how to monitor state budgets. This would following the lead of Ukrainian advocates, who found a way to reallocate a UAH17 million in savings in their elimination program.

Participants generally expressed that the workshop provided new information on hepatitis C treatment and diagnostics and met their expectations. Now that much of the technical information and basics on HCV treatment and diagnostics were covered, in the future, more time should be devoted to working groups and to develop more detailed action plans. Immediate follow up steps include:

- To hold at least one day-long working meeting to elaborate detailed goals and formulate activities. The meeting should be held in the suburbs, not in Tbilisi;
- Find resources for a state and national budget advocacy training;
- Share and coordinate activities for World Hepatitis Day and for the National HBV Conference;
- Create a communications platform (e.g., WhatsApp, Viber);
- Provide feedback/evaluation for conducting future meetings and training topics (however, webinars may not be as effective. Instead, organizers need to find resources for more in-person engagement).

Annex 1: Agenda

Day 1 (May 13, 2019) - *Strengthening Relationships & Building Momentum to Catalyse Diagnostics Advocacy*

Time	Topic	Speaker/Facilitator
9:30-10:00am	Registration & Pre-Workshop Learning Evaluation Form	
10:00-10:15am	Welcoming Remarks & Workshop Objectives	*Presenter:* Maka Gogia
10:15-10:30am	Introductions, Rationale & Learning Needs	*Facilitator:* Maia Butsashvili Bryn Gay (Safe space policy)
10:30-11:10am	Setting the Scene: Georgia HBV and HCV Epidemic, Targets, Current Care Cascade and Routes of Transmission	*Facilitator:* Maka Gogia *Presenter:* Maia Butsashvili
11:10am - 11:30am	Project ECHO Model in Georgia: Successes and challenges	*Facilitator:* Maka Gogia *Presenter:* Maia Butsashvili
11:30am-12:00pm	***Coffee break***	
12:00-12:30pm	Review of HCV Prevention and Harm Reduction Principles	*Facilitator:* Maia Butsashvili *Presenter:* Maka Gogia
12.30-1.00pm	Review HCV Treatment Landscape (Pangenotypic Era)	*Facilitator:* Maia Butsashvili *Presenter:* Bryn Gay
1.00-2.00pm	***Lunch***	
2:00-3:00pm	Diagnostics Basics & What Advocates Need to Know	*Facilitator:* Maia Butsashvili *Presenters:* Bryn Gay and Dr Navneet Tewatia
3:00-3:25pm	Updated WHO Testing Guidelines, Essential Diagnostics List & Simplifying the Diagnostics Algorithm	*Facilitator:* Maia Butsashvili *Presenters:* Bryn Gay and Dr. Navneet Tewatia
3:25-4:00pm	What is in practice for HBV and HCV testing in Georgia? What is in practice for HBV vaccination in community settings? (Other country practice/WHO recommendations to vaccinate PWIDs)	*Presenter and Facilitator:* Maia Butsashvili
4:00-4:20pm	***Coffee break***	
4:20-5:00pm	Visioning Exercise **Ask each group to each address one strategy to improve access to HCV testing**	*Facilitator:* Maia Butsashvili

	based on issues framed in the Setting the Scene, outcomes from Technical Advisory Group meeting, and updates from national elimination planning meetings	
5:00-6:00pm	What screening strategies work most effectively in linking people to care in your community?	*Facilitator:* Maia Butsashvili 4 community members presenters (5-10 min each)
6:00pm		

Day 2 (May 14, 2019) - *Practices in Georgia & Barriers to Diagnostics*

Time	**Topic**	**Speaker/Facilitator**
10:00-10:15am	Recap from Day 1	*Facilitator:* Maka Gogia
10:15-11:00am	Ideal HCV Test & HCV Diagnostics Pipeline	*Facilitator:* Irma Kirtadze *Presenters:* Bryn Gay and Dr Navneet Tewatia
11:00-11:30am	Ending the war on drug users & addressing myths about DAAs for PWID	*Facilitator:* Irma Kirtadze *Presenters*: Bryn Gay and Kote Rukhadze
11:30am-12:00pm	Barriers in HCV elimination program for PWIDs (study results)	*Facilitator:* Irma Kirtadze *Presenter:* Maka Gogia
12:00-12:15pm	***Coffee break***	
12:15-12:45pm	Social Determinants of Health: Stigma & discrimination	*Facilitator:* Irma Kirtadze *Presenter:* Kakha Kvashilava (on Georgian legislation)
12.:45-1:15pm	Addressing Health System Barriers to Diagnosis: Financial barriers to diagnosis Community role in data monitoring	*Facilitator:* Irma Kirtadze *Presenter:* Nino Janashia (regional harm reduction site) *Presenter:* Bryn Gay (mapCrowd/hepatitis data platform)
1:30-2:30pm	***Lunch***	
2:30-3:00pm	Report Back on Intellectual Property and Access to Medicines Training	*Facilitator:* Irma Kirtadze *Presenter:* Tako Zurashvili (GHRN)

3:00-3:30pm	Recap from Visioning Exercise, key themes, and break out group discussions	*Facilitator:* Irma Kirtadze
3:30-4:00pm	***Coffee break***	
4:00-5:30pm	What is Advocacy + Activism? Opportunities for advocacy to overcome diagnostics barriers	*Facilitator:* Irma Kirtadze

Day 3 (May 15, 2019) - *Advocacy Strategies for Overcoming Diagnostics Barriers*

Time	**Topic**	**Speaker/Facilitator**
10:00-10:30am	Opportunities for advocacy to overcome diagnostics barriers (Continued + recap)	*Facilitator:* Irma Kirtadze
10:30-11:15am	Update from FIND Projects in Georgia	*Facilitator:* Irma Kirtadze *Presenter:* Maia Japaridze (FIND - Georgia)
11.15-11.45am	***Coffee break***	
11.45-12.00am	Mapping diagnostics advocacy strategies and priorities	*Facilitator:* Irma Kirtadze
12:00-1:00pm	Identify key action plans and follow up activities	*Facilitator:* Irma Kirtadze
1:00-2:00pm	**Lunch**	
2:00-2:45pm	Group discussion on recommendations for devising community platform, monitoring, and metrics on diagnostics in elimination plan	*Facilitator:* Irma Kirtadze
2:45-3:30pm	Wrap up and post-workshop learning evaluations	*Facilitator:* Irma Kirtadze

Annex 2: Meeting Participants

N	Name/Surname	Affiliation
1	Alex Amirkhanashvili	Activist
2	George Mkalavishvili	Hepa+
3	Zaza Karchkhadze	Rubikoni
4	Dali Usharidze	New Way
5	Kakha Kvashilava	GHRN
6	Ia Jikia	FIND - Georgia
7	Natia Lobjanidze	FIND - Georgia
8	Teona Imerlishvili	Step to Future
9	Tamar Gakhokidze	Hepa+
10	Nikoloz Javakhishvili	New Way
11	Gvanca Chagunava	GHRN
12	Nino Janashia	Qsenoni
13	Cira Egutia	Qsenoni
14	Manana Sologashvili	Hepa+
15	George Karumidze	Hepa+
16	Natia Kharati	Tanadgoma
17	Lika Mamacashvili	Tanadgoma
18	George Jangavadze	Activist
19	Kakha Gvalia	Activist
20	George Metaplishvili	Activist
21	Maka Revishvili	Hepa+
22	Gocha Gabodze	Pomegranade
23	Marina Asatiani	GHRN/GeNPUD
24	Lia Beritashvili	New Vector
25	Maia Japaridze	FIND - Georgia
26	Ketevan Bidzinashvili	Step to Future
27	Nino Tabuashvili	Step to Future
28	Irma Kirtadze	Facilitator/Alternative Georgia
29	Maia Butsashvili	Facilitator/Clinic Neolabi
30	Kote Rukhadze	GHRN/GeNPUD
31	Maka Gogia	GHRN
32	Bryn Gay	TAG
33	Navneet Tewatia	FIND - India
34	Raian Ruiz	FIND - Geneva

Annex 3: Composition of Break Out Groups

Group	Members	Speaker
Increase HBV/HCV screening in the community by way of decentralization	Tsira Egutia Giorgi 1 Giorgi 2 Dali Usharidze Nick Zaza Karchkhadze Ia (FIND) Maia (FIND) Natia (FIND)	Dali Usharidze
Integrate HBV vaccination in low-threshold harm reduction settings	Lika Mamatsashvili Ketevan Bidzinashvili Nino Tabukashvili Teona Imerlishvili Tamar Gakhokidze	Nino Tabukashvili Teona Imerlishvili
Public awareness campaigns/ capacity building on hepatitis C	Kote Rukhadze Marina Asatiani Lika Alexander Amirkhanashvili Gogita Metaphlishvili	Kote Rukhadze
Activities aimed at high level, national policy reforms	Manana Sologhashvili Nino Janashia Natia Kharati Maka Gogia	Manana Sologhashvili Nino Janashia

Annex 4: Working Group Results

Group 1: Increase HCV/HBV screening in the community through the way of decentralization

Strategic goals:

1. **Motivating people to understand their status**
   a. Ensure informative, accurate, tailored, encouraging materials to help, increase awareness of hepatitis C
   b. Provide good quality tests and testing infrastructure
   c. Offer screening for sexually transmissible infections (STI) and tuberculosis
   d. Ensure specific work with high-risk groups and young people (aged 17-25)
   e. Increase access to screening and follow-up procedures.
2. **Efficient utilizations of NGO resources to reach hep C elimination goals**
   a. Engage NGOs in state universal screening program
   b. Integrate HBV and HCV prevention approaches with HIV/AIDS, STI and tuberculosis prevention programs
   c. Use a snowball strategy ("bring a friend"to services) to encourage screening
   d. Efficiently use mobile outpatient clinics
   e. Build capacity for NGOs on all things hep C.

Group 2: Integrate HBV vaccination in low-threshold harm reduction settings

Strategic goals:

- Improve access to HBV tests
- Ensure regular, sustainable access to HBV vaccine for programs
- Provide staff training and financial incentives/motivation
- Equip sites with relevant inventory/instruments
- Create informational campaigns
- Ensure equal, universal access to vaccination.

Group 2 Goal	**What to achieve**	**Responsible entity**	**What is needed**	**Implementation period**
Improve awareness of HBV vaccination in the target group	Increasing awareness of the information campaign by engaging the Ministry of Health (MoH), National Center for Disease Control and Public Health, local self-government and community	GeCab activists, professional community representatives	Patients/ schools; Leaflets; Advertising messages, information peer meetings in social network	Continuously for 1 year
Provide low-threshold service centers with HBV	Identification of the target group for vaccination	MoH and National Center for Disease	Written official application	First quarter of the year

identification tests		Control and Public Health		
Provide staff training and financial motivation	Educating the staff about the vaccination	National Center for Disease Control and Public Health and GeCab	Relevant training package: financial, material and human resources	Continuously for 1 year
Ensure regular, sustainable and equal, universal access to HBV vaccines	Supplying low-threshold service centers with HBV vaccines and initiating the vaccination	National Center for Disease Control and Public Health, GeCab and service centers management	Relevant inventory; HBV vaccines; Trained personnel	Continuously for 1 year

Group 3: Public awareness campaigns/capacity building on hepatitis C

Strategic goals:

- Increase awareness of general public by means of media (holding talk-shows).
- Increase awareness by means of social media and social networks.
- Engage famous people in information campaign.
- Convene meetings with the general public and discussions; campaign motto "Vote for your health!"
- Distribute printed materials.
- Create a short informational/enlightening documentary film.
- Create myth-elimination campaigns.
- Use social advertising banners.
- Engage local municipalities.
- Engage sports federations.
- Create corporate/private sector educational campaigns.

Group 3 Activities	**Method and time of implementation**	**Responsible person, team**	**Support**
Media	Talk-shows Social media – social networks Press club Working with producers for shows in November 2019	Marina Asatiani – the given format allows inviting opponents and distributing relevant messages against various opinions	Financial aid - link with producers to work with them
Information campaign	A short documentary with the participation of treated patients. The documentary will tell about the existing myths,	Makho Berdzenishvili Lika Mari, Kote, Vakho Berdzenishvili	Financial aid to engage famous people; technical means/assistance

	how the patients overcame the barriers and histories of success (on 28 June, 2019)		
Public hearings – meetings with people in streets to have live dialogues	Campaign "Vote for your health!" – holding meetings with people with the participation of the municipalities, as well as well-organized meetings with corporate business representatives. From September through November, 2019	Kote Rukhadze, Lexo	Links; communication with press office and PR agencies

One example from India included media trainings for journalists/media representatives to ensure appropriate coverage of hepatitis C. Media representatives always need statistical data and short press-releases; they like receiving very short pieces of information swiftly to make a sensational news. Advocates can provide this information. In order to avoid such misunderstandings and sensational news, guidelines are being developed for the Indian media to help them highlight the information correctly. Also, engaging famous people in such advocacy activities is good for raising visibility and funding.

Group 4: Activities aimed at high level, national policy reforms

Strategic goals:

- Increase financial resources (e.g., co-payments and incentives).
- Improve geographical access to HCV diagnostics and treatment (e.g., one-stop-shop principle, tuberculosis, substitution therapy, primary healthcare, harm reduction).
- Make drug policy reforms and eliminate drug policy as a (legislative, medical and rehabilitation/harm reduction) barrier.
- Improve infection control measures (i.e., avoiding secondary re-infection).
- Ensure regular community feedback with concerned stakeholders (e.g., dialogues, monitoring); permanent dialogue between service providers, beneficiaries and decision-makers, regarding the existing action plan and achievements.

#	**Group 4** **Activities**	**Measurable**	**Achievable**	**Relevant**	**Time-bound**
1	Cancel co-payment for diagnosing	Free diagnosis fee – 0 GEL	Implementation of these interventions by means of the funds saved by the state within the scope of elimination	There is a backlog by considering TAG recommendations of the National Strategy	• The working group will gather in June for further detailing; • The presentation will be given on July 28; • 09.10.2019 – working with decision-makers • 12.09.2019 – presentation of the results achieved/plan developed for the external TAG
	Provide incentives for patients – support the identification of new cases by using Optimized Case Finder (OCF) principle	OCF is integrated within the Global Fund			
2	Provide the following services by using one-stop-shop principle: tuberculosis, substitution therapy, harm reduction	15 Harm reduction sites TB regional OST major cities (Tbilisi, Batumi, Kutaisi, Zugdidi)	Existing infrastructure Existing experience		
3	Make amendments to the law	Parts 273 and 260-1 are abolished These laws/articles are related to Punishment for drug use (any amount)			
	Finance a long-term treatment program	Fund is allotted			
	Finance rehabilitation centers and other housing solutions for people with substance use disorders	A residence-type rehabilitation center is operating			
4	Prevent re-infection	Comprehensive harm reduction services; accurate information and counseling by providers to patients			

5	Ensure regular community engagement with concerned stakeholders: service providers and community, municipalities and state agencies, the relevant Ministries (MoH, MoI)	Meetings once in three months Engagement in high-level meetings Community engagement to monitor HCV care cascade - Need to treat 5 people for every new infection to achieve targets (5:1 ratio as per Andrew Hill's modeling)	Following the need for monitoring, timely identification of the existing gaps		

Annex 5: HCV Advocacy Workshop Learning Evaluation Form

Instructions: Please circle the correct answers.

1. There are _____ types of viral hepatitis.

A. Only one
B. Four
C. Five
D. Six

Answer: D

2. You can catch hepatitis C by:

A. Unsterilized tattoo or piercing equipment.
B. Sharing eating utensils or glasses with someone who has hepatitis C.
C. Sharing unsterilized needles with someone who injects drugs.
D. Receiving blood donation or blood products that have not been screened.
E. Having condomless anal sex without lube with someone who has hepatitis C.

Answer: All, except B.

3. Circle the things that can cause faster liver damage from hepatitis C.

A. Living with HIV.
B. Being co-infected with hepatitis B and C.
C. Drinking excessive amounts of alcohol.
D. Having excess fat in your liver.
E. The amount of time you have had hepatitis C.

Answer: All

4. Which of the following statements is correct?

A. The majority of HCV infected persons will not have a persistent infection.
B. People with acute HCV infection often do not show any symptoms.
C. Once the hepatitis C virus is cleared from the body, the antibodies to HCV usually disappear and will no longer show up positive on a screening test.
D. People who are co-infected with HIV/HCV have a slower progression of liver disease.

Answer: B

5. Circle the false statement about direct-acting antivirals (DAAs).

A. DAAs are oral medications, taken either once or twice a day.
B. DAAs have high cure rates, sometimes reaching over 95% sustained virological response.
C. DAAs can effectively cure people with HCV in 8-12 weeks.
D. DAAs are effective against many or all HCV genotypes.
E. DAAs have many, intolerable side effects.

Answer: E

6. Which one of the following is NOT a hepatitis C treatment that treats all genotypes of the virus?

A. Sofosbuvir and ledipasvir
B. Sofosbuvir and daclatasvir
C. Sofosbuvir and velpatasvir

D. Glecaprevir and pibrentasvir
Answer: A

7. You cannot be retreated for hepatitis C if you have become reinfected.
A. True
B. False
Answer: False

8. People who actively use drugs do not achieve the same cure rates as people who do not use drugs.
A. True
B. False
Answer: False

9. What does a positive HCV antibody test mean? Circle the true statement.
A. A person may have been exposed recently.
B. A person may have chronic hepatitis C.
C. A person may have had hepatitis C in the past, but has cleared the virus.
D. A person needs a viral load confirmation test.
Answer: All

10. Circle all the steps needed to diagnose hepatitis C and start treatment.
A. Antibody screening test
B. Viral load confirmation test
C. Liver biopsy
D. Liver damage assessment
E. Liver function tests
Answer: All, except C