Global Community Hepatitis Policy Report 2014

A civil society response to information submitted by governments for the first World Health Organization hepatitis policy report
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In her foreword to the 2013 Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States, World Health Organization Director-General Margaret Chan wrote that viral hepatitis is “responsible for a widely prevalent and growing disease burden”, adding that “no country, rich or poor, is spared.” In human terms, that translates into 1.5 million people dying every year, the same as from AIDS and significantly more than from tuberculosis or malaria. Yet for many years, with the exception of scaling up hepatitis B vaccination, almost nothing was done at a global level. So much death and misery. So little action. Inexplicable.

So it was patient groups that stepped into this vacuum. We established World Hepatitis Day in 2008. We galvanised governments to adopt the first ever World Health Assembly resolution on viral hepatitis in 2010 and then another, stronger resolution this year. We persuaded WHO to undertake the Global Policy Report and provided financing for it. That report, however, gave only the government view on policy in each country. We wanted also to solicit the views of civil society to give a fuller, more rounded picture of what is happening across the world to prevent new infections and help the 400 million of us living with chronic viral hepatitis. The result is this report.

What is clear is that not enough is happening. Very few countries have comprehensive national hepatitis strategies and there is a scarcity of global resources. In such an environment we are going to have to be smart. We need to emphasise how much of hepatitis prevention – safe blood, safe injections, safe water, safe food, harm reduction, universal childhood vaccination – should be happening anyway because it is part of a well-functioning health system. We need also to develop innovative funding mechanisms and to use existing resources, programmes and infrastructure cleverly.

Most important of all, when we are short of both human and financial resources, we need to work together. The new hepatitis resolution specifically calls on governments to work with civil society and this report shows how infrequently that happens. This is not simply about governments failing to engage. The different elements of civil society, and patient groups in particular, are not nearly numerous or strong enough. This must change. The World Hepatitis Alliance is committed to strengthening civil society but we need the support and encouragement of governments in doing this. If as a world we need to be smart to tackle viral hepatitis effectively, it is imperative that civil society is fully involved and also has the capacity to be fully involved. That is the key message of this ground-breaking report.

Charles Gore
President, World Hepatitis Alliance
Acknowledgements

The World Hepatitis Alliance would like to thank all of the organisations that took the time to respond to our survey. Many of you are working with extremely limited resources and we appreciate that completing the survey adds an extra burden to your daily work. We assure you that the results of your efforts are of global importance.

This report was written by Jeffrey V. Lazarus, Kelly Safreed-Harmon and Ida Sperle from CHIP, the Centre for Health and Infectious Disease Research, a World Health Organization (WHO) Collaborating Centre at Rigshospitalet, University of Copenhagen, Denmark. The authors designed, implemented and analysed the survey in a six-month period in order to have results ready for World Hepatitis Day 2014. The Alliance is pleased to have continued our collaboration with them, and is grateful for their hard work and commitment to hepatitis as an urgent global public health priority.

Charles Gore, the president of the World Hepatitis Alliance, oversaw the entire process of developing this report, and also provided valuable input regarding its structure and content. Hilary Campbell and Dylan O’Sullivan of the Alliance coordinated the production of the report and commented on its content, while Bridie Taylor assisted with the database of respondents. The Alliance Board Members Christopher Malco, Theobald Owusu-Ansah, Ammal Mokhtar, Dalibor Ruzic, Humayun Kabir and Gerardo Obregon were instrumental in reaching out to Alliance members regarding the report.

Raul Bender and his team prepared an interactive online version of the report available at http://global-report.worldhepatitisalliance.org/en/.

Finally, this report is a response to the 2013 Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States published by the World Health Organization. We applaud WHO for raising the profile of hepatitis within the Secretariat and among Member States.
Executive Summary

The global burden of disease from the five major types of viral hepatitis – A, B, C, D and E – urgently demands an intensified response. As the World Health Assembly’s passage of viral hepatitis resolutions WHA 63.18 in 2010 and WHA 67.6 in 2014 reflects, civil society is helping to define a new era in the response to viral hepatitis. However, the World Hepatitis Alliance is concerned about civil society being insufficiently involved at the national level.

The 2014 Global Community Hepatitis Policy Report is a civil society response to information provided by governments for the World Health Organization’s 2013 Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States. The World Hepatitis Alliance asked civil society organisations to review the information their governments submitted for the 2013 WHO report and to comment on its accuracy using a 25-point survey instrument. The survey also asked civil society organisations to write short statements about what they considered to be key aspects of the policy response to viral hepatitis in their countries.

Ninety-five organisations from 58 countries and one special administrative region responded to the World Hepatitis Alliance’s request. Seventy-six organisations were able to comment on their governments’ responses from the 2013 report. The other 18 organisations responded from countries where the government had provided no information for the 2013 report. They instead provided short statements.

Almost 30% of respondents to the civil society survey identified themselves as hepatitis patient groups, and another 16% identified themselves as nongovernmental direct service providers. Forty-two percent of respondents were from countries in the European region, with considerably less representation of countries in other regions. Most respondents were from either high-income countries (41%) or upper-middle-income countries (22%).

The following survey items were most commonly identified as points on which civil society respondents agreed with their governments’ responses:

- the existence of a national strategy or plan for the prevention and control of viral hepatitis;
- the existence of a national hepatitis A vaccination policy;
- injection safety in health care settings; and
- infection control for blood products.

The following survey items were most commonly identified as points on which civil society respondents disagreed with their governments’ responses:

- whether the government has a viral hepatitis prevention and control programme that targets specific populations;
- viral hepatitis surveillance; and
- disease registration and reporting.

The World Hepatitis Alliance is particularly concerned about five key issues raised by civil society survey findings:

- There appears to be considerable disagreement between governments and civil society organisations about how national responses to viral hepatitis are being managed.
- There does not appear to be a sufficient level of partnership between government and civil society actors in many countries, and civil society actors may not have appropriate input into government hepatitis strategies and policies.
Far too few countries have national viral hepatitis strategies, which are the foundation of an effective response. Even where official strategies are in place, the question remains of whether a strategy is actually guiding a unified national response.

The shortcomings of existing viral hepatitis surveillance systems have the potential to undermine efforts to address this group of diseases at the national, regional and global level.

While recent hepatitis C treatment advances are greatly welcomed, there is the danger that excitement about the new drugs will draw attention and funds away from essential viral hepatitis prevention priorities.

Quantitative and qualitative findings from the 2014 Global Community Hepatitis Policy Report lead the World Hepatitis Alliance to make the following recommendations to governments:

- Establish robust monitoring mechanisms to track viral hepatitis activities and key performance indicators nationally. Monitoring outputs should be widely disseminated, and special efforts should be made to share information with civil society stakeholders.
- Engage more directly with civil society, including hepatitis patient groups, and help foster the creation of new hepatitis patient groups where none exist.
- Develop comprehensive multisectoral national viral hepatitis strategies, drawing on WHO and the World Hepatitis Alliance for technical support. Sufficient funding must be allocated to implement those strategies.
- Integrate the implementation of national viral hepatitis strategies with national public health agendas, while at the same time monitoring specific hepatitis-related outcomes.
- Introduce or improve national viral hepatitis surveillance systems.
- Issue evidence-based guidance on hepatitis prevention and establish consensus about which aspects of viral hepatitis prevention should be prioritised based on the national epidemiological context.
- Recognise and seek to overcome barriers that deter members of most-at-risk populations from accessing hepatitis prevention and treatment services and commodities.
- Ensure access to prevention and treatment services for everyone in need without discrimination.

Encouraging diverse actors to participate in new forms of partnership is of paramount importance because the response to viral hepatitis must take into account many different types of public health and development issues. All voices need to be heard if the global community is to make real progress on viral hepatitis, one of the most complex health threats of the twenty-first century.
Introduction: Why We Need a Unified Global Response to Viral Hepatitis

Main Messages

Civil society is helping to define a new era in the global response to viral hepatitis.

The burden of disease from the five major types of viral hepatitis – A, B, C, D and E – urgently demands the world’s attention. The complexity of viral hepatitis virtually ensures that this group of diseases will not be brought under control by science alone. Instead, people with many different kinds of expertise must work from within and outside of the medical and public health establishments to translate technical knowledge into practical solutions.

As the World Health Assembly’s passage of viral hepatitis resolutions WHA 63.18 in 2010 and WHA 67.6 in 2014 reflects, civil society is helping to define a new era in the global response to viral hepatitis. However, the World Hepatitis Alliance is concerned about civil society being insufficiently involved at the national level.

Governments and the international community must improve their efforts.

Efforts at the national and subnational levels must be tailored to address the diverse vaccination, awareness, prevention, screening and treatment needs of people in different settings. International actors can play an important role in this regard by providing government and civil society stakeholders with tools and resources that can be adapted to fit a wide range of epidemiological and social situations.

To support informed decision-making, viral hepatitis monitoring and reporting activities must be greatly expanded and strengthened in many countries. Furthermore, monitoring and reporting need to be systematised globally, with all countries collecting data in accordance with the same indicators of the hepatitis disease burden as well as indicators of progress toward prevention and treatment goals.
In recent decades, civil society actors have made invaluable contributions to the global response to public health issues such as reproductive health, HIV, and cancer. Involvement of such a nature is our only hope for overcoming the immense barriers to viral hepatitis prevention and control.

Within the civil society realm, the special role of hepatitis patient groups needs to be recognised. Patient groups are uniquely qualified to propose and help implement solutions to problems facing viral hepatitis patients and those who are at high risk of infection.

From a pragmatic standpoint, it is smart for governments and other key stakeholders to welcome the involvement and advocacy efforts of hepatitis patient groups and their allies. From a human rights standpoint, giving the members of these groups a voice in the policy discourse recognises their right to participate in decision-making about the health issues that affect them.

The World Hepatitis Alliance seeks to ensure that a unified global response to viral hepatitis is manifested in the comprehensive national strategies that all countries are being encouraged to develop. A solid strategic foundation exists upon which countries can build. The components of this foundation are put forth in the World Health Assembly viral hepatitis resolutions and in the World Health Organization (WHO) viral hepatitis strategic framework.

As these documents reflect, we already know what to do in many regards in order to prevent new infections and to reduce suffering and death from viral hepatitis. The challenge is to apply this knowledge – which in many parts of the world will involve overcoming formidable barriers relating to complacency, ignorance, stigma and resource limitations. In light of these barriers, the World Hepatitis Alliance believes that building a unified global response to hepatitis is fundamentally about building relationships between stakeholders at all levels – globally, nationally and locally.

Governments can address viral hepatitis more effectively with the help of strong civil society partners.

Building a unified global response to hepatitis requires building relationships among diverse stakeholders.

It is hoped that the World Health Organization, through its global headquarters and its regional and country offices, will serve as an important facilitator of relationships between government and civil society representatives. WHO can also contribute to a unified global response to viral hepatitis by issuing much-needed policy and technical guidance.

Encouraging diverse actors to participate in new forms of partnership is of paramount importance because the response to viral hepatitis must take into account many different types of public health and development issues. All voices need to be heard if the global community is to make real progress on viral hepatitis, one of the most complex health threats of the twenty-first century.

How World Hepatitis Day contributes to a unified global response

World Hepatitis Day was launched in 2008 in response to concern about low awareness of viral hepatitis and lack of willingness to make it a political priority on par with other major communicable diseases. From the outset, World Hepatitis Day has generated widespread public and media interest, as well as support from governments, nongovernmental organisations and supranational bodies.

In May 2010 the World Health Assembly passed resolution WHA 63.18 on viral hepatitis. The resolution provides official endorsement of World Hepatitis Day, with 28 July designated as the date for national and international awareness-raising efforts calling attention to various aspects of viral hepatitis. Thousands of World Hepatitis Day events have taken place in dozens of countries over the years, ranging from ministerial meetings to rock concerts. Numerous events spearheaded or co-ordinated by hepatitis patient groups and their partners are designed to address specific national and community-level needs and priorities. While World Hepatitis Day events often have a national and local focus, they collectively contribute to a unified global response by showing policy-makers that communities in different countries and regions are confronting many of the same key issues.

The theme for World Hepatitis Day 2014, “Hepatitis: think again,” guided the development of eight posters featuring ten key messages. The messages were designed to encourage people to consider different aspects of viral hepatitis such as prevention, treatment and stigma. One of the 2014 posters appears above. World Hepatitis Day posters from 2014 and earlier years appear on the page opposite.

The global response to viral hepatitis is entering a new era – but not the one that might be suggested by the flurry of interest in new hepatitis C drugs with much higher cure rates.

Recent treatment advances are indeed remarkable, especially considering that the virus targeted by these drugs was identified less than three decades ago. But there is an enormous difference between pharmaceutical companies creating a product that can cure a disease and afflicted people obtaining the drugs, care and support that they need in order to regain their health.

Excitement about the “medical triumph” of direct-acting antivirals, as a headline in The New England Journal of Medicine proclaimed it, threatens to overshadow health system shortcomings that may prevent many people with chronic hepatitis C from being treated successfully. Factors potentially limiting access to treatment go far beyond the high cost of the new regimens. Furthermore, there is also insufficient awareness around the world about the need to intensify efforts to prevent all types of viral hepatitis and to challenge hepatitis-related stigma and discrimination.

Thus, while the World Hepatitis Alliance enthusiastically welcomes the great progress in relation to hepatitis C, its member organisations are focusing on a much broader array of issues. The question of who will be able to afford the new drugs is looming large in many countries, while elsewhere there is concern that not even the highly imperfect standard-of-care treatment for hepatitis C – pegylated interferon and ribavirin – is sufficiently available.

Meanwhile, hepatitis B – which cannot be cured – poses a greater threat than hepatitis C in some countries, yet receives even less attention. To the limited extent that it has been prioritised, the main focus has been on the three childhood vaccination doses. The critical role of birth dose vaccination in preventing perinatal hepatitis B transmission has been widely overlooked, as has been the importance of treatment regimens that can reduce the risk of hepatitis B-related liver cancer.

The development of direct-acting antiviral agents has revolutionised [hepatitis C] treatment by offering genuine prospects for the first comprehensive cure of a chronic viral infection in humans.

Raymond T. Chung and Thomas F. Baumert, writing in The New England Journal of Medicine

The cost of the interferon and ribavirin treatment regimen is very expensive in Mongolia. ... It is common for people who receive such treatment [for hepatitis C] to incur out-of-pocket costs of more than US$ 20,000. Mongolia is a low-income country [and] nearly 30% of the ... population is living below the poverty line of US$ 2 per day. Because of these brutal realities, odds are really stacked against Mongolians, and it is no surprise that Mongolia has the highest liver cancer mortality rate in the world.

Mongolian respondent to the World Hepatitis Alliance 2014 civil society survey

Introduction continued
Hepatitis A and hepatitis E are known more for causing short-term discomfort than severe disease. Yet they jointly claim 160,000 lives per year, primarily in resource-limited countries, where they can easily spread through contaminated food and water. Furthermore, even mild illness from either of these viruses can impose a financial burden on households because of lost productivity. Considerable suffering would be prevented with ongoing access to safe water and adequate sanitation.

Recognising that this situation is unacceptable, civil society actors are compelled to work in new ways to influence the response to viral hepatitis on a global scale. This is the “new era” that should be celebrated – one defined by something more important than any single biomedical advance. The complexity of viral hepatitis virtually ensures that this group of diseases will not be brought under control by science alone. Instead, people with many different kinds of expertise must work from within and outside of the medical and public health establishments to translate technical knowledge into practical solutions for communities and individuals.

In 2010, the World Health Assembly approved resolution WHA 63.18 calling on the World Health Organization (WHO) and Member States to intensify efforts against viral hepatitis. 2 WHA 63.18 addressed some of the key concerns of hepatitis patient groups that worked through the World Hepatitis Alliance and through their national governments to ensure that the World Health Assembly considered their perspectives. The resolution spurred promising changes at WHO, but few governments acted on the valuable strategic and technical guidance that the agency offered. The World Hepatitis Alliance and other concerned parties consequently re-engaged key Member States. In May 2014, the passage of World Health Assembly resolution 67.6 on viral hepatitis represented an effort to compel governments to make their commitment to addressing viral hepatitis more tangible. 3

The World Hepatitis Alliance welcomes the progress seen in recent years, but it is concerned about civil society thus far being relegated to a fairly small role in the response to viral hepatitis at the national level. The road ahead is simply too difficult for conventional leaders to navigate on their own. A unified response – one involving hepatitis patient groups, other community and civil society stakeholders, medical professionals, researchers, donors and the private sector – is our only hope of bringing about the myriad changes that will be required in order to greatly reduce suffering and death from all types of viral hepatitis.

People with many different kinds of expertise must work from within and outside of the medical and public health establishments to translate technical knowledge into practical solutions for communities and individuals.

The World Hepatitis Alliance seeks to highlight civil society perspectives in this 2014 report – the first of its kind. Civil society stakeholders are relative newcomers to the global public health arena, and their roles are still being defined in many intergovernmental and national forums, including those involving the World Health Organization. To ensure that their voices are heard, the 2014 Global Community Hepatitis Policy Report has been planned as a civil society response to information provided by governments for the 2013 hepatitis policy report published by WHO. That document, the Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States, is a welcome resource, but it only utilises information provided by governments. A full and accurate picture of the policy response to hepatitis at the country level requires additional input from stakeholders with diverse perspectives.

The basis for the 2014 Global Community Hepatitis Policy Report is a survey of World Hepatitis Alliance member organisations (patient groups) and other civil society actors, including nongovernmental organisations, academic institutions and medical associations. Each organisation was asked to review the information that its government submitted for the 2013 WHO report. The survey asked respondents to comment on the accuracy of the published information and furthermore invited them to provide a more in-depth analysis of key national hepatitis policy issues. Organisations based in countries where governments did not submit information for the 2013 WHO report were asked to comment generally on how their countries are addressing hepatitis. The survey was sent to approximately 800 organisations worldwide as well as being distributed online and via social media. Ninety-five responses were received. (See Annex A for details of the study methodology.)

A unified response – one involving hepatitis patient groups and other civil society stakeholders – is our only hope of bringing about the myriad changes that will be required in order to greatly reduce suffering and death from all types of viral hepatitis.
1.1. What is the purpose of this report?

This report is envisioned as a resource and tool for all stakeholders involved in the policy response to hepatitis, including policy-makers, public health administrators, advocates, researchers, donors and intergovernmental agencies. It is intended to facilitate dialogue between civil society actors and other stakeholders at the community, national, regional and global levels. Additionally, the report is intended to support efforts to have viral hepatitis prioritised more by national and global leaders.

The following objectives further guided the development of the report:

- Identifying gaps and shortcomings in national responses to viral hepatitis;
- Promoting government accountability for explicit and implicit commitments expressed in the 2013 global hepatitis policy report; and
- Conveying civil society priorities and patient perspectives to decision-makers and other stakeholders.

This report is organised as follows. The second chapter of the report presents the World Hepatitis Alliance’s views on key findings from the civil society survey and concludes with recommendations based on the findings. The third chapter of the report provides a global overview of all survey findings. Chapters four through nine present findings organised by geographical region. The six regions are Africa, the region of the Americas, the Eastern Mediterranean, Europe, South-East Asia and the Western Pacific. The regional chapters also summarise findings from each individual survey that was submitted. The study methodology is described in Annex A, and the survey instrument can be found in Annex B. Additional global summary data are presented in tables in Annex C. In Annex D, the full text of World Health Assembly resolution 67.6 is provided.

1.2. What is the burden of disease from viral hepatitis?

The five major types of viral hepatitis contribute in very different ways to the overall burden of disease.

Hepatitis A and hepatitis E are known for causing sudden outbreaks as a result of food or water becoming contaminated. The largest outbreaks have infected many thousands of people.4,5

Box 1. Hepatitis A and hepatitis E

- Hepatitis A and hepatitis E outbreaks are most likely to occur in settings where access to safe water and adequate sanitation is limited.
- The World Health Organization estimates that 119 million cases of hepatitis A occur every year, causing 31 million cases of symptomatic illness.9
- There is no treatment for hepatitis A. Although a safe and effective vaccine has been introduced, it is not incorporated into routine immunisation programmes in all countries.
- Hepatitis A most commonly causes relatively mild disease, with gastrointestinal and flu-like symptoms persisting for one to three weeks. It can take several weeks or months for people to recover fully, and thus hepatitis A has a considerable impact on work productivity and earnings.
- Hepatitis A occasionally causes more severe disease, and older people are at higher risk of developing severe disease. Hepatitis A also can cause acute liver failure, which is a life-threatening condition.
- According to Global Burden of Disease estimates, about 103,000 deaths in 2010 were attributable to hepatitis A.10
- Hepatitis E is believed to infect 20 million people each year, with 3.4 million cases resulting in symptomatic illness.11
- Most people with symptomatic hepatitis E experience mild disease, with symptoms such as nausea, vomiting and fever lasting for one to two weeks.
- A small proportion of hepatitis E infections result in acute liver failure and death. Pregnant women and infants are at highest risk of death from hepatitis E.
- According to Global Burden of Disease estimates, hepatitis E caused 57,000 deaths in 2010.12
- A vaccine for hepatitis E was licensed in China in 2012. It is not yet available in other countries, and there is no clear consensus regarding the role of vaccination in hepatitis E prevention worldwide.
Hepatitis B is transmitted through blood and other body fluids. Although the virus is extremely infectious, it only causes chronic disease in some cases, most commonly when acquired in infancy or early childhood. No cure exists for chronic hepatitis B, and disease progression can lead to cirrhosis, liver cancer and death.\(^6\) Some cases of hepatitis B infection are complicated by co-infection with hepatitis D, a distinct virus that only strikes people who already have hepatitis B.\(^7\)

Hepatitis C is spread primarily through infected blood. Unlike hepatitis B, it is curable. People who do not have access to hepatitis C treatment or who do not respond to treatment may experience long-term liver damage leading to the same outcomes that occur with the progression of hepatitis B disease — cirrhosis, liver cancer and death.\(^8\)

Other key points about the five major types of viral hepatitis are presented in Boxes 1–3.

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**Box 2. Hepatitis B and hepatitis D**

- Modes of transmission for hepatitis B include mother-to-child transmission at birth, sexual contact, the transfusion of infected blood products, the use of contaminated needles in health care settings, and the sharing of injection equipment among people who inject drugs.
- A safe and highly effective hepatitis B vaccine became available in 1982. It has been introduced in infant immunisation programmes in more than 180 countries, but coverage is uneven. The World Health Organization estimates that 79% of infants born in 2012 received the recommended three doses of hepatitis B vaccine.\(^13\)
- There is no cure for chronic hepatitis B. Infants and children are much more likely to develop chronic hepatitis B than are people who become infected in adulthood.
- Chronic hepatitis B may be asymptomatic for years or even decades while causing extensive liver damage. Cirrhosis and liver cancer are both serious long-term outcomes.
- According to one published source, up to 40 percent of people who acquire hepatitis B neonatally will eventually develop liver cancer.\(^14\) Chronic hepatitis B is the leading cause of liver cancer, which in turn is the second most common cause of cancer death.\(^15,16\)
- According to the World Health Organization, 240 million people worldwide have chronic hepatitis B.\(^17\) Another source puts this figure at 350 million.\(^18\)
- Global Burden of Disease estimates indicate that hepatitis B caused 786,000 deaths in 2010: 17% from acute infection, 40% from cirrhosis and 43% from liver cancer.\(^19\) Another source concluded that mortality may be somewhat lower, with an estimated 235,000 deaths annually caused by cirrhosis secondary to hepatitis B and 328,000 deaths annually caused by liver cancer secondary to hepatitis B.\(^20\)
- Between 15 and 20 million people may be co-infected with hepatitis B and hepatitis D, but the reliability of these estimates is uncertain.\(^21\)
- Co-infection with hepatitis D appears to put people who have hepatitis B at considerably higher risk of cirrhosis, liver cancer and death.\(^22,23,24\)

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**Box 3. Hepatitis C**

- Hepatitis C disease was known as “non-A, non-B hepatitis” for more than a decade after it was first recognised in the 1970s. The hepatitis C virus was not definitively identified until 1989.
- Hepatitis C is transmitted primarily through exposure to infected blood. In resource-limited countries, exposure frequently occurs in health care settings, e.g. as a result of unsafe injection practices or insufficient screening of blood products. In high-income countries, the use of contaminated injecting equipment by people who inject drugs is a major transmission pathway. Other routes of transmission include tattooing, sexual contact involving blood, and mother-to-child transmission at birth.
- No vaccine exists for hepatitis C, nor is one likely to be developed in the near future.
- In 15 to 45 percent of people who acquire hepatitis C, the virus will be cleared by the body within six months of infection; these people are cured without any treatment.\(^25\)

For everyone else, infection with the hepatitis C virus becomes a chronic condition. People with chronic hepatitis C are at high risk of developing cirrhosis and liver cancer.

- Antiviral treatment can cure chronic hepatitis C, but not everyone is responsive to the treatment regimens that are currently available. The newest regimens are associated with the highest cure rates, but access to these regimens is limited in many countries.
- According to the World Health Organization, between 130 million and 150 million people are chronically infected with hepatitis C.\(^26\)
- Global Burden of Disease estimates indicate that hepatitis C caused 499,000 deaths in 2010: 3% from acute infection, 58% from cirrhosis and 39% from liver cancer.\(^27\) Another source calculated somewhat lower mortality levels, concluding that 366,000 deaths annually are caused by either cirrhosis or liver cancer secondary to hepatitis C.\(^28\)
1.3. How must governments and the international community improve their response?

An essential foundation for an effective global response to viral hepatitis is a national hepatitis strategy in every country — no country can consider itself to not be affected in one way or another by viral hepatitis. The 2013 Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States indicated that fewer than 40% of the 126 governments that submitted information appear to have such a strategy. A follow-up questionnaire by the WHO Global Hepatitis Programme suggested that in fact just 17 have comprehensive strategies.²⁹

It is imperative to remedy this situation as quickly as possible, and the World Health Organization has a vital role to play in helping governments develop comprehensive national strategies. There is also much work to be done to improve the implementation of existing national strategies, as reflected in the observations of some of the civil society organisations contributing to this report. Efforts at the national and subnational level must be tailored to address the diverse vaccination, awareness, prevention, screening and treatment needs of people in different settings. International actors can play an important role in this regard by providing government and civil society stakeholders with tools and resources that can be adapted to fit a wide range of epidemiological and social situations.

Only by measuring progress — or the lack thereof — can governments and the international community make informed decisions about how to allocate limited resources. Monitoring and reporting activities need to be greatly expanded and strengthened in many countries. Furthermore, monitoring and reporting need to be systematised globally, with all countries collecting data in accordance with the same indicators of the hepatitis disease burden as well as indicators of progress toward prevention and treatment goals.

Another key to improving the response to viral hepatitis is to integrate the expertise of civil society organisations into government initiatives. Governments should seek to foster strong government and civil society coalitions that include not only patient groups and activists, but also other civil society actors such as foundations, medical societies, academic institutions, the private sector, and governmental and non-governmental organisations (NGOs) working in the field of hepatitis. It is important to reach out to civil society actors with synergistic interests. Depending on the setting, this might include, for example, antenatal care clinics, advocacy groups working to protect the interests of people who inject drugs, or HIV service providers with large caseloads of patients who are coinfected with HIV and hepatitis.

1.4. Why is civil society involvement so important?

In recent decades, civil society actors have made invaluable contributions to the global response to public health issues such as reproductive health, HIV and cancer. In some ways, they have even helped to shape fundamental public health paradigms. Involvement of such a nature is our only hope for overcoming the immense barriers to viral hepatitis prevention and control. There are at least six major reasons for why governments need strong civil society partners to help them address hepatitis:

1. Members of civil society can raise awareness about viral hepatitis, and in some situations can do so more effectively than government agencies.
2. Members of civil society can offset resource limitations by contributing lay and professional health resources.
3. Members of civil society can draw on first-hand knowledge of community dynamics to share strategic insights about what types of hepatitis interventions are likely to be the most successful.
4. Members of civil society are ideally positioned to monitor and challenge hepatitis-related stigma as it manifests in various health care and community settings.
5. Members of civil society have opportunities to develop trusting relationships with marginalised groups that may not respond to government-driven hepatitis control efforts. These groups include immigrants, indigenous people, prisoners and people who inject drugs.
6. Members of civil society can carry out advocacy among government actors and the general public to win support for measures that government health officials would otherwise be unable to implement successfully.

Within the civil society realm, the special role of hepatitis patient groups needs to be recognised. The World Hepatitis Alliance brings together 181 patient groups based in 69 countries. Time and again, patient groups have demonstrated that they are uniquely qualified to propose and help implement solutions to problems facing viral hepatitis patients and those who are at high risk of infection.

Patient groups often have detailed knowledge of patients’ needs, along with experience providing peer education and other essential services. They are eager to share their expertise by partnering with governments and other stakeholders at the community, provincial and national levels. Patient groups furthermore can serve as a conduit for bringing the insights and priorities of the most affected populations — including marginalised populations — into the dialogue about how governments and international actors should be addressing hepatitis.

From a pragmatic standpoint, it is smart for governments and other key stakeholders to welcome the involvement and advocacy efforts of hepatitis patient groups and their allies. From a human rights standpoint, giving the members of these groups a voice in the policy discourse recognises their right to participate in decision-making about the health issues that affect them, which is a component of the right to health (Box 4).

1.5. What are the next steps in charting the course for a unified global response?

The World Hepatitis Alliance seeks to ensure that a unified global response to viral hepatitis is manifested in the comprehensive national strategies that all countries are being encouraged to develop in a timely manner. A solid strategic foundation exists upon which all countries can build. The components of this foundation are put...
forth in World Health Assembly resolutions WHA 63.18 and WHA 67.6 and in the WHO viral hepatitis strategic framework.\textsuperscript{31, 32, 33} As the resolutions and strategic framework reflect, we already know what to do in many regards in order to prevent new infections and to reduce suffering and death from viral hepatitis. Indeed, the section of resolution WHA 67.6 that is directed at governments itemises 16 key actions that could potentially have an enormous impact on hepatitis prevention and treatment (Box 5). The challenge is to apply this knowledge – which in many parts of the world will involve overcoming formidable barriers relating to complacency, ignorance, stigma and resource limitations.

**Box 4.** United Nations Committee on Economic, Social and Cultural Rights, General Comment 14, the Right to the Highest Attainable Standard of Health

...The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.\textsuperscript{34}

**Box 5.** World Health Assembly resolution WHA 67.6

The following text is excerpted from World Health Assembly resolution WHA 67.6,\textsuperscript{35} the full text of which appears in Annex D.

*This resolution, approved in May 2014, calls on World Health Organization Member States to:*\textsuperscript{36}

1. ... develop and implement coordinated multisectoral national strategies for preventing, diagnosing, and treating viral hepatitis based on the local epidemiological context;
2. ... enhance actions related to health promotion and prevention of viral hepatitis, while stimulating and strengthening immunisation strategies, including for hepatitis A, based on the local epidemiological context;
3. ... promote the involvement of civil society in all aspects of preventing, diagnosing and treating viral hepatitis;
4. ... put in place an adequate surveillance system for viral hepatitis in order to support decision-making on evidence-based policy;
5. ... strengthen the system for collection of blood from low-risk, voluntary, non-remunerated donors, for quality-assured screening of all donated blood to avoid transmission of HIV, hepatitis B, hepatitis C and syphilis, and for good transfusion practices to ensure patient safety;
6. ... strengthen the system for quality-assured screening of all donors of tissues and organs to avoid transmission of HIV, hepatitis B, hepatitis C and syphilis;
7. ... reduce the prevalence of chronic hepatitis B infection as proposed by WHO regional committees, in particular by enhancing efforts to prevent perinatal transmission through the delivery of the birth dose of hepatitis B vaccine;
8. ... strengthen measures for the prevention of hepatitis A and E, in particular the promotion of food and drinking water safety and hygiene;
9. ... strengthen infection control in health care settings through all necessary measures to prevent the reuse of equipment designed only for single use, and cleaning and either high-level disinfection or sterilization, as appropriate, of multi-use equipment;
10. ... include hepatitis B vaccine for infants, where appropriate, in national immunisation programmes, working towards full coverage;
11. ... make special provision in policies for equitable access to prevention, diagnosis and treatment for populations affected by viral hepatitis, particularly indigenous people, migrants and vulnerable groups, where applicable;
12. ... consider, as necessary, national legislative mechanisms for the use of the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights in order to promote access to specific pharmaceutical products;
13. ... consider, whenever necessary, the use of administrative and legal means in order to promote access to preventive, diagnostic and treatment technologies against viral hepatitis;
14. ... implement comprehensive hepatitis prevention, diagnosis and treatment programmes for people who inject drugs, including the nine core interventions,\textsuperscript{37} as appropriate, in line with the WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users,\textsuperscript{38} and in line with the global health sector strategy on HIV/AIDS, 2011–2015, and the United Nations General Assembly resolution 65/277, taking into account the domestic context, legislation and jurisdictional responsibilities;
15. ... aim to transition by 2017 to the exclusive use, where appropriate, of WHO prequalified or equivalent safety-engineered injection devices including reuse-prevention syringes and sharp injury prevention devices for therapeutic injections and develop related national policies;
16. ... review, as appropriate, policies, procedures and practices associated with stigmatization and discrimination, including the denial of employment, training and education, as well as travel restrictions, against people living with and affected by viral hepatitis, or impairing their full enjoyment of the highest attainable standard of health.
Introduction continued

In light of these barriers, the World Hepatitis Alliance believes that building a unified global response to hepatitis is fundamentally about building relationships between stakeholders at all levels – globally, nationally and locally. Some World Hepatitis Alliance member organisations have set notable precedents in this regard by establishing a dialogue with governmental decision-makers in their countries and communities. Some of these organisations are even participating in formal processes to develop hepatitis policies, guidelines and programmes. These efforts need to continue, and in countries where civil society actors are not providing input, political and public health leaders need to do more to foster civil society engagement.

It is hoped that WHO, through its global headquarters and its regional and country offices, will serve as an important facilitator of relationships between government and civil society representatives. WHO can also contribute to a unified global response to viral hepatitis by issuing much-needed policy and technical guidance (Box 6). Just as importantly, WHO should seek greater civil society involvement in the deliberations that shape its viral hepatitis agenda.

Activities such as the March 2014 “global partners meeting” convened by the WHO Global Hepatitis Programme show great promise. More than 100 civil society representatives from around the world participated in this two-day event in Geneva. Meeting attendees identified new opportunities for collaboration between WHO and civil society partners, and the Call to Action to Scale Up Global Hepatitis Response resulting from the meeting articulates a number of civil society priorities in relation to prevention, treatment, advocacy and evidence-informed decision-making.

Finally, an important consideration for all stakeholders responding to viral hepatitis is the composition of “civil society.” It is not enough to welcome and encourage the most visible civil society actors in the hepatitis policy discourse. Who is not being represented? And why?

The World Hepatitis Alliance is especially mindful of these questions in light of findings presented in this very report. The survey that provides the basis for the report was e-mailed to approximately 800 civil society organisations, with at least one organisation approached in virtually every country of the world. (It was also distributed in other ways – see Annex A for information about the methodology.) Yet in spite of extensive outreach to encourage the submission of surveys, the report only contains responses from 95 organisations representing fewer than 60 countries. Forty-one percent of the surveys are from organisations based in the European region. One can only speculate about reasons for the lack of a response to the survey in many countries, but it is not difficult to see how resource limitations might have played a role. Most notably, the World Hepatitis Alliance did not have sufficient funding to conduct the survey in any language other than English. It would be unrealistic to expect many civil society organisations in countries where English is not widely spoken to have the means to report on the governmental response to hepatitis via an English-language survey. Even in low- and middle-income countries where language was not a barrier to responding to the survey, a lack of staff or volunteer capacity may have discouraged engagement among some organisations.

While these observations suggest a possible limitation of the report findings, they are put forth here in order to call attention to a larger concern. Do patient groups and other civil society organisations in countries heavily affected by viral hepatitis have the means to participate in global civil society? For that matter, do they have the means to engage with their own governments? What resources might they need? And what of countries that appear to have only sporadic or no civil society activity relating to viral hepatitis? How can the voices of the people most affected by viral hepatitis be brought into the discourse in these countries?

The World Hepatitis Alliance encourages all readers to be attentive to these questions as they consider the report’s findings and as they continue to work toward key viral hepatitis goals. It is anticipated that some readers will disagree with some of the information provided, just as civil society organisations have indicated in survey responses that they disagree with some of the information provided by governments for the 2013 WHO report. Disagreements are potentially important opportunities for relationship-building. Ideally they will provide an impetus for key actors in the response to hepatitis to critically examine the available evidence, reflect on their assumptions, consider other points of view, and affirm shared goals.

By challenging each other within the context of a respectful dialogue, government and civil society stakeholders have the potential to forge a new type of partnership globally. Establishing a partnership that encourages the full participation of diverse actors is of paramount importance because the response to viral hepatitis must take into account many different types of public health and development issues. Safe water and sanitation, prenatal care, infant immunisation, adherence to universal precautions in health care facilities, the societal response to illegal drug use, health care standards for incarcerated populations, stigma and discrimination, changing immigration and travel patterns, the pricing of pharmaceutical products... these are only some of the issues that come into play. All voices need to be heard if the global community is to make real progress on viral hepatitis, one of the most complex health threats of the twenty-first century.

Box 6. Recent and forthcoming guidance from the World Health Organization

- Guidelines for the Screening, Care and Treatment of Persons with Hepatitis C Infection (2014)
- Guidelines for the Screening, Care and Treatment of Persons with Hepatitis B Infection (forthcoming 2014)
- Screening Guidelines for Hepatitis B and Hepatitis C (forthcoming 2014)
Chapter 1 References

36. Needle and syringe programmes, opioid substitution therapy and other drug dependence treatment; HIV testing and counselling; antiretroviral therapy; prevention and treatment of sexually transmitted infections; condom programmes for people who inject drugs and their sexual partners; targeted information, education and communication for people who inject drugs and their sexual partners; vaccination, diagnosis and treatment of viral hepatitis; prevention, diagnosis and treatment of tuberculosis.
Global Hepatitis Priorities: Five Key Issues Raised by Civil Society Survey Findings

In this chapter, the World Hepatitis Alliance offers insights about how some of the most notable findings from the 2014 survey of civil society stakeholders should inform the global response to viral hepatitis.

For the survey, 76 civil society organisations reviewed a total of 25 items of information reported by their governments for the 2013 World Health Organization (WHO) Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States. Regarding each item, civil society respondents indicated whether they thought the government reporting was accurate or inaccurate. (They could also choose to take no position.) These civil society organisations represented 46 countries. A quantitative analysis of responses to the 25 items provided the basis for part of the findings presented in this report. Other findings are drawn from qualitative data, which were collected from the 76 civil society organisations and from 19 additional civil society organisations in countries where government information was not available. (Details can be found in Chapters 3–9 and in Annex A.)

2.1. Disagreement between governments and civil society organisations

There appears to be considerable disagreement between governments and civil society organisations about some aspects of how national responses to viral hepatitis are being managed.

What does the evidence indicate?
Approximately half of 76 civil society respondents thought that their governments had reported inaccurate information for at least five of 25 survey items, as described in Chapter 3. Some of the most common areas of disagreement included the existence of government hepatitis programmes targeting specific populations; hepatitis surveillance; and disease registration and reporting. For example, 33% of survey respondents indicated that they thought their governments had provided inaccurate information in response to the following 2013 question to governments:
Does your government have a viral hepatitis prevention and control programme that includes activities targeting specific populations? If yes, please indicate which populations.

Why is the World Hepatitis Alliance concerned?
Comments provided by civil society survey respondents suggest more than one possible explanation for why some government information was characterised as inaccurate – but most explanations present cause for concern. At best, it appears that some instances of disagreement might be attributable to civil society respondents recognising improvements that occurred after governments reported to WHO, because the government data were collected between July 2012 and February 2013 while the civil society data were collected approximately one year later. In other cases, one can speculate that inadequate communication between government and civil society stakeholders might have left civil society survey respondents misinformed about government policies and programmes. It is also conceivable that in relation to some reporting topics, government and civil society representatives might characterise the viral hepatitis situation in their country differently because they interpret key concepts differently. Finally, in some cases the explanation could simply be that governments did indeed provide inaccurate information to WHO in 2013.

Regardless of how specific instances of disagreement came about, the quantitative and qualitative findings taken together suggest the overall conclusion that civil society does not appear to be properly engaged with national governments in a number of countries. This effort to assess the level of disagreement only takes into account data from the 46 countries where governments reported to WHO in 2013 and civil society organisations reported to the World Hepatitis Alliance in 2014. In many other countries, it was not possible to analyse civil society perspectives on what governments claim to be doing in response to hepatitis. Thus, the disconnect between government and civil society might actually be much more extensive worldwide.

Disagreement between governments and civil society organisations regarding how viral hepatitis is being handled at the national level seems likely to be a symptom of insufficient civil society engagement, which is the focus of the next section.
2.2. Civil society engagement

Much needs to change in order for civil society stakeholders to become full partners in the response to viral hepatitis in many countries.

What does the evidence indicate?
In 2013, the governments of 60 countries reported to WHO that they collaborated with in-country civil society groups to develop and implement viral hepatitis prevention and control programmes. In ten of those countries, one or more civil society respondents indicated that to their knowledge, the government information was not accurate, as reported in Annex C. In other words, the civil society survey findings raise the question of whether the number of governments collaborating with civil society might be considerably lower.

Why is the World Hepatitis Alliance concerned?
Tremendous improvements are needed at the national and community level in relation to many aspects of viral hepatitis prevention and control. It is difficult to imagine those improvements occurring without strong partnerships between government and civil society in all countries affected by viral hepatitis. As discussed in Chapter 1, civil society has the potential to make unique and valuable contributions. Furthermore, it is the right of civil society participants to have a voice in the decision-making processes that determine government hepatitis strategies, policies and programmes.

The World Hepatitis Alliance therefore is alarmed to see that so few governments appear to collaborate with civil society. Furthermore, even in countries where it is agreed that such collaboration takes place, little is known about whether civil society organisations are satisfied with the outcomes.

What is the way forward?
The World Hepatitis Alliance recommends that governments engage and work with civil society. Given the importance in particular of patient groups and the comparative under-resourcing of those groups that this report has highlighted in part through the low response rates, the Alliance recommends that governments actively seek them out and promote them. Where no patient groups exist, governments and work with the Alliance to foster their creation. Good examples of successful engagement between governments and patient groups can be found in France, where such engagement is a legal requirement, and in Australia, where hepatitis patient groups are supported by the government at both the national and state level.

2.3. The existence of written national strategies for viral hepatitis

Information from civil society organisations reinforces the World Hepatitis Alliance’s concern that many countries lack the necessary strategic foundation for a comprehensive response to viral hepatitis.

What does the evidence indicate?
In 2013, 37% of 126 reporting governments indicated to WHO that their countries had written national strategies or plans that focused exclusively or primarily on the prevention and control of viral hepatitis. The 2014 civil society survey asked respondents whether or not they thought this information was accurate. Sixty civil society respondents (79%) indicated that to their knowledge, the 2013 government information was accurate, as reported in Chapter 3 and Annex C. Therefore, it is possible that even less than 37% of governments have written national strategies or plans for viral hepatitis. When the WHO Global Hepatitis Programme asked about this issue in a questionnaire, responses indicated that there were comprehensive strategies in only 17 countries.

Why is the World Hepatitis Alliance concerned?
In light of the burden of disease from viral hepatitis, it is flatly unacceptable for governments to not have strategies or plans in place to guide national responses. This has been recognised by the World Health Assembly: the very first clause of the viral hepatitis resolution approved by this body in May 2014 urges WHO Member States “to develop and implement coordinated multisectoral national strategies for preventing, diagnosing, and treating viral hepatitis based on the local epidemiological context.”

Calls for national viral hepatitis strategies may be met with resistance in some quarters because of concerns about the drawbacks of vertical disease programming. Such concerns are valid, and it is important to clarify that the creation and implementation of a national viral hepatitis strategy are not envisioned as activities that should take place apart from the rest of the national public health agenda. Indeed, integrating the hepatitis response with other components of the public
health agenda is highly advisable. At the same time, national strategies specifically addressing viral hepatitis are necessary in order to remedy the greatly inadequate response to this group of diseases to date. The existence of national strategies can promote accountability, especially when strong monitoring mechanisms are employed.

The World Hepatitis Alliance urges the global community to recognise that a functional national viral hepatitis strategy is something more than words in a document. Civil society survey responses from Austria and Mongolia are instructive in this regard. In 2013, the governments of both countries reported to WHO that written national viral hepatitis strategies or plans existed in their countries. However, in a civil society survey submission, a representative of the Austrian Society of Gastroenterology and Hepatology commented about the government claim:

This is probably accurate, but it is not widely known. Even I myself as a citizen of Austria working in the field for years have never seen this strategy/plan nor has it ever been communicated openly.

A civil society survey from Mongolia’s Onom Foundation commented regarding the same point:

It all exists on paper but not a lot of actions are happening. Hepatitis B vaccination is the one part being done quite well. Other points do not have enough funding and there are not real orchestrated efforts that we can see.

As these statements reflect, simply drafting a national strategy is far from sufficient. Strategies must incorporate costed implementation plans. Also, progress must be tracked throughout implementation using clearly defined metrics. Progress or the lack thereof must be shared with all concerned stakeholders.

What is the way forward?
The World Hepatitis Alliance recommends that governments make use of technical support from WHO and other bodies, including the Alliance, to begin at once the development of comprehensive multisectoral national viral hepatitis strategies. Funding for a strategy needs to be secured early, and proper accountability and monitoring established. Any strategy needs to make full use of existing resources such as those provided by HIV or cancer programmes and also needs to be integrated into other public health strategies. At the same time, it is imperative that even when viral hepatitis strategies are implemented in a fully integrated manner, outcomes related solely to hepatitis should be monitored in order to gauge progress on national and global viral hepatitis goals and targets.

2.4. Surveillance

Surveillance is an absolutely essential tool for understanding the burden of disease and planning an effective strategic response to all forms of viral hepatitis.

What does the evidence indicate?
In 2013, the governments of 104 countries reported to WHO that they had routine surveillance for viral hepatitis. In 19 of those countries, one or more civil society respondents indicated that to their knowledge, the government information was not accurate, as reported in Chapter 3 and Annex C.

There are also instances of civil society survey respondents agreeing with government reports that routine hepatitis surveillance exists, while adding comments regarding surveillance limitations. For example, the German Liver Foundation noted, “No differentiation between acute and chronic hepatitis C.” Associazione EpaC in Italy wrote, “There is a registry for acute hepatitis, but not all local health district departments adhere to this system.” The Hiroshima University Institute of Biomedical and Health Sciences in Japan reported, “Although we have a national surveillance system for viral hepatitis, the rate of reporting from medical doctors for acute hepatitis cases is insufficient. Government should have a policy for raising awareness among all medical doctors regarding the importance of surveillance.”

Why is the World Hepatitis Alliance concerned?
Without knowing the national disease burden or transmission patterns, it is impossible for governments to make informed decisions about how to allocate resources for hepatitis prevention and treatment. It is also impossible to tailor hepatitis control strategies to the segments of the population that are most at risk. The ramifications of a country having poor viral hepatitis surveillance extend beyond that specific country. The net effect of widespread surveillance shortcomings is the undermining of strategic efforts at the regional and global level.

The viral hepatitis surveillance issues documented in the 2014 civil society survey findings are not surprising.
Regarding hepatitis C, a 2013 review article commented that “despite increasing morbidity and mortality, surveillance is incomplete, out of date and in some countries non-existent.”

World Health Assembly resolution WHA 67.6, approved in May 2014, notes that “most” of the 194 Member States of the World Health Organization “lack adequate surveillance systems for viral hepatitis to enable them to take evidence-based policy decisions.”

In the resolution, one of the 16 measures that Member States are urged to take is putting in place adequate surveillance (Box 5, p13).

**What is the way forward?**

The World Hepatitis Alliance recommends that all countries have functional hepatitis surveillance systems. Countries with systems already in place are advised to introduce enhanced surveillance of the hepatitis B and hepatitis C viruses, such as the European Centre for Disease Prevention and Control began implementing in 2010.

Enhanced hepatitis B and hepatitis C surveillance should include the reporting of acute and chronic cases. Furthermore, standardized case definitions, including a definition for late presentation, are needed. The current dearth of surveillance and the heterogeneity in existing surveillance systems, coupled with varying national case definitions of hepatitis, severely hinders efforts to interpret data.

### 2.5. Viral hepatitis prevention

Qualitative data from a large number of civil society survey respondents call attention to the significance of viral hepatitis prevention activities worldwide and the need to intensify these efforts.

**What does the evidence indicate?**

Multiple aspects of viral hepatitis prevention were highlighted in statements from civil society survey respondents. Some examples:

- The hepatitis B vaccine is available in most hospitals, although the accessibility and availability of this vaccine in the rural areas is poor. Another challenge is the vaccination schedule (0, 1, 6), which makes follow-up difficult for clients. There is a general lack of knowledge about mother-to-child transmission of hepatitis B and its prevention among care providers.
  — Comfort Foundation, Ghana

- There is no government protocol, guideline or standard operating procedure on prevention of hepatitis transmission for any target population. Even health workers with all the risks and job hazards are not protected by any government policy on post-exposure prophylaxis.
  — Chagro-Care Trust and Elohim Foundation, Nigeria

- There are many small blood banks selling blood which has never been screened. Only reputable labs screen blood for both hepatitis B and hepatitis C.
  — The Health Foundation, Pakistan

- The highest-incidence groups for hepatitis C in Germany are drug users and men who have sex with men. But no prevention programmes are established for either. Also, there are no specific hepatitis B programmes for migrants coming from highly endemic countries.
  — Deutsche Leberhilfe e.V., Germany

- Harm reduction programmes must not only be sustained, but urgently scaled up and expanded to provide adequate coverage and a wide range of services including needle and syringe programmes.
  — Union C, Nepal

- The Department of Health has a free hepatitis B vaccine programme for infants (birth to age one). But since the Philippines is an archipelago, bringing vaccine to far-flung provinces poses a challenge. We can see this because of the increase in the prevalence of hepatitis B. We believe strict implementation and monitoring would solve this problem.
  — Yellow Warriors Society, Philippines

**Why is the World Hepatitis Alliance concerned?**

Given the global prevalence of viral hepatitis and the lack of awareness about the nature of the threat, the World Hepatitis Alliance is extremely concerned about the limited scope of most types of hepatitis prevention efforts. Recent excitement about a new hepatitis C treatment with high cure rates should not draw attention away from the imperative to prevent this disease.
Nor should “treatment as prevention” seduce the global community into diverting meagre viral hepatitis prevention resources to the provision of overly expensive hepatitis C drugs.

At the same time, the Alliance cautions against basing policy decisions and resource allocation decisions on an unhelpful “prevention versus treatment” paradigm. Ultimately what matters more than providing access to any specific viral hepatitis prevention or treatment intervention is making systemic improvements that will give public health officials and civil society partners flexibility in how they address viral hepatitis on an ongoing basis. All stakeholders must have access to the necessary data and resources to make informed decisions about how to respond in a coordinated manner to changing disease patterns and how to apply new knowledge strategically.

What is the way forward?
The World Hepatitis Alliance recommends that all governments issue evidence-based guidance on hepatitis prevention and that they share this guidance with all stakeholders. In the absence of national guidance, global guidance from the World Health Organization should be utilised. Depending on a country’s epidemiological context, the following may be considered viral hepatitis prevention priorities:

- Including hepatitis B vaccine in national immunisation programmes, including provision of a birth dose.
- Recommending hepatitis B vaccination to travelers to regions with high hepatitis B prevalence.
- Promoting and enabling safe injection practices in health care settings.
- Conducting campaigns to reduce the number of unnecessary injections.
- Improving the safety of blood and blood products.
- Implementing harm reduction interventions for people who inject drugs.

Efforts also must recognise the barriers that deter members of most-at-risk populations from accessing prevention and treatment services and commodities, and must include provisions for overcoming the barriers. This could mean, for example, educating people in rural communities about the importance of vaccination, or ensuring equitable access to treatment for people who inject drugs.

2.6. Recommendations

The World Hepatitis Alliance urges all stakeholders in the response to viral hepatitis to take note of the findings from its 2014 survey of civil society stakeholders. The Alliance makes the following recommendations based on its analysis of survey findings and other evidence:

- Establish robust monitoring mechanisms to track viral hepatitis activities and key performance indicators nationally. Monitoring outputs should be widely disseminated, and special efforts should be made to share information with civil society stakeholders.
- Introduce or improve national viral hepatitis surveillance systems.
- Engage more directly with civil society, including hepatitis patient groups. Help foster the creation of new hepatitis groups, including patient groups and other groups, where none exist.
- Develop comprehensive multisectoral national viral hepatitis strategies, drawing on WHO, the World Hepatitis Alliance and others for technical support. Sufficient funding must be allocated to implement the strategies.
- Integrate the implementation of national viral hepatitis strategies with national public health agendas, while at the same time monitoring specific hepatitis-related outcomes.
- Issue evidence-based guidance on hepatitis prevention and share this guidance with all stakeholders.
- Establish consensus about which aspects of viral hepatitis prevention should be prioritised based on the national epidemiological context.
- Recognise and seek to overcome barriers that deter members of most-at-risk populations from accessing hepatitis prevention and treatment services and commodities.
- Ensure access to hepatitis prevention and treatment for everyone in need without discrimination.
Chapter 2 References


This chapter presents global findings from the World Hepatitis Alliance’s 2014 civil society survey in two sections.

The first section provides an overview of respondents. The second section describes the extent to which respondents agreed or disagreed with what their governments reported about hepatitis policies and programmes for the 2013 World Health Organization (WHO) *Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States*. It also notes the issues associated with the greatest amount of agreement and disagreement.

Civil society survey respondents based in countries where governments did not submit information for the 2013 WHO global policy report did not have any information to review and hence did not complete this component of the survey. They only completed a survey component in which respondents were invited to write brief statements discussing the policy response to viral hepatitis in their countries. Excerpts from these statements are presented in the first part of the Africa, Europe and Western Pacific chapters of this report to highlight key areas of concern. The full text of all respondents’ statements can be found in the individual respondent entries in the second part of all regional chapters.

### 3.1. Respondents

Ninety-five organisations from 58 countries and one special administrative region responded to the World Hepatitis Alliance’s 2014 civil society survey. The governments of 46 countries provided information for the 2013 WHO global policy report, and thus the 76 respondents based in those countries were able to comment on the accuracy of their governments’ responses. The governments of 12 countries did not provide information for the 2013 report. The 18 respondents based in those countries instead commented on their governments’ responses to viral hepatitis by writing short statements about key issues. One additional respondent provided a short statement about how viral hepatitis is being addressed by the Special Administrative Region of Hong Kong, which was not invited to submit information for the WHO global policy report because it is part of China. Information about respondents is presented in Table 3.1.

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1 For the purposes of this report, Taiwan (Chinese Taipei) is referred to as a “country.” The World Hepatitis Alliance takes no position regarding the legal status of Taiwan (Chinese Taipei) as a sovereign state.

2 Eleven of the 12 countries did not submit information for the 2013 WHO global policy report. One other country, Taiwan (Chinese Taipei), was not invited to submit information because it is not a WHO Member State.
Table 3.1. Respondents to the World Hepatitis Alliance’s 2014 civil society survey (N=95)

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<th>Country</th>
<th>Civil society survey respondents (#)</th>
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<td>NGO – hepatitis patient group</td>
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<tr>
<td>Italy</td>
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<tr>
<td>Latvia</td>
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<tr>
<td>Netherlands</td>
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<tr>
<td>Norway</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
### Global Findings continued

<table>
<thead>
<tr>
<th>Country</th>
<th>Type of respondent (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Civil-society survey respondents (#)</td>
</tr>
<tr>
<td>European region (continued)</td>
<td></td>
</tr>
<tr>
<td>Poland</td>
<td>2</td>
</tr>
<tr>
<td>Portugal</td>
<td>1</td>
</tr>
<tr>
<td>Romania</td>
<td>1</td>
</tr>
<tr>
<td>Russian Federation</td>
<td>1</td>
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<tr>
<td>Serbia</td>
<td>1</td>
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<tr>
<td>Spain</td>
<td>1</td>
</tr>
<tr>
<td>Switzerland</td>
<td>1</td>
</tr>
<tr>
<td>The former Yugoslav Republic of Macedonia</td>
<td>2</td>
</tr>
<tr>
<td>Ukraine</td>
<td>3</td>
</tr>
<tr>
<td>United Kingdom of Great Britain and Northern Ireland</td>
<td>3</td>
</tr>
<tr>
<td>South-East Asia region</td>
<td></td>
</tr>
<tr>
<td>Bangladesh</td>
<td>2</td>
</tr>
<tr>
<td>India</td>
<td>2</td>
</tr>
<tr>
<td>Indonesia</td>
<td>1</td>
</tr>
<tr>
<td>Myanmar</td>
<td>1</td>
</tr>
<tr>
<td>Nepal</td>
<td>1</td>
</tr>
<tr>
<td>Thailand</td>
<td>2</td>
</tr>
<tr>
<td>Western Pacific region</td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>1</td>
</tr>
<tr>
<td>China*</td>
<td>4</td>
</tr>
<tr>
<td>Japan</td>
<td>3</td>
</tr>
<tr>
<td>Mongolia</td>
<td>1</td>
</tr>
<tr>
<td>New Zealand</td>
<td>1</td>
</tr>
<tr>
<td>Philippines</td>
<td>1</td>
</tr>
<tr>
<td>Taiwan (Chinese Taipei)</td>
<td>1</td>
</tr>
</tbody>
</table>

*One of the four civil society respondents from China was Asiahep Hong Kong Limited, which assessed the hepatitis response of the Special Administrative Region of Hong Kong rather than the hepatitis response of the Chinese government.*
Almost 30% of respondents to the civil society survey identified themselves as hepatitis patient groups, and another 16% identified themselves as nongovernmental direct service providers (Figure 3.1). Eleven percent identified themselves as medical societies.

Sixty-three percent of respondents were either voting or non-voting members of the World Hepatitis Alliance at the time they submitted their surveys (data not shown).

Response levels by region are presented in Table 3.2, along with response levels by income group.

3.2. Highlights relating to civil society agreement or disagreement with what governments reported

The civil society survey contained 25 items based on the information that governments provided for the 2013 WHO global policy report. For each item, civil society stakeholders were asked to consider the government response to one or more questions about national hepatitis policies and programmes, and to select one of the following three statements: To our knowledge, this information is accurate; To our knowledge, this information is not accurate; or We take no position regarding this statement.

Detailed findings for all civil society survey items are presented in Annex C. In sum, approximately half of all civil society respondents thought that the information from their governments was accurate for 18 or more of the 25 items. Regarding the proportions of respondents who marked items as “not accurate,” approximately half thought that the information from their governments was not accurate for five or more items.
Global Findings continued

The following survey items were most commonly identified as points on which civil society respondents agreed with their governments’ responses: item 1.1, regarding the existence of a national strategy or plan for the prevention and control of viral hepatitis; item 4.1, regarding the existence of a national hepatitis A vaccination policy; item 4.6, regarding injection safety in health care settings; and item 4.8, regarding infection control for blood products. Further details are presented in Table 3.3.

The following survey items were most commonly identified as points on which civil society respondents disagreed with their governments’ responses: item 1.3, regarding whether the government has a viral hepatitis prevention and control programme that includes activities targeting specific populations; item 3.1, regarding viral hepatitis surveillance; and item 3.3, regarding disease registration and reporting. Further details are presented in Table 3.4.

### Table 3.3. Survey items eliciting the highest levels of agreement from civil society respondents (N=76)

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Question(s) addressed by governments for 2013 WHO global policy report</th>
<th># (%) of respondents who indicated agreement with their governments’ response(s) by selecting “to our knowledge, this information is accurate”</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>In your country, is there a written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis? If yes, is it exclusive for viral hepatitis or does it also address other diseases? Please indicate components of the strategy or plan.</td>
<td>60 (78.9%)</td>
</tr>
<tr>
<td>4.1</td>
<td>Is there a national hepatitis A vaccination policy? If yes, what groups does the policy address?</td>
<td>59 (77.6%)</td>
</tr>
<tr>
<td>4.6</td>
<td>Is there a national policy on injection safety in health care settings? If yes, what type of syringes does the policy recommend for therapeutic injections? Are single-use or auto-disable syringes, needles and cannulas always available in all health care facilities?</td>
<td>59 (77.6%)</td>
</tr>
<tr>
<td>4.8</td>
<td>Is there a national infection control policy for blood banks? Are all donated blood units (including family donations) and blood products nationwide screened for hepatitis B? Are all donated blood units (including family donations) and blood products nationwide screened for hepatitis C?</td>
<td>64 (84.2%)</td>
</tr>
</tbody>
</table>

### Table 3.4. Survey items eliciting the highest levels of disagreement from civil society respondents (N=76)

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Question(s) addressed by governments for 2013 WHO global policy report</th>
<th># (%) of respondents who indicated disagreement with their governments’ response(s) by selecting “to our knowledge, this information is not accurate”</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3</td>
<td>Does your government have a viral hepatitis prevention and control programme that includes activities targeting specific populations? If yes, please indicate which populations.</td>
<td>25 (32.9%)</td>
</tr>
<tr>
<td>3.1</td>
<td>Is there routine surveillance for viral hepatitis? If yes, is there a national surveillance system for the following types of acute hepatitis? A, B, C Is there a national surveillance system for the following types of chronic hepatitis? B, C</td>
<td>22 (28.9%)</td>
</tr>
<tr>
<td>3.3</td>
<td>Are liver cancer cases registered nationally? Are cases of HIV/hepatitis co-infection registered nationally? How often are hepatitis disease reports published?</td>
<td>25 (32.9%)</td>
</tr>
</tbody>
</table>
African Region
This chapter presents African region findings from the World Hepatitis Alliance’s 2014 civil society survey in three sections. The first section provides an overview of respondents. The second section describes the extent to which respondents agreed or disagreed with what their governments reported about hepatitis policies and programmes for the 2013 World Health Organization (WHO) Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States. It also notes the issues associated with the greatest amount of agreement and disagreement. The third section highlights some of the qualitative findings from respondents based in countries where governments did not submit information for the 2013 WHO global policy report.

Table 4.1. African region respondents to the World Hepatitis Alliance’s 2014 civil society survey (N=18)

<table>
<thead>
<tr>
<th>Country</th>
<th>Civil society respondents (#)</th>
<th>NGO – hepatitis patient group (#)</th>
<th>NGO – direct service provider (#)</th>
<th>NGO – other (#)</th>
<th>Medical society</th>
<th>Private foundation</th>
<th>Other</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameroon</td>
<td>1</td>
<td></td>
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<tr>
<td>Democratic Republic of the Congo</td>
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<tr>
<td>Gambia</td>
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<tr>
<td>Ghana</td>
<td>3</td>
<td>1</td>
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<td></td>
<td></td>
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<tr>
<td>Mali</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mauritius</td>
<td>1</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Nigeria</td>
<td>5</td>
<td>3</td>
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<td></td>
<td></td>
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<tr>
<td>Togo</td>
<td>1</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uganda</td>
<td>4</td>
<td>2</td>
<td></td>
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</tr>
</tbody>
</table>
4.1. Respondents

Eighteen organisations from nine countries in the African region responded to the World Hepatitis Alliance’s 2014 civil society survey. The governments of three of those countries provided information for the 2013 WHO global policy report, and thus the seven respondents based in those countries were able to comment on the accuracy of their governments’ responses. The governments of the other six countries did not provide information for the 2013 report; the eleven respondents based in those countries instead commented on their governments’ responses to viral hepatitis by writing short statements about key issues. Additional information about respondents is presented in Table 4.1 on previous page.

Almost 40% of respondents identified themselves as hepatitis patient groups, and another 28% identified themselves as nongovernmental direct service providers (Figure 4.1).

Eighty-nine percent of respondents were either voting or non-voting members of the World Hepatitis Alliance at the time they submitted their surveys [data not shown].

Half of respondents were based in lower-middle-income countries, and almost half were based in low-income countries. One respondent was based in an upper-middle-income country (Figure 4.2).

Table 4.2. Survey items eliciting the highest levels of agreement from civil society respondents, African region (N=7)

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Question(s) addressed by governments for 2013 WHO global policy report</th>
<th># (%) of respondents who indicated agreement with their governments’ response(s) by selecting “to our knowledge, this information is accurate”</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2</td>
<td>Is there a designated governmental unit/department responsible only for coordinating and/or carrying out viral hepatitis-related activities? If yes, what is its name? How many people work full-time (or how many full-time equivalent staff) on hepatitis-related activities in all government agencies/bodies?</td>
<td>7 (100%)</td>
</tr>
<tr>
<td>4.1</td>
<td>Is there a national hepatitis A vaccination policy? If yes, what groups does the policy address?</td>
<td>7 (100%)</td>
</tr>
</tbody>
</table>

4.2. Highlights relating to civil society agreement or disagreement with what governments reported

The civil society survey contained 25 items based on the information that governments provided for the 2013 WHO global policy report. For each item, civil society stakeholders were asked to consider the government response to one or more questions about national hepatitis policies and programmes, and to select one of the following three statements: To our knowledge, this information is accurate; To our knowledge, this information is not accurate; or We take no position regarding this statement.

Detailed findings for all civil society survey items are presented in Annex C. In sum, almost half of all civil society respondents thought that the information from their governments was accurate for 20 or more of the 25 items. Regarding the proportions of respondents who marked items as “not accurate,” more than half thought that the information from their governments was not accurate for at least four items.

The following survey items were most commonly identified as points on which civil society respondents in the African region agreed with their governments’ responses: item 1.2, regarding the existence of a designated governmental unit/department responsible for viral hepatitis-related activities and the number of government staff working on hepatitis-related activities, and item 4.1, regarding the existence of a national hepatitis A vaccination policy. Further details are presented in Table 4.2.

The following survey items were most commonly identified as points on which civil society respondents in the African region disagreed with their governments’ responses: item 1.3, regarding whether the government has a viral hepatitis prevention and control programme that includes activities targeting specific populations; item 3.2, regarding hepatitis case definitions and the reporting of deaths; item 3.3, regarding disease registration and reporting; and item 3.4, regarding the reporting and investigation of hepatitis outbreaks. Further details are presented in Table 4.3.

Table 4.3. Survey items eliciting the highest levels of disagreement from civil society respondents, African region (N=7)

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Question(s) addressed by governments for 2013 WHO global policy report</th>
<th># (%) of respondents who indicated disagreement with their governments’ response(s) by selecting “to our knowledge, this information is not accurate”</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3</td>
<td>Does your government have a viral hepatitis prevention and control programme that includes activities targeting specific populations? If yes, please indicate which populations.</td>
<td>5 (71.4%)</td>
</tr>
<tr>
<td>3.2</td>
<td>Are there standard case definitions for hepatitis infections? Are deaths, including from hepatitis, reported to a central registry? What percentage of hepatitis cases are reported as “undifferentiated” or “unclassified” hepatitis?</td>
<td>3 (42.9%)</td>
</tr>
<tr>
<td>3.3</td>
<td>Are liver cancer cases registered nationally? Are cases of HIV/hepatitis co-infection registered nationally? How often are hepatitis disease reports published?</td>
<td>4 (57.1%)</td>
</tr>
<tr>
<td>3.4</td>
<td>Are hepatitis outbreaks required to be reported to the government? If yes, are they further investigated? Is there adequate laboratory capacity nationally to support viral hepatitis outbreak investigations and other surveillance activities?</td>
<td>3 (42.9%)</td>
</tr>
</tbody>
</table>
4.3. Qualitative findings from countries where government information is lacking

Civil society survey respondents based in countries where governments did not submit information for the 2013 WHO global policy report did not have any information to review and hence did not complete the component of the survey discussed in the preceding section. They only completed a survey component in which respondents were invited to write brief statements discussing the policy response to viral hepatitis in their countries. Respondents were encouraged to focus on one or more of five topics: national coordination, awareness-raising, partnerships and resource mobilisation, evidence-based policy and data for action; prevention of transmission; and screening, care and treatment.

The purpose of this section is to present some excerpts that are generally reflective of the concerns of respondents in the African region. The following data represent only the views of the 11 civil society survey respondents that did not have government information to review (four from Uganda, three from Ghana, and one each from the Democratic Republic of the Congo, the Gambia, Ghana and Mauritius). The full text of all respondents’ statements can be found later in this chapter.

Theobald Hepatitis B Foundation in Ghana and Action for Rural Transformation in Uganda both wrote about the need for better efforts to raise awareness about viral hepatitis.

According to Theobald Hepatitis B Foundation, about one-third of Ghanaians living with viral hepatitis are unaware of their status. The organisation stated:

> Culturally and linguistically appropriate educational messages and materials are required to make appropriate hepatitis B information available to Ghana’s diverse population. Because people access information in different ways, information must be available in a variety of formats.

Action for Rural Transformation expressed the following concern about the situation in Uganda:

> The people who commonly serve as resources for raising awareness about issues in communities – health workers, politicians, and cultural and religious leaders – themselves have very little factual information on viral hepatitis. National booklets developed for health education have not been translated into local languages for information dissemination.

Survey respondents from Ghana and Uganda presented a complex picture regarding how much progress is being made on hepatitis B vaccination in those countries. According to Long Life Africa in Ghana, that country’s Ministry of Health introduced a policy incorporating hepatitis B vaccination into the childhood immunization programme in 2002. Long Life Africa characterized this as “a step in the right direction, but woefully inadequate.” The organisation explained:

> Only children born after 2002 are protected against the disease, while the vast majority of the youth who are the future leaders of this nation are left to die.

According to Comfort Foundation Ghana, hepatitis B screening and vaccination outside of the childhood immunisation programme is generally not covered by health insurance. The organisation wrote:

> Screening is only covered and prescribed at hospitals for patients suspected to be reactive to hepatitis B or hepatitis C. Hepatitis B immunoglobulin G and hepatitis B monovalent vaccine for babies born to hepatitis B-reactive mothers are also not covered.

Both Long Life Africa and Comfort Foundation Ghana also noted that the hepatitis B vaccine is not sufficiently available in rural health care settings. Long Life Africa suggested that this problem may contribute to high hepatitis B prevalence rates in rural parts of Ghana.

According to Uganda’s National Organization for People Living with Hepatitis B, “The Ugandan government introduced HBsAg vaccine in the extended programme of immunisation for infants in 2002. However, this programme does not cover the vaccination of adults and at-risk population. Mothers are also still reluctant to take their babies for immunisation.”

Respondents from several countries called attention to the role and needs of the health workforce in relation to viral hepatitis. Encadrement des Personnes Infectedes par l’Hépatite noted that the Democratic Republic of the Congo does not have nearly enough hepatology specialists. Hep Support in Mauritius wrote:

> Doctors are not well informed about viral hepatitis and its management. ... We cannot refer to people diagnosed with viral hepatitis as “patients” – they are just told they are positive and left to themselves.

Association Sauvons l’Afrique Des Hépatites of Togo noted the absence of national clinical guidelines for the management of viral hepatitis and suggested that health professionals do not have sufficient competence in this area of health care.

Hope Life International in the Gambia called on that country’s government to enlist the Ministry of Health and the World Health Organization to organise training workshops for health workers who staff hepatitis programmes.

From Uganda, Action for Rural Transformation wrote:

> Health facilities and health staff have not been adequately prepared for case management. A comprehensive policy for management of hepatitis B virus has yet to be approved.

At the same time, this organisation observed that there has been some progress in protecting health workers from hepatitis B, with the Ugandan Ministry of Health procuring hepatitis B vaccine for health workers as well as encouraging health workers to use universal precautions. The Ministry of Health was reported to also be backing efforts to phase out the re-use of syringes and introduce auto-disabling syringes at all levels of care in public and private health facilities.

On a related note, another Ugandan organisation went into some detail about the progress it has observed in that country. Giving Hope Foundation wrote:

> The biggest challenge for civil society organizations involved in hepatitis is that there has been little involvement from the Ministry of Health (MoH), and we have found it hard to carry out some national activities that require MoH endorsement. The MoH has cited lack of personnel and resources for its lack of interest. But because of continued outreach and advocacy, there has been growing interest and involvement from the MoH since late 2013. ... In 2014, we have seen increased interest around viral hepatitis in Uganda. The President of Uganda, during the National Resistance Movement Day on 26 January, made special mention of the need to raise awareness regarding this preventable illness. The MoH together with other stakeholders is planning to hold a series of events across the country to commemorate World Hepatitis Day 2014. ... With continued advocacy, 2014 is promising to be a breakthrough year with regard to hepatitis in Uganda.
SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Cameroon reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 68.0% of items.

Survey points marked “accurate”: 1.1, 1.2, 1.3, 2.1, 3.1, 3.2, 3.3, 3.5, 4.1, 4.2, 4.3, 4.6, 4.7, 4.8, 4.9, 5.1, 5.3 and 5.4.

The government information was thought to not be accurate for 32.0% of items.

Survey points marked “not accurate”: 1.3, 2.2, 3.4, 4.4, 4.5, 4.10, 5.2 and 5.5.

Survey comments from Positive-Generation:

Information reported by government (2012–2013)

5.5. No drug for treating hepatitis B is on the national essential medicines list or subsidised by the government. The following drugs for treating hepatitis C are on the national essential medicines list or subsidised by the government: pegylated interferon and lamivudine.

Lamivudine is used in the national HIV protocol.

Civil society respondent comments (2014)

Statement from Positive-Generation regarding key hepatitis policy issues in Cameroon:

The main problems related to testing, care and treatment of viral hepatitis nationally are:

- Screening. The vaccine remains expensive (7000 CFA Francs each dose per week) given the very low standard of living of the population. No one has access or the disease is discovered already in an advanced state.

- Care. This is also very expensive and is only 30% funded by the government. Most patients prefer to be cared for traditionally because it is also considered a mystical disease by those who are not diagnosed in the hospital.

- Treatment. It is long, arduous and expensive, so patients need patience for both themselves and their friends and family members. The major problem with treatment is ignorance on the part of the patient about the illness. Very often the patient abandons the treatment due to a lack of financial means.

* World Hepatitis Alliance member.
Democratic Republic of the Congo

Encadrement des Personnes Infectées par l’Hépatite (EPIH)*

NGO – hepatitis patient group
Goma, Democratic Republic of the Congo

SURVEY HIGHLIGHTS


The organisation provided the following general statement regarding key hepatitis policy issues in the Democratic Republic of the Congo:

What are the greatest problems with the national response to viral hepatitis?

- Lack of mechanisms for enhancing hepatitis B and hepatitis C screening.
- Lack of appropriate sanitation screening for hepatitis.
- Very insufficient number of hepatology specialists.
- No access to medicines.
- Officials should give the population necessary information about the dangers of hepatitis.

What needs to change?

- The whole health care system must be reformed.

What should be the government’s role in bringing about these changes? What responsibilities should the government have?

- The government should establish a national hepatitis programme that promotes the following:
  - Strengthen screening and early treatment to stop transmission.
  - Information on the prevention of hepatitis to assist in the adoption of responsible behaviour.
  - Early treatment, support and assist people.
  - Destigmatization and the fight against discrimination in order to promote the implementation of prevention combined with screening and treatment for other diseases.
  - Train professionals in different cross-cultural approaches to counselling.
  - Improve the link between awareness, prevention, screening and care.

What should be the roles and responsibilities of other stakeholders at the community, national and international levels?

- At their respective levels, other stakeholders must respect and enforce treaties and resolutions. They should sensitise decision-makers such as government officials, representatives of foundations, and benefactors. Stakeholders must make funds available to fight this disease. They must also fight against discrimination in speeches and through the distribution of funds allocated to four priority public health diseases: malaria, tuberculosis, HIV and hepatitis.

What evidence exists to support your organisation’s viewpoint?

- World newspapers.
- Reports on campaigns in schools, the university, churches and markets.
- The interventions of national and international radio and television stations (RFI, TRNC, Okapi, Kivu ONE).

The organisation provided the following general statement regarding key hepatitis policy issues in the Gambia:

**Awareness-raising, partnerships and resource mobilisation.** Some of the greatest problems with this component of the national response to viral hepatitis are as follows:

- The government does not prioritise fighting viral hepatitis like it does HIV/AIDS despite the increasing hepatitis infection rate.
- The government does not designate any department or unit to carry out viral hepatitis-related activities, such as prevention and control.
- There are few health care institutions/NGOs that are carrying out viral hepatitis activities in the country.
- The government does not have a viral hepatitis prevention and control programme that includes activities targeting health-care workers.

**What needs to change?**

- The government needs to provide a conductive atmosphere to healthcare institutions and NGOs that are carrying out viral hepatitis activities in the country.
- The government needs to realise the magnitude of the problem that viral hepatitis poses for communities and needs to encourage and support health care institutions and NGOs to fight it.
- The government needs to designate a department or unit responsible solely for carrying out viral hepatitis activities.
- The government needs to employ and train new staff to handle viral hepatitis activities.
- Adequate information needs to be provided on the viral hepatitis prevention and control programme.
- The government needs to be more committed in fighting hepatitis.

**What should be the government’s role in bringing about these changes? What responsibilities should the government have?**

- National governments should recognize viral hepatitis as an urgent public health issue and prioritise hepatitis. Governments should collect complete and accurate data on the screening of donated blood and institute or strengthen blood screening programmes in the country.
- The government has not established the goal of eliminating hepatitis B.
- The government should provide full support to health care institutions and NGOs working on viral hepatitis activities in terms of funding, technical support and moral support.
- The government should provide a link between health care institution/NGOs and World Health Organization (WHO) country representative programmes on hepatitis activities.
- The government through the Ministry of Health and WHO should organise training workshops for health care workers who work in hepatitis programmes.
- The government should designate a department or unit to work and gather information on liver cancer cases registered nationally as well as publish hepatitis disease reports monthly.
- The government should employ and train new staff to handle viral hepatitis activities.
- The government should have a national policy for hepatitis vaccination.
- Implement programmes to reduce viral hepatitis infections in the communities.
- Develop, expand, and support outreach services for clients with a higher risk of acquiring viral hepatitis.
- Support the government’s efforts to reduce stigma and discrimination against viral hepatitis in the community.
- Fund treatment and care for people living with viral hepatitis in the community.
- Liaise with WHO to provide technical support to ensure that national governments are able to conduct effective surveillance and publish national incidence and prevalence statistics.
- Implement awareness-raising programmes to reduce stigma and prevent infection.
- Cooperate and partners with member and suppliers to ensure the affordable supply of auto-disable syringes and a timeline for their mandatory use in all national healthcare systems.

The evidence exists to support our organisation based on information gathered from other colleagues working in the Ministry, hospitals and from our daily activities. The Gambian government has really done well in the provision of health facilities but more needs to be done.
The organisation provided the following general statement regarding key hepatitis policy issues in Ghana:

**Prevention of transmission**

**Current situation:**

Ghana has a National Health Insurance Scheme (NHIS). Hepatitis B vaccination of babies is part of the Expanded Programme of Immunization. Babies from 6 weeks onwards receive the pentavalent vaccine (diphtheria, polio, tetanus, hepatitis B, influenza type B).

The coverage of this programme is good in all regions of the country.

Unfortunately, hepatitis B screening and vaccination outside this programme is not covered by the health insurance. Screenings are only covered and prescribed at hospitals for patients suspected to be reactive to hepatitis B and/or C. Hepatitis B immunoglobulin G and hepatitis B monovalent vaccine for babies born to hepatitis B reactive mothers are also not covered by NHIS.

The hepatitis B vaccine is available in most hospitals, although the accessibility and availability of this vaccine in the rural areas is poor. Another challenge is the vaccination schedule (0,1,6), which makes follow-up difficult for clients. There is a general lack of knowledge about mother-to-child transmission of hepatitis B and its prevention among care providers. There is a lack of knowledge about mother-to-child transmission of hepatitis B and its prevention among care providers (administration of immunoglobulin and monovalent vaccine immediately after birth).

Unfortunately, hepatitis B screening and vaccination outside this programme is not covered by the health insurance. Screenings are only covered and prescribed at hospitals for patients suspected to be reactive to hepatitis B and/or C. Hepatitis B immunoglobulin G and hepatitis B monovalent vaccine for babies born to hepatitis B reactive mothers are also not covered by NHIS.

The hepatitis B vaccine is available in most hospitals, although the accessibility and availability of this vaccine in the rural areas is poor. Another challenge is the vaccination schedule (0,1,6), which makes follow-up difficult for clients. There is a general lack of knowledge about mother-to-child transmission of hepatitis B and its prevention among care providers (administration of immunoglobulin and monovalent vaccine immediately after birth).

There are a lot of misconceptions about hepatitis B among the public. Unfortunately, civil society organisations (CSOs) and other health professionals often give varied information about the causes and transmission of viral hepatitis, thus causing fear and panic among patients and the public, leading to stigmatization.

Little work is done on research and statistics on prevalence of hepatitis B and C infections in the country. In general, the government and CSOs/NGOs are less active in the area of viral hepatitis, because of the limited funds available for its prevention.

**What needs to change?**

- Everyone should have access to hepatitis B and C screening under the nation’s health insurance scheme.
- Hepatitis B vaccination should be covered by the nation’s insurance, preferably for every citizen. If this is not realistic, it should be open to at least all family members/close contacts of the person with hepatitis B.
- Although major international funds for prevention of viral hepatitis are not available, the government should take the initiative to develop a strong agenda for the prevention of viral hepatitis.
- The risk of getting hepatitis B and C could be reduced if proper education campaigns are carried out. Collaboration of government and civil society organisations is required.
- On a national and international level the prevention of viral hepatitis should be given the same attention and funds as that of malaria, HIV, tuberculosis, etc.
- Stakeholders should form hepatitis alliances on a national level, to be able to have more impact on the national hepatitis agenda.

**Screening, care and treatment**

**Current situation:**

National Health Insurance is available for consultations and basic care, but most of the medications for viral hepatitis are not covered. The treatment options and outcomes are not well explained to patients by care providers or prescribers.

One of the consequences of this is that many chronic hepatitis B patients receive treatment thinking they will be cured. Due to misconceptions about viral hepatitis, patients and their relatives need a lot of counselling in order to be able to know and accept their condition. Counsellors are often not available.

There is a lack of detailed knowledge about hepatitis B and C among caregivers in local hospitals. In many cases, equipment for further investigations is not available to them. The country as a whole only has a very small number of specialists in hepatology. Due to stigmatization, viral hepatitis patients sometimes do not find their way to proper care. The formation of patient groups remains a challenge for the same reason. In Ghana, the preference for local herbal treatment by the public for various sicknesses is high. This is also the case for viral hepatitis. This exposes patients to further liver damage.

**What needs to change?**

- In-service trainings and workshops should be organized periodically on viral hepatitis for caregivers and CSOs by government and other alliances.

The organisation provided the following general statement regarding key hepatitis policy issues in Ghana:

According to the Ghana demographic health survey, hepatitis B virus is very endemic in Ghana particularly in the Upper East Region where it is believed that about 21% of the population is hepatitis-B positive. Currently it is circulated in the media and many other places that about four million Ghanaians are hepatitis-B positive. This information could be quite true since there are inadequate data on this condition in the country.

In Ghana the Ministry of Health has a policy that incorporated the condition into the childhood immunization programme in 2002. This is a step in the right direction but woefully inadequate. The inadequacy of this policy is that only children born after 2002 are protected against the disease, while the vast majority of the youth who are the future leaders of this nation are left to die.

Besides, most of these vaccines can only be found in some prestigious hospitals in urban areas, while those hospitals in rural areas do not have access to these vaccines. Records available to us revealed that there is a high prevalence rate among the rural population due to lack of vaccines in these areas coupled with the fact that there are no treatment guidelines for this condition. Patients who are diagnosed with hepatitis B are left with no option other than to buy medications at exorbitant prices, while in contrast HIV treatment is completely free. Long Life Africa has constantly appealed to the Ministry of Health, Ghana AIDS commission and National Health Authority to look into this situation and make an effort to arrest the situation. To date, nothing seems to be happening in this regard.

Furthermore, ignorance about the condition remains a major challenge. Research conducted by Long Life Africa revealed that about 70% of senior high students have no knowledge about this condition and this seems to be the situation among the general population. The Ministry of Health and the Ghana Health Service seem to be doing poorly in this regard. This apathy and lukewarm attitude from government has compelled Long Life Africa to enter into partnership with community radio networks to intensify campaigns in communities and schools.

In addition, Long Life Africa is collaborating with various district assemblies to provide free hepatitis B screening and vaccination for junior high schools in the country. The aim of this exercise is to protect those without the virus and to refer those with the virus for immediate treatment.
The Government of Ghana did not respond to the World Health Organization survey for the 2013 Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States, and therefore Theobald Hepatitis B Foundation could not comment on government information for this report.

The organisation provided the following general statement regarding key hepatitis policy issues in Ghana:

Viral hepatitis, a silent and underestimated public health problem worldwide, is particularly endemic in Sub-Saharan Africa and Ghana. Thousands of Ghanaians live with viral hepatitis. About a third of Ghanaians living with viral hepatitis are unaware of their status and are not receiving care and treatment for the condition.

Raising awareness about hepatitis is crucial to effectively fight social stigma, stem the tide of new infections, and ensure that testing, information, counselling and treatment reach those in need.

We believe that educating the general public regarding hepatitis B, including how it is transmitted, prevented and treated, will result in more people reducing or eliminating their risk, getting screened, diagnosed and vaccinated. By raising awareness about the disease, public education will also reduce the stigma and discrimination associated with hepatitis B.

Knowledge of hepatitis B among health and human service providers promotes the delivery of quality care and vaccination, creates awareness and changes practices and attitudes.

The government together with other stakeholders should advocate for stressing the need for education among healthcare providers on viral hepatitis as this disease is just as fatal as other communicable diseases such as HIV, malaria and tuberculosis.

Culturally and linguistically appropriate educational messages and materials are required to make appropriate hepatitis B information available to Ghana’s diverse population. Because people access information in different ways, information must be available in a variety of formats through traditional, news media and technology.

Breaches in infection control can result in healthcare-associated transmission of hepatitis B. An increase in awareness, understanding and adherence to proper infection control practices will prevent such transmission.

In addition to becoming knowledgeable regarding hepatitis B, newly diagnosed persons need appropriate information to maintain a healthy lifestyle. Examples include avoiding alcohol and certain medications, proper diet and exercise.

Written educational materials, support groups and peer training programmes are just a few ways to help promote a healthy lifestyle and prevent disease progression.

We believe these things can be achieved through the collaborative efforts of the following:

- Government, ministries and other stakeholders must be involved in the allocation of funds for awareness campaigns.
- Inclusion of co-operate organisations and public and private institutions in the awareness programme.
- Inclusion of health insurance and other stakeholders in the awareness programme.
- Inclusion of awareness campaign programmes at the various community-based health planning services, district health facilities and regional health facilities across the nation.

* World Hepatitis Alliance member.
SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Mali reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

- The government information was thought to be accurate for 20.0% of items.
  - Survey points marked “accurate”: 1.2, 2.2, 4.1, 4.4 and 4.8.

- The government information was thought to not be accurate for 48.0% of items.
  - Survey points marked “not accurate”: 1.1, 1.3, 2.1, 3.1, 3.2, 3.3, 3.4, 3.5, 4.2, 4.5, 4.6 and 5.3.

- The respondent took no position on the government information for 32.0% of items.
  - Survey points marked “take no position”: 4.3, 4.7, 4.9, 4.10, 5.1, 5.2, 5.4 and 5.5.

Survey comments from SOS Hépatites Mali:

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<tr>
<th>Information reported by government (2012–2013)</th>
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<tr>
<td>1.2 There is no designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities. It is not known how many people work full-time on hepatitis-related activities in all government agencies/bodies.</td>
<td>A focal point has been appointed in the Ministry of Health.</td>
</tr>
<tr>
<td>2.2 The government collaborates with the following in-country civil society group to develop and implement its viral hepatitis prevention and control programme: SOS Hepatitis.</td>
<td>The government does collaborate with CSOs, but does not support them technically or financially.</td>
</tr>
<tr>
<td>4.1 There is a national hepatitis A vaccination policy.</td>
<td>Included in the hepatitis B immunisation programme for children.</td>
</tr>
<tr>
<td>4.4 There is a national policy specifically targeting mother-to-child transmission of hepatitis B (Annex B).</td>
<td>Yes, at least the national immunisation programme for children takes this into account.</td>
</tr>
</tbody>
</table>

* World Hepatitis Alliance member.
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<tr>
<td><strong>1.1</strong> There is no written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis.</td>
<td><strong>In Mali a national strategy and plan are not written – no plan or national programme that takes into account the fight against viral hepatitis.</strong></td>
</tr>
<tr>
<td><strong>1.3</strong> The government does not have a viral hepatitis prevention and control programme that includes activities targeting specific populations.</td>
<td><strong>No doesn’t exist, nothing in this direction has been done.</strong></td>
</tr>
<tr>
<td><strong>2.1</strong> The government did not hold events for World Hepatitis Day 2012 and has not funded other viral hepatitis public awareness campaigns since January 2011.</td>
<td><strong>No the government does not organise, only SOS Hépatites while the ministers participate.</strong></td>
</tr>
<tr>
<td><strong>3.1</strong> There is no routine surveillance for viral hepatitis.</td>
<td><strong>Formal routine surveillance does not exist.</strong></td>
</tr>
<tr>
<td><strong>4.8</strong> There is a national infection control policy for blood banks. All donated blood units (including family donations) and blood products nationwide are screened for hepatitis B and hepatitis C.</td>
<td><strong>The only structure that does this in Mali are the blood banks during blood donations. But from national policy.</strong></td>
</tr>
</tbody>
</table>

To our knowledge, this information is not accurate.

To our knowledge, this information is accurate.
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<tr>
<td><strong>3.2</strong> There are no standard case definitions for hepatitis. Hepatitis deaths are not reported to a central registry. Of the hepatitis B and hepatitis C cases, 15%–20% and 4.98%, respectively, are reported as “undifferentiated” or “unclassified” hepatitis</td>
<td>No centralised data on national level, except the national centre for blood transfusions.</td>
</tr>
<tr>
<td><strong>3.3</strong> Liver cancer cases and cases with HIV/hepatitis coinfection are registered nationally. The government publishes hepatitis disease reports annually.</td>
<td>No, only SOS Hépatites Mali, in collaboration with the blood transfusion centre and Gabriel Touré hospital, publicly present the cases on 28th July.</td>
</tr>
<tr>
<td><strong>3.4</strong> It is not known whether hepatitis outbreaks are required to be reported to the government. There is adequate laboratory capacity nationally to support investigation of viral hepatitis outbreaks and other surveillance activities.</td>
<td>No, only blood banks do this during blood donations.</td>
</tr>
<tr>
<td><strong>3.5</strong> It is not known whether there is a national public health research agenda for viral hepatitis, or whether viral hepatitis serosurveys are conducted regularly.</td>
<td>No nothing in this direction.</td>
</tr>
<tr>
<td><strong>5.3</strong> People testing for both hepatitis B and hepatitis C register by name; the names are kept confidential within the system. Hepatitis B and hepatitis C tests are not free of charge for all individuals, but they are free of charge for blood donors. Hepatitis B and hepatitis C tests are compulsory for blood donors.</td>
<td>But SOS Hépatites and blood banks regularly do this. But people are not taken up/supported after their test.</td>
</tr>
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</table>
Mali

SOS Hépatites Mali continued

Statement from SOS Hépatites Mali regarding key hepatitis policy issues in Mali:

Information, communication, sensibilisation populations for prevention against hepatitis.

Advocacy/lobbying for the Mali Government to develop a national programme against viral hepatitis and build partnership relations with the World Health Organization and other organisations around the world.

We take no position regarding this statement.

Information reported by government (2012–2013)

4.3 It is not known what percentage of newborn infants nationally in a given recent year received the first dose of hepatitis B vaccine within 24 hours of birth or what percentage of one-year-olds (ages 12–23 months) in a given recent year received three doses of hepatitis B vaccine.

5.1 It is not known how health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis. There are no national clinical guidelines for the management of viral hepatitis. There are national clinical guidelines for the management of HIV, which include recommendations for coinfection with viral hepatitis.

5.2 The government does not have national policies relating to screening and referral to care for hepatitis B or hepatitis C.

5.4 Publicly funded treatment is not available for hepatitis B or hepatitis C.

Civil society respondent comments (2014)

But I know that in some health centres, the registers contain the statistics of children vaccinated against hepatitis especially hepatitis B.

However there is a network of professionals created by seven hepatitis specialists.

Nothing has been done officially in Mali apart from the actions of SOS Hépatites Mali who fight for that.

But that doesn’t exist.

Scale up and implement programme against hepatitis and care of patients.

Strengthening capacities/support orphans, widows and widowers of hepatitis.

Create a dynamic database to track the evolution of hepatitis in Mali.

Information reported by government (2012–2013)

4.3 It is not known what percentage of newborn infants nationally in a given recent year received the first dose of hepatitis B vaccine within 24 hours of birth or what percentage of one-year-olds (ages 12–23 months) in a given recent year received three doses of hepatitis B vaccine.

5.1 It is not known how health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis. There are no national clinical guidelines for the management of viral hepatitis. There are national clinical guidelines for the management of HIV, which include recommendations for coinfection with viral hepatitis.

5.2 The government does not have national policies relating to screening and referral to care for hepatitis B or hepatitis C.

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5.4 Publicly funded treatment is not available for hepatitis B or hepatitis C.

Civil society respondent comments (2014)

But I know that in some health centres, the registers contain the statistics of children vaccinated against hepatitis especially hepatitis B.

However there is a network of professionals created by seven hepatitis specialists.

Nothing has been done officially in Mali apart from the actions of SOS Hépatites Mali who fight for that.

But that doesn’t exist.

Scale up and implement programme against hepatitis and care of patients.

Strengthening capacities/support orphans, widows and widowers of hepatitis.

Create a dynamic database to track the evolution of hepatitis in Mali.
SURVEY HIGHLIGHTS

The Government of Mauritius did not respond to the World Health Organization survey for the 2013 Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States, and therefore Hep Support could not comment on government information for this report.

The organisation provided the following general statement regarding key hepatitis policy issues in Mauritius:

There is no national response to Hepatitis C.

Hepatitis B is being taken care of – vaccination of newborns, school children, pregnant women, medical professionals, dialysis patients. Nothing as such has been done to deal with Hepatitis C; only blood donors are being screened.

There is no register for any viral hepatitis-positive people. We cannot refer to people diagnosed with viral hepatitis as “patients” – they are just told they are positive and left to themselves. There is no hepatology unit. Doctors are not well informed about viral hepatitis and its management. People coinfected with HIV and viral hepatitis are not being made aware of the consequences. Nothing is being done to destigmatise people who have viral hepatitis.

The Government should set up a national awareness campaign covering all regions at risk, most firms, students at all levels, paramedicals, and dentists.

Government should involve NGOs to have access to these places, to deliver talks and screen people for viral hepatitis. Television programmes, radio and written media should also be involved in order to help achieve large-scale awareness.

A central or regional hepatology unit must be set up where NGOs could share the work, where anyone can get any information about viral hepatitis.

Doctors in hospitals and dispensaries should be trained specifically so that they become fully conversant with viral hepatitis and are prepared to refer appropriate cases of viral hepatitis to hepatology units.

Government should accept help from NGOs, from corporate social responsibility providers, through Ministry of Finance, should give more attention to those projects.

The World Health Organization (WHO) should help those involved NGOs to address WHO guidelines.

HepSupport has been celebrating World Hepatitis Day for many years and there are lots of newspaper articles, radio programmes (interactive), and television programmes.

In my opinion, HepSupport has done a lot for awareness and screening – Elisa test, viral load and genotyping.Patients just ask “what else?” Treatment is given to a very few “and selective.” There are no established criteria (to our knowledge) set up for giving treatment to patients suffering from hepatitis C in government hospitals. Only a very few are being chosen each year, and at times no one is chosen.

Private treatment is expensive and is not affordable to most people who have viral hepatitis.
The respondent reviewed 25 items of information that the government of Nigeria reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

- The government information was thought to be accurate for 36.0% of items. Survey points marked “accurate”: 1.1, 1.2, 3.4, 4.1, 4.2, 4.4, 4.7, 4.10 and 5.5.

- The government information was thought to not be accurate for 4.0% of items. Survey points marked “not accurate”: 4.6.

- The respondent took no position on the government information for 60.0% of items. Survey points marked “take no position”: 1.3, 2.1, 2.2, 3.1, 3.2, 3.3, 3.5, 4.3, 4.5, 4.8, 4.9, 5.1, 5.2, 5.3 and 5.4.

Survey comments from Beacon Youth Movement:

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<tbody>
<tr>
<td>1.1 There is no written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis.</td>
<td>There is no national strategy or plan available to civil society organization working in Nigeria yet. But information going round is that government has set up a committee but no feedback on this matter yet to the various CSOs working on Hepatitis.</td>
</tr>
<tr>
<td>1.2 There is no designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities. It is not known how many people work full-time on hepatitis-related activities in all government agencies/bodies.</td>
<td>To my knowledge, this data is right because the government has not been involving the various stakeholders working on hepatitis like CSOs. Thereby not knowing those staff or various departments working to confront viral hepatitis in Nigeria.</td>
</tr>
<tr>
<td>3.4 Hepatitis outbreaks are required to be reported to the government and are further investigated. There is inadequate laboratory capacity nationally to support investigation of viral hepatitis outbreaks and other surveillance activities.</td>
<td>The information is correct. Despite the fact that we are not actively involved in the whole process.</td>
</tr>
<tr>
<td>4.4 There is no national policy that specifically targets mother-to-child transmission of hepatitis B.</td>
<td>The information is accurate information on this matter but involvement of CSOs is poor.</td>
</tr>
</tbody>
</table>

To our knowledge, this information is accurate.
4.7 Official government estimates of the number and percentage of unnecessary injections administered annually in healthcare settings were not known. This information is correct because no research has being carried out to ascertain the number of unnecessary injections administered but involvement of the various stakeholders will help to give more accurate data.

4.6 There is a national policy on injection safety in health-care settings, which recommends auto-disable syringes for therapeutic injections. It is not known whether single-use or auto-disable syringes, needles and cannulas are always available in all health-care facilities. The majority of health care settings lack most of the materials listed by the Nigerian Government.

1.3 The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific population: health-care workers (including health-care waste handlers). Records and research available to our organisation indicate that many health care personnel are not benefiting from this programme due to a lack of vaccines in the various departments or units.

2.1 Information was not provided on whether the government held events for World Hepatitis Day 2012 or funded other viral hepatitis public awareness campaigns since January 2011. Not one single time has the government ever involved the various CSOs working on hepatitis in any activities to mark World Hepatitis Day or any programme to confront hepatitis in Nigeria either through partnership or funding.

2.2 Information was not provided on whether the government collaborates with in-country civil society groups to develop and implement its viral hepatitis prevention and control programme. Because they know the area they are lacking – that is why no information was provided.
### Nigeria

#### Beacon Youth Movement continued

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<tbody>
<tr>
<td><strong>3.1</strong> There is routine surveillance for viral hepatitis. Information was not provided about which specific types of acute and chronic hepatitis are monitored by surveillance systems.</td>
<td>The CSOs were not involved in this whole process. Therefore, making it sound new to us.</td>
</tr>
<tr>
<td><strong>3.2</strong> There are standard case definitions for hepatitis. Deaths, including from hepatitis, are reported to a central registry. Information was not provided on the percentage of hepatitis cases reported as “undifferentiated” or “unknown” hepatitis.</td>
<td>We are so ignorant of these matters.</td>
</tr>
<tr>
<td><strong>3.3</strong> Liver cancer cases are registered nationally. Information was not provided on whether cases with HIV/hepatitis coinfection are registered nationally. The government publishes hepatitis disease reports monthly.</td>
<td>We are not actively involved nor has data on this been provided to CSOs.</td>
</tr>
<tr>
<td><strong>3.5</strong> Information was not provided on whether there is a national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are not conducted regularly.</td>
<td>No response from the government because the CSOs are not actively involved.</td>
</tr>
<tr>
<td><strong>4.3</strong> Information was not provided regarding the percentage of newborn infants nationally in a given recent year who had received the first dose of hepatitis B vaccine within 24 hours of birth or the percentage of one-year-olds nationally (ages 12–23 months) in a given recent year who had received three doses of hepatitis B vaccine.</td>
<td>No government policy is in place regarding the prevention of new cases of infected mothers to their babies through the administration of the first dose, thereby fuelling the rate at which infection is increasing.</td>
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</table>

*We take no position regarding this statement.*

*Beacon Youth Movement continued*
4.8 There is a national infection control policy for blood banks. All donated blood units (including family donations) and blood products nationwide are screened for hepatitis B. It is not known whether all donated blood units (including family donations) and blood products nationwide are screened for hepatitis C.

4.9 It is not known whether there is a national policy relating to the prevention of viral hepatitis among people who inject drugs.

5.1 Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools for health professionals (pre-service education), on-the-job training and postgraduate training. There are national clinical guidelines for the management of viral hepatitis, but information was not provided on whether these guidelines include recommendations for cases with HIV coinfection. Information was not provided on whether there are national clinical guidelines for the management of HIV, which include recommendations for coinfection with viral hepatitis.

5.2 It is not known whether the government has national policies relating to screening and referral to care for hepatitis B or hepatitis C.

5.3 The government has specific policies on preventing viral hepatitis in health-care settings. It is not known whether health care workers are vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood.

5.4 It is not known whether the government has national policies relating to screening and referral to care for hepatitis B or hepatitis C.

5.5 The government has a specific national strategy and/or policy/guidelines for preventing hepatitis B and hepatitis C infection in health-care settings. It is not known whether health care workers are vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood.

We take no position regarding this statement.

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<tr>
<td>4.5 There is a specific national strategy and/or policy/guidelines for preventing hepatitis B and hepatitis C infection in health-care settings. It is not known whether health care workers are vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood.</td>
<td>The CSOs working on viral hepatitis in Nigeria are not aware of this strategy because the government has not involved CSOs in this process.</td>
</tr>
<tr>
<td>4.8 There is a national infection control policy for blood banks. All donated blood units (including family donations) and blood products nationwide are screened for hepatitis B. It is not known whether all donated blood units (including family donations) and blood products nationwide are screened for hepatitis C.</td>
<td>Just a few of the blood banks screen for Hepatitis B and hepatitis C. Most of them only screen for HIV and syphilis.</td>
</tr>
<tr>
<td>4.9 It is not known whether there is a national policy relating to the prevention of viral hepatitis among people who inject drugs.</td>
<td>No information as it relates to the policies of those who inject drugs.</td>
</tr>
<tr>
<td>5.1 Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools for health professionals (pre-service education), on-the-job training and postgraduate training. There are national clinical guidelines for the management of viral hepatitis, but information was not provided on whether these guidelines include recommendations for cases with HIV coinfection. Information was not provided on whether there are national clinical guidelines for the management of HIV, which include recommendations for coinfection with viral hepatitis.</td>
<td>In order to effectively combat this viral infection, all stakeholders like the CSOs working on hepatitis need to be trained alongside the medical personnel because health workers alone cannot combat hepatitis.</td>
</tr>
<tr>
<td>5.2 It is not known whether the government has national policies relating to screening and referral to care for hepatitis B or hepatitis C.</td>
<td>Non-involvement of CSOs has caused a delay in referrals thereby making the infected most of times confused as to the next step to take toward the management of viral hepatitis in Nigeria. Thereby increasing the complications of this infection.</td>
</tr>
</tbody>
</table>
Hepatitis-related issues have raised a lot of concern when it comes to awareness, sensitization, partnership and resources mobilisation in Nigeria.

The Nigerian Government has turned deaf ears to the rate at which hepatitis is spreading by not identifying and mobilising resources at both the federal and state level to tackle hepatitis through budgeting a specific percentage of the yearly budget to fight viral hepatitis in Nigeria.

Over the years, the issue of partnership has become so problematic that there is no recognition of other relevant stakeholders: the various CSOs working to tackle the infection at the local and regional levels.

Awareness is very key to the reduction of any infectious disease in the world. Here in Nigeria, awareness is very low, which has helped to fuel the spread of the virus. Policies on hepatitis are not in place and therefore there is no implementation of any kind to fight the high burden in Nigeria.

Partnership is a very important issue when it comes to tackling hepatitis and other health-related problems because of the huge burden it has in the society. Partnership of various stakeholders will be very key because it will help to confront the burden of viral hepatitis within a short period of time. But the issue here in Nigeria has a lot of devastating effects because of lack of partnership between the Nigerian Government and other relevant shareholders have slowed down progress on awareness and reduction of viral hepatitis in Nigeria.

Resource mobilisation has been another burden to the actualization of free hepatitis generation due to funding issues. World Hepatitis Day has not been celebrated by most CSOs because no monetary assistance is being offered in helping to fight hepatitis in Nigeria.

We take no position regarding this statement.

Testing for hepatitis B and hepatitis C is not free in Nigeria. A database is in place but no action has been taken to implement the data at hand.

Not aware because we are not involved in the process.

Information reported by government (2012–2013)  

5.3 People testing for both hepatitis B and hepatitis C register by name; the names are kept confidential within the system. Hepatitis B and hepatitis C tests are not free of charge. Information was not provided on whether hepatitis B or hepatitis C tests are compulsory for members of any specific group.

5.4 Publicly funded treatment is not available for hepatitis B or hepatitis C.

Civil society respondent comments (2014)
The respondent reviewed 25 items of information that the government of Nigeria reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 84.0% of items.

Survey points marked “accurate”:
1.1, 1.2, 2.1, 2.2, 3.1, 3.4, 4.1, 4.2, 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, 4.10, 5.1, 5.2, 5.3, 5.4 and 5.5.

The government information was thought to not be accurate for 16.0% of items.

Survey points marked “not accurate”:
1.3, 3.2, 3.3 and 4.3.

Survey comments from Chagro-Care Trust:

Information reported by government (2012–2013)

2.1 Information was not provided on whether the government held events for World Hepatitis Day 2012 or funded other viral hepatitis public awareness campaigns since January 2011.

Most World Hepatitis Day events are organized by patient groups, professional groups and NGOs.

2.2 Information was not provided on whether the government collaborates with in-country civil society groups to develop and implement its viral hepatitis prevention and control programme.

There is little or no government collaboration with civil society, especially at the national level. At the state level, some state governments have engaged civil society on creating awareness, like Taraba State and few other states in the country.

3.1 There is routine surveillance for viral hepatitis. Information was not provided about which specific types of acute and chronic hepatitis are monitored by surveillance systems.

There is no deliberate effort by government to conduct surveillance activities on viral hepatitis.

3.5 Information was not provided on whether there is a national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are not conducted regularly.

Most data on viral hepatitis are obtained from NGOs, patients groups and academic studies.

Civil society respondent comments (2014)

To our knowledge, this information is accurate.

* World Hepatitis Alliance member.
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<td><strong>4.2</strong> The government has not established the goal of eliminating hepatitis B.</td>
<td>There is no strategic framework, guidelines or tools available.</td>
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<td><strong>1.3</strong> The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific population: health-care workers (including health-care waste handlers).</td>
<td>Although this is a global policy, it is not being practised in our country. Health workers or other vulnerable groups are not protected by any policy like post-exposure prophylaxis.</td>
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<td><strong>3.2</strong> There are standard case definitions for hepatitis. Deaths, including from hepatitis, are reported to a central registry. Information was not provided on the percentage of hepatitis cases reported as ‘undifferentiated’ or ‘unknown’ hepatitis.</td>
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<td><strong>3.3</strong> Liver cancer cases are registered nationally. Information was not provided on whether cases with HIV/hepatitis co-infection are registered nationally. The government publishes hepatitis disease reports monthly.</td>
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<td>The government has a policy for infant vaccination and these are documented in all designated health facilities across the nation.</td>
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Statement from Chagro-Care Trust regarding key hepatitis policy issues in Nigeria:

**National coordination.** There is no system in place in Nigeria for coordination of activities either by government or civil organisations working on viral hepatitis. Until two years ago, when a group of NGOs initiated the formation of a national coordinating body for all civil society groups and patients groups working on viral hepatitis in Nigeria. A structure and framework for a national network was recently set up and strengthened in Abidjan during the first Pan African hepatitis workshop. Civil Society Alliance Against Viral Hepatitis (CiSAVHiN) was formed to coordinate all patients groups and NGOs working on viral hepatitis in the country. An interim leadership comprising of the National Coordinator, Deputy National Coordinator, General Secretary and four other portfolios were appointed to steer the leadership of the organisation and to coordinate actions leading up to registration with relevant government agencies and the World Hepatitis Alliance.

At the government level, there is no policy in place to guide coordination of actions and activities on viral hepatitis in the country.

**Awareness-raising, partnerships and resource mobilisation.** There is no clear policy or guideline on awareness-raising on viral hepatitis in Nigeria. Most awareness-raising events are left in the hands of patients groups, NGOs, and professional associations such as the Society of Gastroenterologists. Most awareness activities are uncoordinated and lack depth and focus, due largely to lack of resources and poor support from government and donors.

Partnerships are rare, except for a few instances where some pharmaceuticals offer support to organisations on awareness-raising.

Resource mobilisation is a big challenge. Only in a few instances do patients groups or professional associations receive support on their activities.

Support from individuals on awareness-raising is not very common in the country.

**Evidence-based policy and data for action.** There is no evidence-based policy from government on data. There is no framework of action on sentinel or prevalence studies available in the country. Most data on hepatitis in the country are obtained from NGOs, patients groups or academic studies from individuals.

**Prevention of transmission.** There are no government protocols, guidelines or standard operating procedures on prevention of transmission for any target population or group. Even health workers with all the risks and job hazards are not protected by any government policy on post-exposure prophylaxis.

**Screening, care and treatment.** There are no protocols from government on screening, care and treatment of viral or chronic hepatitis. This is posing a big challenge, as it allows room for all manner of unethical practices and sharp practices by all and sundry in the name of hepatitis treatment, which is detrimental to the health and well-being of people living with chronic hepatitis in the country.

**Other comments:**

The absence or lack of a framework on national coordination, standard operating procedures or guidelines on prevention of transmission, guidelines on treatment and care on viral hepatitis, leaves much to be desired. A lot of activities are going on but mostly uncoordinated and as a result are not in most cases evidence-based, or in line with best practices.

Civil society has risen to the challenge recently by setting up a national alliance that would be responsible for coordinating all NGOs and patients groups working on hepatitis in the country. The network is named “Civil Society Alliance on Viral Hepatitis in Nigeria.”

It is our belief that the network will strengthen civil society capacity to deliver more evidence-based and sustainable interventions that meet the needs of the populace. However, government too has a role to play, as recently done by the setting up of a technical working group on viral hepatitis in the country. But this effort should go beyond rhetoric to action.

Government’s engagement with civil society and patient groups working on viral hepatitis is very weak and poor at best. The government needs to engage civil society in a more pragmatic manner, devoid of any sentiments or bias, in developing a national framework of action on viral hepatitis.

What needs to change is the government’s approach, especially at the national level. Until recently, the government has not shown any commitment to the fight against viral hepatitis in the country. Most government policies exist only on paper, but are not working documents, despite the government signing the World Health Assembly 2010 Hepatitis Resolution.

Due to the lack of funding on viral hepatitis activities in the country, most NGOs and patients groups are incapacitated in carrying out activities to mitigate the scourge of viral hepatitis across the country, despite the seemingly very high incidence and prevalence of the disease in the country.
Nigeria

Elohim Foundation*
NGO – direct service provider and hepatitis patient group
Abuja FCT, Nigeria
www.elohimfoundation.org

SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Nigeria reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 84.0% of items.
Survey points marked “accurate”:
1.1, 1.2, 2.1, 2.2, 3.1, 3.4, 3.5, 4.1, 4.2, 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, 4.10, 5.1, 5.2, 5.3, 5.4 and 5.5.

The government information was thought to not be accurate for 16.0% of items.
Survey points marked “not accurate”:
1.3, 3.2, 3.3 and 4.3.

Survey comments from Elohim Foundation:

Information reported by government (2012–2013) Civil society respondent comments (2014)

2.1 Information was not provided on whether the government held events for World Hepatitis Day 2012 or funded other viral hepatitis public awareness campaigns since January 2011.
Most World Hepatitis Day events are organized by patient groups, professional groups and NGOs.

2.2 Information was not provided on whether the government collaborates with in-country civil society groups to develop and implement its viral hepatitis prevention and control programme.
There is little or no government collaboration with civil society, especially at the national level. At the state level, some state governments have engaged civil society on creating awareness, like Abuja FCT and few other states in the country.

3.1 There is routine surveillance for viral hepatitis. Information was not provided about which specific types of acute and chronic hepatitis are monitored by surveillance systems.
There is no deliberate effort by government to conduct surveillance activities on viral hepatitis.

3.5 Information was not provided on whether there is a national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are not conducted regularly.
Most data on viral hepatitis are obtained from NGOs, patients groups and academic studies.

* World Hepatitis Alliance member.
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<td>There is no strategic framework, guidelines or tools available.</td>
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<td>4.4 There is no national policy that specifically targets mother-to-child transmission of hepatitis B.</td>
<td>This is sad to note – despite interventions to prevent mother-to-child transmission of HIV, nothing is being done regarding viral hepatitis.</td>
</tr>
<tr>
<td>1.3 The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific population: health-care workers (including health-care waste handlers).</td>
<td>This policy though shown in the Global Policy, but is not existing or being practiced. Health workers or other vulnerable groups are not protected by any policy like post-exposure prophylaxis.</td>
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**Nigeria**

**Elohim Foundation continued**

**Statement from Elohim Foundation regarding key hepatitis policy issues in Nigeria:**

**National coordination.** There is no system in place in Nigeria for coordination of activities either by government or civil organisations working on viral hepatitis. Until two years ago, when a group of NGOs initiated the formation of a national coordinating body for all civil society groups and patients groups working on viral hepatitis in Nigeria. A structure and framework for a national network was recently set up and strengthened in Abidjan during the first Pan African hepatitis workshop. Civil Society Alliance Against Viral Hepatitis (CISAVHIN) was formed to coordinate all patients groups and NGOs working on viral hepatitis in the country. An interim leadership comprising of the National Coordinator, Deputy National Coordinator, General Secretary and four other portfolios were appointed to steer the leadership of the organisation and to coordinate actions leading up to registration with relevant government agencies and the World Hepatitis Alliance.

At the government level, there is no policy in place to guide coordination of actions and activities on viral hepatitis in the country.

**Awareness-raising, partnerships and resource mobilisation.** There is no clear policy or guideline on awareness-raising on viral hepatitis in Nigeria. Most awareness-raising events are left in the hands of patients groups, NGOs, and professional associations such as the Society of Gastroenterologists. Most awareness activities are uncoordinated and lack depth and focus, due largely to lack of resources and poor support from government and donors.

Partnerships are rare, except for a few instances where some pharmaceuticals offer support to organisations on awareness-raising.

Resource mobilisation is a big challenge. Only in a few instances do patients groups or professional associations receive support on their activities.

Support from individuals on awareness-raising is not very common in the country.

Evidence-based policy and data for action. There is no evidence-based policy from government on data. There is no framework of action on sentinel or prevalence studies available in the country. Most data on hepatitis in the country are obtained from NGOs, patients groups or academic studies from individuals.

**Prevention of transmission.** There are no government protocols, guidelines or standard operating procedures on prevention of transmission for any target population or group. Even health workers with all the risks and job hazards are not protected by any government policy on post-exposure prophylaxis.

**Screening, care and treatment.** There are no protocols from government on screening, care and treatment of viral or chronic hepatitis. This is posing a big challenge, as it allows room for all manner of unethical practices and sharp practices by all and sundry in the name of hepatitis treatment, which is detrimental to the health and well-being of people living with chronic hepatitis in the country.

**Other comments:**

The absence or lack of a framework on national coordination, standard operating procedures or guidelines on prevention of transmission, guidelines on treatment and care on viral hepatitis, leaves much to be desired. A lot of activities are going on but mostly uncoordinated and as a result are not in most cases evidence-based, or in line with best practices.

Civil society has risen to the challenge recently by setting up a national alliance that would be responsible for coordinating all NGOs and patients groups working on hepatitis in the country. The network is named “Civil Society Alliance on Viral Hepatitis in Nigeria.”

It is our belief that the network will strengthen civil society capacity to deliver more evidence-based and sustainable interventions that meet the needs of the populace. However, government too has a role to play, as recently done by the setting up of a technical working group on viral hepatitis in the country. But this effort should go beyond rhetoric to action.

Government’s engagement with civil society and patient groups working on viral hepatitis is very weak and poor at best. The government needs to engage civil society in a more pragmatic manner, devoid of any sentiments or bias, in developing a national framework of action on viral hepatitis.

What needs to change is the government’s approach, especially at the national level. Until recently, the government has not shown any commitment to the fight against viral hepatitis in the country. Most government policies exist only on paper, but are not working documents, despite the government signing the World Health Assembly 2010 Hepatitis Resolution.

Due to the lack of funding on viral hepatitis activities in the country, most NGOs and patients groups are incapacitated in carrying out activities to mitigate the scourge of viral hepatitis across the country, despite the seemingly very high incidence and prevalence of the disease in the country.
SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Nigeria reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 84.0% of items.

Survey points marked “accurate”: 1.1, 1.2, 2.1, 2.2, 3.1, 3.4, 3.5, 4.1, 4.2, 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, 4.10, 5.1, 5.2, 5.3, 5.4 and 5.5.

The government information was thought to not be accurate for 4.0% of items.

Survey points marked “not accurate”: 3.3.

The respondent took no position on the government information for 12.0% of items.

Survey points marked “take no position”: 1.3, 3.2 and 4.3.

Survey comments from GAMMUN Centre for Care and Development Nigeria:

We take no position regarding this statement.

1.3 The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific population: health-care workers (including health-care waste handlers).

We are not aware of this position by government.

Statement from GAMMUN Centre for Care and Development Nigeria regarding key hepatitis policy issues in Nigeria:

The government of Nigeria just like other governments gives little priority to viral hepatitis. This situation, like HIV during its early phase, will sooner or later become endemic, killing many people and placing a greater burden on orphans before the government’s attention is drawn to it.

The government’s attitude to viral hepatitis would need to change to prioritise this as important as other infections like HIV, tuberculosis and malaria.

The government should show serious political will in ensuring that all line ministries have a desk officer in charge of Hepatitis. At the national, state and local government levels, there should be a National Agency for the Control of Hepatitis, State Agency for the Control of Hepatitis and Local Action Committee for the Control of Hepatitis respectively.

National Agency: will coordinate national interventions.

State Agency: will coordinate state-level interventions.

Local Action Committee: will coordinate local/grassroots interventions.

Civil society organisations at all levels should be involved as they are closer to the people and have different ways of encouraging community involvement and participation in activities.
Nigeria

LiveWell Initiative*
NGO – direct service provider
Lagos, Nigeria
www.livewellng.org

SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Nigeria reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

- The government information was thought to be accurate for 60.0% of items.
  
  Survey points marked “accurate”:
  1.1, 1.2, 3.3, 3.5, 4.1, 4.2, 4.4, 4.6, 4.7, 4.9, 4.10, 5.1, 5.2, 5.3 and 5.4.

- The government information was thought to not be accurate for 12.0% of items.
  
  Survey points marked “not accurate”:
  1.3, 3.1 and 3.4.

- The respondent took no position on the government information for 28.0% of items.
  
  Survey points marked “take no position”:
  2.1, 2.2, 3.2, 4.3, 4.5, 4.8 and 5.5.

LiveWell Initiative provided no comments about survey items.

Statement from LiveWell Initiative regarding key hepatitis policy issues in Nigeria:

National coordination. The greatest problems with coordination have to do with funding and the huge size of the population. Having been recently appointed the Deputy National Coordinator for the Hepatitis Alliance in Nigeria; however it is a herculean task amalgamating the organisations. Government needs to throw its weight behind organisations, however the first thing is for government to put in place a policy on hepatitis, and thereafter to put in place a monitoring and evaluation body, to ensure that programme targets are met and exceeded. In addition, for sustainability, local and international communities need to support the initiatives.

Awareness-raising, partnerships and resource mobilisation. There is a strong need to raise awareness on hepatitis through the sensitisation of communities, health talks, screening and care. The greatest problems with creating awareness have to do with high levels of illiteracy, poor use of pictorials and other communication tools, poor funding and the high level of poverty among the people. Government and stakeholders can help by generating awareness through electronic and print media, and by improving on policy. Thereafter, the health system can implement based on policy. As is being done here at LiveWell Initiative, community leaders should be recognised as major stakeholders and they should be carried along, to facilitate stakeholder engagement and ownership.

Evidence-based policy and data for action. This is essential for informing and driving the direction of policy. To build up evidence-based data for hepatitis, strict guidelines need to be followed, with algorithms and organisations which work on hepatitis should work together in unison. Data gathering should be ethical, and a quarterly data analysis should be conducted. Hepatitis disease sufferers should form cohort groups where they will benefit from a win-win hepatitis study.

Prevention of transmission. Condom social marketing and coinfection with HIV should be foremost on the mind.

Screening, care and treatment. Screening is a very important component of hepatitis detection, treatment and care, and this should be done among high-risk populations and the general population at large. The major challenges with screening have to do with cost, since there is little or no availability of free screening tests. Government should provide funding and should work in partnership with organisations like LWI, which provide all of the above services in an ethical and process-driven manner. Communities should surrender themselves for screening, for early detection, prevention and treatment where necessary while government should formulate policy, ensure the strengthening of such policy and facilitate implementation thereof through regulation, and should generate awareness through the use of the electronic and print media.

* World Hepatitis Alliance member
1. This statement refers to the director of LiveWell Initiative serving as deputy national coordinator of the Hepatitis Alliance in Nigeria.
SURVEY HIGHLIGHTS


The organisation provided the following general statement regarding key hepatitis policy issues in Togo:

National coordination. There is no national strategy or plan to fight against viral hepatitis and therefore, there is no programme/service focusing on viral hepatitis. We need a national strategy that will lead to a national programme. It suits the government to mobilise the resources needed to develop a national plan/strategy that will lead to the creation of a programme to promote the creation of organisations. International organisations must put pressure on our leaders to create programmes. The community has a responsibility to assist the Government in the fight against the disease.

Awareness-raising, partnerships and resource mobilisation. In the area of awareness we have a serious problem: financial resources, on-site inspection, lack of advertising posters (showing indigenous, posters in local language). We are limited by our means. (We are working on our own funds.) We do not have a partner, only the World Health Organization.

We need the Government involved to provide technical and financial support.

Evidence-based policy and data for action. There is no systematic monitoring of viral hepatitis. There is no standard case definition for hepatitis. Hepatitis deaths are not reported to a central registry. Among hepatitis B and hepatitis C cases, <8% and <3% respectively are presented as “undifferentiated” or “unclassified” hepatitis. Liver cancer cases and cases of HIV/hepatitis B coinfection are recorded nationally. In 2011, our organisation began to conduct screening campaigns within the population. We want partners and the Government to get involved and allow a struggle worthy.

Prevention of transmission. Poor access to vaccines against hepatitis A and B for the population. High cost of vaccines. Newborns do not receive their first dose of vaccine against hepatitis B within 24 hours. Availability of vaccines to the capital not within the country at an affordable cost. Routine vaccination of newborns at D0 as the World Health Organization advocated in our regions. The government must screen people at risk and adopt a large-scale national policy. Availability of essential drugs for the management of hepatitis at the central and peripheral level needs to improve. Test must be made accessible and available in hospitals such as: markers of hepatitis B viral load and other for better support. Skills training and continuing health care education is needed. In that respect, drugs must be subsidised to make it accessible to patients living with hepatitis. Partners must put pressure on Governments and provide support. The community comes relay to the government.

Screening, care and treatment: Health care professionals do not have sufficient competences to effectively treat people with viral hepatitis. There are no national clinical guidelines for the management of viral hepatitis.

The government must screen people at risk and adopt a large-scale national policy. Availability of essential drugs for the management of hepatitis at the central and peripheral level needs to improve. Test must be made accessible and available in hospitals such as: markers of hepatitis B viral load and other for better support. Skills training and continuing health care education is needed. In that respect, drugs must be subsidised to make it accessible to patients living with hepatitis. Partners must put pressure on Governments and provide support. The community comes relay to the government.

* World Hepatitis Alliance member.
Chapter 4: African Region

African Region

Chapter 4: African Region

Policy issues in Uganda:

- Lack of central government support and funding. No government institution has been assigned to handle this highly prevalent disease.
- Limited donor support for Hepatitis B activities in the affected regions.
- Health facilities and health workers have not been adequately prepared for case management. A comprehensive policy for management of Hepatitis B virus has yet to be approved.
- The Ministry of Health, NGOs and community-based organisations should be supported to carry out capacity assessment and plan accordingly.

Awareness-raising, partnerships and resource mobilisation. A national task force for Hepatitis B has not been established, yet this is very important in steering awareness campaigns at the national, regional and district levels. The people who commonly serve as resources for raising awareness about issues in communities – health workers, politicians, and cultural and religious leaders – themselves have very little factual information on viral hepatitis. National booklets developed for health education have not been translated into local languages for information dissemination. No clear partnership exists from national to grassroots levels, and integration of Hepatitis B activities at various levels is still poor in regard to resource mobilisation and awareness-raising.

There is a need for collaboration at the international level and for engaging government to continue to provide leadership to address this problem.

- Vaccination of children with pentavalent vaccine that protects children against hepatitis B has been introduced in all the health facilities.
- The Ministry of Health has procured vaccine for more at-risk populations, especially health workers.
- Information, education and communication materials have been developed by the health education department, but they are inadequate in number and not translated into local languages.
- The Ministry of Health is encouraging health workers to use universal precautions in patient management.
- Phased out re-use of syringes by introducing auto-disabling syringes in all levels of care in public and private facilities.
- National medical stores are to take the lead in procuring reagents for hepatitis screening.

However this has not fully addressed the challenges of patients who are exposed and those with active disease as most facilities cannot do a baseline investigation for decision-making regarding initiation of treatment. No specific standard treatment guideline has been developed for case management.

The government to move to the grassroots.

Local NGOs and community-based organisations could help in sensitisation but lack resources.

University/medical school study centres could be established in areas with high prevalence, such as the West Nile here in Uganda, to help in the study of this disease.

Prevention of transmission. Since 2002, efforts by the Ministry of Health to reduce Hepatitis B infection in the country are being addressed although at a slow pace in the following ways:

- The drug in use is lamivudine, which is restricted for case management of HIV. Authorities are reluctant to allow its use for management of Hepatitis B for fear of resistance.
- Civil society should provide funding for training/retraining health workers to enable them to improve in case management.

Sources

- http://www.monitor.co.ug/SpecialReports/Hepatitis-B-slowly-eating-up-West-Nile/-/e88342/1947904/-/69kkuuj/-/index.html
- http://ugandaharmreduction.wordpress.com/2014/01/15/mps-quiz-minister-on-hepatitis-b-prevalence/
The international community should

National-level task forces should

The community should actively

Mobilising and allocating funds

Building the capacity of health care

Collecting baseline data on the

* World Hepatitis Alliance member.

Prevention and Control of Viral Hepatitis in WHO Member States, and therefore the Cancer and AIDS Relief Organization could not comment on government information for this report.

The organisation provided the following general statement regarding key hepatitis policy issues in Uganda:

**Awareness raising, partnerships and resource mobilisation.** In Uganda, most people are ignorant about viral hepatitis due to lack of information, myths and misconceptions associating it with poisoning, no partners in place to avert vice. High costs limit service delivery due to mass poverty across the country.

There is a need to create awareness about hepatitis B, advocate for the formulation of effective guidelines and policies to address hepatitis B issues, urgent mobilisation of partners and funding opportunities to support hepatitis B service delivery to communities.

In bringing about these changes, the government will be responsible for:

- Developing friendly policies and measures regarding hepatitis B.
- Collecting baseline data on the prevalence of hepatitis B to influence the World Health Organization to prioritise and integrate its management into the health system.
- Building the capacity of health care providers and other stakeholders in the management of hepatitis B.
- Mobilising and allocating funds to combat hepatitis B.

**Other stakeholders’ responsibilities:**

- The community should actively be involved in disseminating hepatitis B information.
- National-level task forces should be formed to collaborate and network with service providers and the community, provide expertise and logistics to support service delivery and integrate hepatitis activities into the existing health care system.
- The international community should provide expertise and logistics to support service delivery.

The existing evidence about hepatitis B in Kasese District is based on data collected by the Cancer and AIDS Relief Organisation from March 2011 to December 2013:

- Have tested 1,951 people for Hepatitis B surface Antigen (HBsAg); out of these, 1,705 tested negative and 242 tested HBsAg positive. Among those who tested positive, only 78 people could afford to raise funds for hepatitis B profile monitoring tests which determine initiation of treatment. Out of those clients who tested Hepatitis B envelope Antigen (HBeAg) positive and/or with abnormal liver function tests, 42 are on treatment for hepatitis B viral infection, whereas those who tested HBeAg-negative are being monitored.
- Have vaccinated 835 clients against hepatitis B viral infection out of 1,705 clients.
- Have treated nine patients with chronic hepatitis B viral infection.
- Have provided hospice care to 75 patients with severe pain controlled on oral morphine; out of these, four patients had cancer and HIV, 56 had cancer only and 15 other causes. Hepatocellular carcinoma and liver cirrhosis were leading with 29 patients. Thirty-three patients out of 75 died.

**Prevention of transmission.** There is a need to strengthen advocacy and partnerships for equitable access to quality hepatitis B information about screening, which is the entry to prevention and other services, as well as effective treatment of infected persons with hepatitis B so as to eliminate further transmission.

The role of the government in bringing about these changes includes accessing affordable testing kits, drugs and vaccines to the clients and building the capacity of health care providers about viral hepatitis B infection.

**Other stakeholders’ responsibilities:**

- The community should promote sensitisation programmes by distributing information, education and communication materials for information dissemination.
- Civil society organisations shall collaborate with the government in mobilisation and service delivery.
- At the national level, the government shall support hepatitis B activities by developing implementation policies/guidelines and allocating resources while advocating and providing technical support on hepatitis B at all levels and integrating it into existing health systems.
- The international community shall provide logistics to support service delivery.

**Screening, care and treatment.** In Uganda, chronic hepatitis B infection, defined as persistence of hepatitis B surface antigen for more than six months, has been demonstrated in 10% of the population but with a varying distribution due to limited knowledge and data issues about hepatitis B virus in regions in the country (ATIC newsletter, volume 6, issue 6, November 2009).

Hepatitis B screening services are not sufficiently accessible to most-at-risk populations, which include all children, sexually active adults and adolescents, discordant couples, people with HIV, diabetic patients, health care providers, house contacts with carriers and public safety workers with occupational risks, disabled persons, prisoners and pregnant mothers.

The proportions which are tested hepatitis B positive fail to meet funds for carrying out other profile tests to fit in the criterion for treatment initiation which impacts on their immune responses.
Despite the approval of treatment for hepatitis B viral infection by FDA like the injectable alpha interferon’s, orally administered ART, the patients have always failed to meet the cost of treatment leading to progression of cirrhosis and hepatocellular carcinoma due to high viral loads.

There is need for addressing the gaps/challenges that inhibit Hepatitis B prevention at the international, national, district and community level through advocacy, collaboration, sensitisation and capacity-building.

The role of the government in bringing about these changes includes accessing affordable testing kits, drugs and vaccines; building the capacity of health care providers about viral hepatitis; and creating awareness on hepatitis B viral infection.

Other stakeholders’ responsibilities:

- The community shall promote sensitisation programmes by distributing information, education and communication materials for information dissemination.
- Civil society organisations shall collaborate with the government in mobilisation and service delivery.
- At the national level, the government shall support hepatitis B activities by developing implementation policies/guidelines and allocating resources while advocating and providing technical support on hepatitis B at all levels.
- The international community shall provide logistics to support service delivery.
The Government of Uganda did not respond to the World Health Organization survey for the 2013 Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States, and therefore Giving Hope Foundation could not comment on government information for this report.

The organisation provided the following general statement regarding key hepatitis policy issues in Uganda:

Giving Hope Foundation (GHF) is an indigenous not-for-profit nongovernmental organisation based in Kampala, Uganda. GHF aims at restoring hope among vulnerable children and communities that have been affected by poverty, abuse, violence, disease and other natural calamities.

To mark World Hepatitis Day in 2011, Minister of State for Health – General Duties Hon. Dr. Richard Nduhuura made a communication to commemorate World Hepatitis Day. The minister committed to health promotion and education, routine immunisation, and vaccination of health workers and medical students, scaling up of sanitation and provision of safe water practices, early screening, infection prevention and control of health care waste management and control of all non-communicable diseases.

An awareness walk was held through Kampala city to commemorate the day and many Ugandans including health practitioners joined the cause.

In 2012, following a series of planning meetings for World Hepatitis Day, there was an outbreak of the Ebola haemorrhagic fever (Sudan ebolavirus) in Kibaale District (midwestern Uganda). The Ministry of Health confirmed this outbreak on 28 July 2012 following weeks of speculation about the cause of a strange disease that had many people fleeing their homes. Because of this outbreak, the Ministry of Health turned its attention and focused all of its resources to this cause; consequently, World Hepatitis Day was not celebrated in 2012.

In 2013, there was another outbreak in July which forced the Ministry of Health to allocate resources again to the emergency. The national celebration was rescheduled for a later date, but did not take place due to insecurity in the capital city.

There have been inquiries and calls from the parliament and other security organisations for the Ministry of Health to make a statement and combat the growing cases of hepatitis in Uganda that have not been sufficiently attended to.

The biggest challenge for civil society organisations involved in hepatitis is that there has been little involvement from the Ministry of Health, and we have found it hard to carry out some national activities that require its endorsement. The Ministry of Health has cited lack of personnel and resources for its lack of interest. But because of continued outreach and advocacy, there has been growing interest and involvement from the Ministry of Health since late 2013.

Government has a role in supporting the work and efforts of civil society organisations because we actually carry out activities that are meant to be performed by the government. Government also needs to be more open and reduce the bureaucratic process of acquiring information and access to key personnel.

Since civil society organisations work to support the efforts of government in Uganda, their roles include:

- Playing positive roles as strengthening the voices of the vulnerable and enhancing their participation in development processes.
- Representing and actively advocating for the interest of their members including hepatitis advocacy and support for patients among others.
- Influencing political agenda-setting and putting forward those social needs that represent the general demands of the population like including communicable diseases like viral hepatitis on the national agenda.

In 2014, we have seen increased interest around viral hepatitis in Uganda. The President of Uganda, during the National Resistance Movement Day on 26 January, made special mention of the need to raise awareness regarding this preventable illness. The Ministry of Health together with other stakeholders is planning to hold a series of events across the country to raise awareness; screen and set up support for hepatitis patients; and commemorate World Hepatitis Day on July 28, 2014. There is a need to integrate hepatitis activities with other similar government efforts like HIV/AIDS, tuberculosis and malaria programmes.

Donor agencies like the World Health Organization, Clinton Health Initiative, UNICEF, USAID and foreign embassies need to come on board to support the efforts of civil society organisations in raising awareness, vaccinations, treatment and support for hepatitis patients in Uganda. With continued advocacy, 2014 is promising to be a breakthrough year with regard to hepatitis in Uganda.
Uganda

The National Organization for People Living with Hepatitis B (NOPLHB)*

NGO – hepatitis patient group
Kampala, Uganda
www.freetocharities.org.uk/noplhb/

SURVEY HIGHLIGHTS

The Government of Uganda did not respond to the World Health Organization survey for the 2013 Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States, and therefore the National Organization for People Living with Hepatitis B could not comment on government information for this report.

The organisation provided the following general statement regarding key hepatitis policy issues in Uganda:

**Awareness-raising, partnerships and resource mobilisation.** Currently the awareness of the general public about hepatitis is very poor. Even among health care workers, the specialists seem to be better informed than the general physicians and other ancillary workers. Furthermore there is a lot of stigma and misconception attached to viral hepatitis among the general public. Policy-makers are aware of the issues but seem to be tied down due to other priorities and lack of funding. There is therefore a need for public awareness campaigns through the use of traditional communication channels spearheaded by the Government.

The Ministry of Health should start awareness programmes for health care workers through workshops and health economic studies to inform policy makers that acting on hepatitis can save the economy more than Government would spend. Collaboration exists among the National Organization for People Living with Hepatitis B, Uganda Gastroenterology Society and Giving Hope Foundation, and all are working towards the development of awareness and policies. The Government should leverage existing partnerships.

The Government should also extend the partnerships to include HIV and antenatal initiatives. Hepatitis can be easily combined with HIV initiatives as this would save infrastructure costs and also would ensure easier implementation of policies. The Ministry of Health should review HMIS to include hepatitis for proper data collection.

**Screening, care and treatment.** Lack of awareness, clear guidelines and referral system for testing, the diagnosis rate of hepatitis B and hepatitis C infections are very low. Hence the majority of cases present at a late stage, sometimes with complications. The high cost of hepatitis B and hepatitis C diagnosis is another factor contributing to lack of diagnosis. Generally 30% of hepatitis B cases and 45% to 70% of hepatitis C cases are eligible for treatment. However, 85% to 90% of hepatitis B cases receive treatment while only 1% to 5% of hepatitis C cases get treated. This disparity is mainly due to the unaffordability of hepatitis C treatment. Treatment for viral hepatitis is generally out-of-pocket. No government support or private insurance for treating viral hepatitis exists. The Ugandan government introduced HBsAg vaccine in the extended programme of immunisation for infants in 2002. However, this programme does not cover the vaccination of adults and at-risk population. Mothers are also still reluctant to have their babies immunized.

There is a need to conduct health economic studies to encourage support for diagnosis, prevention and treatment for viral hepatitis cases. Mothers should also be sensitised about the importance of immunisation programmes.

The Government should design proper guidelines to address diagnosis and treatment challenges and provide affordable sources of diagnostics. This would reduce cost of diagnosis and in turn increase the diagnosis rate.

* World Hepatitis Alliance member.
Region of the Americas
This chapter presents the region of the Americas findings from the World Hepatitis Alliance’s 2014 civil society survey in two sections.

The first section provides an overview of respondents. The second section describes the extent to which respondents agreed or disagreed with what their governments reported about hepatitis policies and programmes for the 2013 World Health Organization (WHO) Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States. It also notes the issues associated with the greatest amount of agreement and disagreement.

5.1. Respondents

Ten organisations from four countries in the region of the Americas responded to the World Hepatitis Alliance’s 2014 civil society survey. The governments of all of those countries provided information for the 2013 WHO global policy report, and thus all respondents were able to comment on the accuracy of their governments’ responses. Additional information about respondents is presented in Table 5.1.

Table 5.1. Region of the Americas respondents to the World Hepatitis Alliance’s 2014 civil society survey (N=10)

<table>
<thead>
<tr>
<th>Country</th>
<th>Civil society respondents (#)</th>
<th>NGO – hepatitis patient group</th>
<th>NGO – direct service provider</th>
<th>NGO – other</th>
<th>Medical society</th>
<th>Private foundation</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Canada</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mexico</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United States of America</td>
<td>4</td>
<td>1</td>
<td></td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Argentina
- Fundación HCV Sin Fronteras
- Hepatitis Rosario

Canada
- Action Hepatitis Canada/Action Hépatites Canada
- AIDS Kootenay Outreach Support Society (ANKORS)
- Hep C Support Group

Mexico
- Fundación Mexicana para la Salud Hepática

United States of America
- Hep Free Hawaii
- Hepatitis B Foundation
- Hep C Connection
- San Francisco Hepatitis C Task Force
Thirty percent of respondents identified themselves as hepatitis patient groups, and another 10% identified themselves as nongovernmental direct service providers (Figure 5.1).

Eighty percent of respondents were either voting or non-voting members of the World Hepatitis Alliance at the time they submitted their surveys (data not shown).

Seventy percent of respondents were based in high-income countries and the remainder were based in upper-middle-income countries (Figure 5.2).

5.2. Highlights relating to civil society agreement or disagreement with what governments reported

The civil society survey contained 25 items based on the information that governments provided for the 2013 WHO global policy report. For each item, civil society stakeholders were asked to consider the government response to one or more questions about national hepatitis policies and programmes, and to select one of the following three statements: To our knowledge, this information is accurate; To our knowledge, this information is not accurate; or We take no position regarding this statement.

Detailed findings for all civil society survey items are presented in Annex C. In sum, half of all civil society respondents thought that the information from their governments was accurate for 19 or more of the 25 items. Regarding the proportions of respondents who marked items as “not accurate,” more than half thought that the information from their governments was not accurate for at least six items.

The following survey items were most commonly identified as points on which civil society respondents in the region of the Americas agreed with their governments’ responses: item 3.3, regarding disease registration and reporting, and item 4.1, regarding the existence of a national hepatitis A vaccination policy. Further details are presented in Table 5.2.

The following survey items were most commonly identified as points on which civil society respondents in the region of the Americas disagreed with their governments’ responses: item 1.2, regarding the existence of a designated governmental unit/department responsible for viral hepatitis-related activities and the number of government staff working on hepatitis-related activities; item 1.3, regarding whether the government has a viral hepatitis prevention and control programme that includes activities targeting specific populations; item 2.1, regarding World Hepatitis Day activities and viral hepatitis awareness campaigns; item 2.2, regarding government collaboration with civil society groups; and item 4.2, regarding the goal of eliminating hepatitis B. Further details are presented in Table 5.3.
### Table 5.2. Survey items eliciting the highest levels of agreement from civil society respondents, region of the Americas (N=10)

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Question(s) addressed by governments for 2013 WHO global policy report</th>
<th># (%) of respondents who indicated agreement with their governments’ response(s) by selecting “to our knowledge, this information is accurate”</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3</td>
<td>Are liver cancer cases registered nationally?</td>
<td>9 (90.0%)</td>
</tr>
<tr>
<td></td>
<td>Are cases of HIV/hepatitis co-infection registered nationally?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How often are hepatitis disease reports published?</td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td>Is there a national hepatitis A vaccination policy?</td>
<td>9 (90.0%)</td>
</tr>
<tr>
<td></td>
<td>If yes, what groups does the policy address?</td>
<td></td>
</tr>
</tbody>
</table>

### Table 5.3. Survey items eliciting the highest levels of disagreement from civil society respondents, region of the Americas (N=10)

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Question(s) addressed by governments for 2013 WHO global policy report</th>
<th># (%) of respondents who indicated disagreement with their governments’ response(s) by selecting “to our knowledge, this information is not accurate”</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2</td>
<td>Is there a designated governmental unit/department responsible only for coordinating and/or carrying out viral hepatitis-related activities? If yes, what is its name?</td>
<td>4 (40.0%)</td>
</tr>
<tr>
<td></td>
<td>How many people work full-time (or how many full-time equivalent staff) on hepatitis-related activities in all government agencies/bodies?</td>
<td></td>
</tr>
<tr>
<td>1.3</td>
<td>Does your government have a viral hepatitis prevention and control programme that includes activities targeting specific populations? If yes, please indicate which populations.</td>
<td>3 (30.0%)</td>
</tr>
<tr>
<td>2.1</td>
<td>Did your government hold events for World Hepatitis Day 2012?</td>
<td>3 (30.0%)</td>
</tr>
<tr>
<td></td>
<td>Has your government funded any public viral hepatitis awareness campaigns since January 2011, other than World Hepatitis Day?</td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>Does your government collaborate with any civil society group within your country (such as patient groups or national or local nongovernmental organisations) to develop and implement its viral hepatitis prevention and control programme? If yes, please name major partners.</td>
<td>3 (30.0%)</td>
</tr>
<tr>
<td>4.2</td>
<td>Has your government established the goal of eliminating hepatitis B? If yes, in what timeframe?</td>
<td>5 (50.0%)</td>
</tr>
</tbody>
</table>
5.2 The government has national policies relating to screening and referral to care for hepatitis B and hepatitis C.

3.3 Liver cancer cases and cases with HIV/hepatitis coinfection are registered nationally. The government publishes hepatitis disease reports annually. The amount of information received is very low.

4.5 There is a specific national strategy and/or policy/guidelines for preventing hepatitis B and hepatitis C infection in health-care settings. Health-care workers are vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood.

4.6 There is a national policy on injection safety in health-care settings, which recommends single-use syringes for therapeutic injections. Single-use or auto-disable syringes, needles and cannulas are always available in all health-care facilities.

5.2 The government has national policies relating to screening and referral to care for hepatitis B and hepatitis C.

4.6 There is a national policy on injection safety in health-care settings, which recommends single-use syringes for therapeutic injections. Single-use or auto-disable syringes, needles and cannulas are always available in all health-care facilities.

4.6 This national strategy is not always respected around the country.

5.2 These policies are still insufficient.

2.1 The government held events for World Hepatitis Day 2012 and has funded other viral hepatitis public awareness campaigns since January 2011 (Annex A). July 28, 2012, the government participates in the first celebration. In 2013 made a little action in their offices, as it plans for this year 2014.

1.1 There is a written national strategy or plan that focuses exclusively on the prevention and control of viral hepatitis. It includes components for raising awareness, surveillance, vaccination, prevention in general, prevention of transmission in health-care settings, treatment and care, and coinfection with HIV. Only hepatitis C, and prevention information is scarce.

1.1 To our knowledge, this information is accurate.

3.3 Liver cancer cases and cases with HIV/hepatitis coinfection are registered nationally. The government publishes hepatitis disease reports annually. The amount of information received is very low.

3.3 The respondent took no position on the government information for 8.0% of items. Survey points marked “take no position”: 3.2 and 3.5.

3.3 Survey points marked “accurate”: 1.1, 1.2, 1.3, 2.1, 3.1, 3.3, 3.4, 4.1, 4.3, 4.4, 4.5, 4.6, 4.8, 4.9, 4.10, 5.2, 5.3, 5.4 and 5.5.

4.2 This national strategy is not always respected around the country.
### Information reported by government (2012–2013)

<table>
<thead>
<tr>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5.4</strong> Publicly funded treatment is available for hepatitis B and hepatitis C. The following groups are eligible: all people without social coverage. The government spends 40 million pesos (US$ 8.8 million) annually on publicly funded treatment for hepatitis B and hepatitis C.</td>
</tr>
<tr>
<td><strong>5.5</strong> The following drugs for treating hepatitis B are on the national essential medicines list or subsidised by the government: pegylated interferon, lamivudine, entecavir and tenofovir. The following drugs for treating hepatitis C are included on the national essential medicines list or subsidised by the government: pegylated interferon and ribavirin.</td>
</tr>
</tbody>
</table>

### Civil society respondent comments (2014)

<table>
<thead>
<tr>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is accurate, just do not know how much money the government intended for treatments.</td>
</tr>
<tr>
<td>Since 2014 also included telaprevir and boceprevir for hepatitis C.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5.4</strong> Publicly funded treatment is available for hepatitis B and hepatitis C. The following groups are eligible: all people without social coverage. The government spends 40 million pesos (US$ 8.8 million) annually on publicly funded treatment for hepatitis B and hepatitis C.</td>
<td>Is accurate, just do not know how much money the government intended for treatments.</td>
</tr>
<tr>
<td><strong>5.5</strong> The following drugs for treating hepatitis B are on the national essential medicines list or subsidised by the government: pegylated interferon, lamivudine, entecavir and tenofovir. The following drugs for treating hepatitis C are included on the national essential medicines list or subsidised by the government: pegylated interferon and ribavirin.</td>
<td>Since 2014 also included telaprevir and boceprevir for hepatitis C.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement from Fundación HCV Sin Fronteras regarding key hepatitis policy issues in Argentina:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The government does not conduct prevention and information campaigns for hepatitis C, works with his participation in campaigns by civil society or medical associations. No hits on hepatitis C in diffusion media. The government should carry out prevention campaigns, information, and especially hepatitis C screening.</td>
</tr>
<tr>
<td>Health professionals do not fully comply with mandatory reporting of cases of hepatitis B and hepatitis C. The information reported cases of hepatitis is poor. The difficulties are bureaucratic, centralising information is also missing cases are diagnosed in the field of private health. The government is working to improve this information but in our opinion the work is very slow. Missing strategies for the prevention of transmission of hepatitis C.</td>
</tr>
<tr>
<td>The government should do more biosecurity education campaigns in the health centres. Missing policies aimed at at-risk or vulnerable groups.</td>
</tr>
<tr>
<td>It is serious that our government does not have a policy of screening for hepatitis B and hepatitis C. A national and international level should promote detection of hepatitis and join forces to gather resources to make tests in at-risk populations.</td>
</tr>
</tbody>
</table>

| 4.2 The government has not established the goal of eliminating hepatitis B. |
| 5.1 Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through on-the-job training and postgraduate training. There are national clinical guidelines for the management of viral hepatitis, which include recommendations for cases with HIV coinfection. There are national clinical guidelines for the management of HIV, which include recommendations for coinfection with viral hepatitis. |
| The government introduced free universal hepatitis B vaccination with success, as well as advertising campaigns for vaccination. |
| There are also guidelines on hepatitis B and hepatitis C conducted in 2012. |

<table>
<thead>
<tr>
<th>To our knowledge, this information is not accurate.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fundación HCV Sin Fronteras participates on the honorary Advisory Committee of the National Hepatitis Programme, and is working with the Ministry of Health.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To our knowledge, this information is accurate.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The government collaborates with the following in-country civil society group to develop and implement its viral hepatitis prevention and control programme: Fundación HCV Sin Fronteras.</td>
</tr>
</tbody>
</table>

### Chapter 5: Region of the Americas

**Global Community Hepatitis Policy Report**

Chapter 5: Region of the Americas
SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Argentina reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 56.0% of items.
Survey points marked “accurate”: 1.1, 3.3, 4.1, 4.2, 4.3, 4.5, 4.6, 4.8, 4.9, 4.10, 5.1, 5.2, 5.3 and 5.5.

The government information was thought not to be accurate for 36.0% of items.
Survey points marked “not accurate”: 1.3, 2.1, 2.2, 3.1, 3.2, 3.4, 3.5, 4.4 and 4.7.

The respondent took no position on the government information for 8.0% of items.
Survey points marked “take no position”: 1.2 and 5.4.

Survey comments from Hepatitis Rosario:

3.3 Liver cancer cases and cases with HIV/hepatitis coinfection are registered nationally. The government publishes hepatitis disease reports annually.

Public hospitals give information.

4.3 Nationally, 94.4% of newborn infants in a given recent year received the first dose of hepatitis B vaccine within 24 hours of birth and 92.5% of one-year-olds (ages 12–23 months) in a given recent year received three doses of hepatitis B vaccine.

Yes, we do well with hepatitis A and hepatitis B until age 11. After this is the problem.

4.5 There is a specific national strategy and/or policy/guidelines for preventing hepatitis B and hepatitis C infection in health-care settings. Health-care workers are vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood.

Health workers are vaccinated.

4.8 There is a national infection control policy for blood banks. All donated blood units (including family donations) and blood products nationwide are screened for hepatitis B and hepatitis C.

Yes, in blood banks they screen for hepatitis.

4.9 There is no national policy relating to the prevention of viral hepatitis among people who inject drugs.

Nor do they even know who injects drugs.
### Information reported by government (2012–2013)

1. **3.1** The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific populations: health-care workers (including health-care waste handlers), people living with HIV and the uninsured.

2. **2.1** The government held events for World Hepatitis Day 2012 and has funded other viral hepatitis public awareness campaigns since January 2011 (Annex A).

3. **2.2** The government collaborates with the following in-country civil society group to develop and implement its viral hepatitis prevention and control programme: Fundación HCV Sin Fronteras.

4. **5.2** The government has national policies relating to screening and referral to care for hepatitis B and hepatitis C.

5. **5.3** People testing for both hepatitis B and hepatitis C register by name; the names are kept confidential within the system. Hepatitis B and hepatitis C tests are free of charge for all individuals and are not compulsory for members of any specific group.

6. **5.5** The following drugs for treating hepatitis B are on the national essential medicines list or subsidised by the government: pegylated interferon, lamivudine, entecavir and tenofovir. The following drugs for treating hepatitis C are included on the national essential medicines list or subsidised by the government: pegylated interferon and ribavirin.

### Civil society respondent comments (2014)

1. **1.3** The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific populations: health-care workers (including health-care waste handlers), people living with HIV and the uninsured.

2. **2.1** The government held events for World Hepatitis Day 2012 and has funded other viral hepatitis public awareness campaigns since January 2011 (Annex A).

3. **2.2** The government collaborates with the following in-country civil society group to develop and implement its viral hepatitis prevention and control programme: Fundación HCV Sin Fronteras.

4. **3.1** Yes, there is a national programme but it is bad, incomplete, bureaucratic to the point of exaggeration and therefore does not serve to detect the ill. It is a disgrace. Those who are ill do not know. The government does not pay much attention to this. It does very little. Their bureaucracy makes it difficult for them to tell the public that they do anything.

5. **3.2** People are free to be tested. But they do not know they should do it. As I’ve said, there is no good health policy for hepatitis.

6. **3.3** Yes, but we remind you that only very few people who have hepatitis are detected. In the province of Buenos Aires, which has 16 million inhabitants, there are 66 cases of ongoing hepatitis treatment. A shame.

7. **3.5** The government controls HIV very well. Very little importance is given to hepatitis. That is our fight. To report what the government does not report. They are complicit in the silence of the evolution of the disease. There is not good public health policy.

8. **3.6** There are only 12 Argentinian groups. It is very difficult to reach the government and get them to listen to us. The 12 groups manage the campaigns. The government only does a small amount of vaccination against hepatitis B. There is a lack of education, prevention, information and, logically, treatments.

9. **3.7** Fundación HCV Sin Fronteras is like a mother of the Argentinian groups. The government collaborates too little. People develop badly and do not know they have hepatitis.
3.1 There is routine surveillance for viral hepatitis. There is a national surveillance system for the following types of acute hepatitis: A, B, C, D and E, and for the following types of chronic hepatitis: B, C and D.

3.2 There are standard case definitions for hepatitis. Deaths, including from hepatitis, are reported to a central registry. Information was not provided regarding the percentage of hepatitis cases reported as "undifferentiated" or "unknown" hepatitis.

3.4 Hepatitis outbreaks are required to be reported to the government and are further investigated. There is adequate laboratory capacity nationally to support investigation of viral hepatitis outbreaks and other surveillance activities.

3.5 There is a national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are conducted regularly; the target population is children. Information was not provided regarding when the last serosurvey was carried out.

4.4 There is a national policy specifically targeting mother-to-child transmission of hepatitis B (Annex B).

4.7 Official government estimates of the number and percentage of unnecessary injections administered annually in health-care settings are not known.

Information reported by government (2012–2013)

To our knowledge, this information is not accurate.

There is vaccination for hepatitis A and B, not massive, but pretty good. There is no information about the existence of hepatitis C. When a patient arrives at a public hospital, it normally follows. This is the problem. When they arrive, what happens is people do not know they have this silent disease and will develop in darkness/ignorance.

Confirmed statistics do not exist anywhere in Argentina. It is assumed that 1,000,000 people are infected with hepatitis B and hepatitis C, but this is data taken from the blood banks. Therefore it is not accurate.

I am overwhelmed by the government’s disinterest in keeping statistics.

All newborns are vaccinated against hepatitis B and again when they turn 11 years old. It seems the rest does not interest them. We are the groups that report this.

No, we are fighting to get statistics.

All disposable material is used.
**Statement from Hepatitis Rosario regarding key hepatitis policy issues in Argentina:**

The main problem is ignorance. They do not do timely diagnosis for then subsequent timely treatment.

Health policy must be changed so that people have access to prevention, screening and treatment.

**Information reported by government (2012–2013)**

1.2 There is a designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities. This programme is part of the AIDS and STD Directorate. Information was not provided regarding how many staff members this office has. There are eight full-time equivalent staff members who work on hepatitis-related activities in all government agencies/bodies.

**Civil society respondent comments (2014)**

National Hepatitis, HIV and STI Programme exists. It works with lots of bureaucracy and does not reach the majority of people.

5.4 Publicly funded treatment is available for hepatitis B and hepatitis C. The following groups are eligible: all people without social coverage. The government spends 40 million pesos (US$ 8.8 million) annually on publicly funded treatment for hepatitis B and hepatitis C.

I do not know what they do. We were never told.

The government has all responsibility and should produce statistics for all of Argentina. In order to vaccinate, prevent, screen and give treatments for all.

Our role is to collaborate. But in reality if we exist, it is because governments do not fulfil their functions globally.

The evidence shows that people in general will only learn about chronic viral hepatitis thanks to the work of helping organisations. And not thanks to information from governments. Our work is not paid for by anyone. And our main collaborators are doctors and hepatologists.
Canada

Action Hepatitis Canada/Action Hépatites Canada

NGO – national coalition of hepatitis B and hepatitis C organisations
Victoria, British Columbia, Canada
http://www.actionhepatitiscanada.ca

SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Canada reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3 The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific populations: health-care workers (including health-care waste handlers), people who inject drugs, migrants, prisoners, the homeless, people living with HIV, low-income populations, indigenous people, ethnocultural populations and youth.</td>
<td>However, the level at which prevention and control programmes are delivered is far from adequate and there lacks coordination between federal and provincial governments for whom this is a shared responsibility. The federal government shows little leadership and in fact hampers efforts by some provinces especially in the areas of harm reduction. No consistency from one institution to another either federally or provincially. No needle exchanges in prisons. Condoms, bleach and other harm measures not always readily available as they should be. It can be difficult for prisoners to access a doctor or a nurse. Consequently, HIV, hepatitis B and hepatitis C infection rates remain quite high in the prison system despite being preventable infections.</td>
</tr>
<tr>
<td>3.4 Hepatitis outbreaks are reported to local public health authorities and are further investigated only at the local level. There is adequate laboratory capacity nationally to support investigation of viral hepatitis outbreaks and other surveillance activities.</td>
<td>Hepatitis B is a reportable disease as is hepatitis C and reported to Health Canada. Reporting parameters should be expanded; the details required are currently limited so important indicators such as genotype and access to treatment are not consistently monitored. There should be systematic HIV, hepatitis B and hepatitis C testing at annual check-ups particularly for those at risk either because of lifestyle or age group (baby boomers) who may have been infected and do not know.</td>
</tr>
<tr>
<td>3.5 There is a national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are conducted regularly; the target population is the general population. The last serosurvey was carried out from 2009 to 2011.</td>
<td>Insufficient funding both federally and provincially/territorially (for non-pharmaceutical research topics and areas). Greater overall coordination needed nationally. Lack of transparency as to how federal funds are used. More psycho-social focused research funding needed, including community-based research. Need for a coordinated national knowledge dissemination and sharing mechanism with sufficient and reliable financial support from provincial, territorial and federal governments.</td>
</tr>
</tbody>
</table>

Survey comments from Action Hepatitis Canada/Action Hépatites Canada:

To our knowledge, this information is accurate.

The government information was thought to be accurate for 56.0% of items.

Survey points marked “accurate”:
1.3, 3.1, 3.3, 3.4, 3.5, 4.1, 4.4, 4.6, 4.7, 4.8, 4.10, 5.1, 5.2 and 5.3.

The government information was thought to not be accurate for 44.0% of items.

Survey points marked “not accurate”:
1.1, 1.2, 2.1, 2.2, 3.2, 4.2, 4.3, 4.5, 4.9, 5.4 and 5.5.

To our knowledge, this information is accurate.
5.1 Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools of health professionals (pre-service education), on-the-job training and post-graduate training. There are national clinical guidelines for the management of viral hepatitis, which include recommendations for cases with HIV coinfection.

To our knowledge, this information is accurate.

4.4 There is a national policy specifically targeting mother-to-child transmission of hepatitis B.

To our knowledge, this information is accurate.

1.1 There is a written national strategy or plan that focuses primarily on the prevention and control of viral hepatitis, and also integrates other diseases. It includes components for raising awareness, surveillance, vaccination, prevention in general, prevention of transmission via injecting drug use, prevention of transmission in health-care settings, treatment and care, and coinfection with HIV.

To our knowledge, this information is not accurate.

Civil society respondent comments (2014)

The Public Health Agency of Canada (PHAC) recommends infants born to hepatitis B-positive mothers receive the appropriate dose of hepatitis B vaccine within 12 hours of birth and one at one month of age. The third needle is given at six months of age. Immune globulin is also given at birth. PHAC recommends that all pregnant women be routinely screened for hepatitis B. Nothing noted about counselling. PHAC does not recommend pregnant women be routinely screened for hepatitis C.

Hepatitis B and hepatitis C training and continuing education are available to various levels of healthcare providers in a variety of formats. Training needs to be mandatory for emergency room staff and nurses. More efforts are required to improve enrolment and uptake of knowledge.

The Public Health Agency of Canada (PHAC) did a national consultation in 2008 and released a report in 2009 in the form of a framework which was coined as a renewed public health response to address hepatitis C. (http://publications.gc.ca/collections/collection_2010/aspc-phac/HP40-44-2009-eng.pdf) PHAC often refers to this framework as a national strategy but in effect it is not a national strategy which PHAC representatives have publicly acknowledged. Canada has yet to have a written national strategy which the medical and civil society communities have been requesting Health Canada to create. Provincial funding has been relatively stable and supportive in some instances, but in others has been inadequate or non-existent. Federal funding has been inconsistent, and delays in renewing funding agreements has been an ongoing problem putting at risk the very existence of many organisations. PHAC has not lived up to its ongoing funding promise made by the Minister of Health in 2008. Resources are still scarce and difficult to access. Strong resistance at the federal level to the concept of harm reduction.
2.2 The government collaborates with the following in-country civil society groups to develop and implement its viral hepatitis prevention and control programme: Canadian Society for International Health, Canadian AIDS treatment Information Exchange and University of British Columbia Hepatitis Services.

This list should be more extensive as the Public Health Agency of Canada (PHAC) has funded many more civil society groups and has renewed the funding for the next three years. No new groups however may be funded until PHAC completes its reforms.

3.2 There are standard case definitions for hepatitis. Deaths, including from hepatitis, are reported to a central registry. Of hepatitis cases, 0%–10.0% is reported as “undifferentiated” or “unclassified” hepatitis.

National acute and chronic definitions are used, but a case definition for resolved infection is required.

4.2 The government has established the goal of eliminating hepatitis B but information was not provided about a specific timeframe for this goal.

Hepatitis B vaccine programmes are supposed to be publicly funded across Canada which is not the case in all provinces as some Canadians must pay and others do not have to. Greater consistency is needed both in terms of availability for all children and public coverage.
### Information reported by government (2012–2013)

| 4.3 | Information was not provided on the percentage of newborn infants nationally in a given recent year who received the first dose of hepatitis B vaccine within 24 hours of birth or the percentage of one-year-olds nationally (ages 12–23 months) in a given recent year who received three doses of hepatitis B vaccine. |
| 4.5 | There is a specific national strategy and/or policy/guidelines for preventing hepatitis B and hepatitis C infection in health-care settings. Health-care workers are vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood. |

### Civil society respondent comments (2014)

| 4.9 | There is a national policy relating to the prevention of viral hepatitis among people who inject drugs. |
| 5.4 | Publicly funded treatment is available for hepatitis B and hepatitis C. All Canadian residents are eligible for this. The amount spent by the government on such treatment for hepatitis B and hepatitis C is not known. |

Publicly-funded hepatitis B vaccination programmes are available in all provinces and territories. The age at which vaccinations are offered varies from region to region. The Public Health Agency of Canada (PHAC) recommends universal hepatitis B vaccination; schedule varies from region to region. PHAC recommends hepatitis B vaccination specifically for those at risk (e.g. health care workers, people who use drugs, newcomers to Canada). PHAC recommends pre-exposure prophylaxis for individuals at risk of hepatitis A infection or at risk of greater severity of hepatitis A infection. The combined hepatitis A/hepatitis B vaccine is recommended to children scheduled for hepatitis B vaccine who have an indication for hepatitis A virus and for groups at risk of either type of hepatitis.

Health-care settings and correctional facilities have up-to-date and enforced infection control policies. Personal services settings (body art, beauty, acupuncturist facilities) need to be regulated across the nation and control/enforcement measures put into place. In a few locations, the personal services settings industry is creating training and testing for practitioners, and some cities are working to develop more stringent control/enforcement measures as well as public education.

This is an opportunity to treat, prevent and educate a very high-risk population in relation to viral hepatitis and other infectious diseases, as well as drug treatment strategies including methadone. No consistency from one institution to another either federally or provincially. No needle exchanges in prisons. Condoms, bleach and other harm reduction measures not always readily available as they should be. It can be difficult for prisoners to access a doctor or a nurse. Consequently, HIV, hepatitis B and hepatitis C infection rates remain quite high in the prison system despite being preventable infections.

Hepatitis B treatment and hepatitis C treatment are generally available but not uniformly in all Canadian regions or in all correctional settings. More specialists are needed and waiting time needs to be reduced. Individuals perceived as at risk of re-infection need to be treated along with supports and services that help ensure preventing re-infection. Cost for treatment disparities need to be reduced or eliminated.
Chapter 5: Region of the Americas

Canada

Action Hepatitis Canada/Action Hépatites Canada continued

Information reported by government (2012–2013)

The following drugs for treating hepatitis B are on the national essential medicines list or subsidised by the government: interferon alpha, pegylated interferon, lamivudine, adefovir dipivoxil, entecavir and telbivudine. The following drugs for treating hepatitis C are on the national essential medicines list or subsidised by the government: pegylated interferon, ribavirin, boceprevir and telaprevir.

Civil society respondent comments (2014)

Drug approval process is good but more consistency in coverage and access among provinces would be desirable. Sometimes drugs can receive a fast track review by Health Canada. In general, once approved by Health Canada provinces can be very slow to review them and approve them for their own formulary. Each province makes its own decisions, leading to inequities across Canada. Eligibility criteria established by provinces are not always based on medical recommendations and are usually more restrictive, creating access issues for some individuals who would benefit from treatment. One national drug plan would be desirable.

Statement from Action Hepatitis Canada/Action Hépatites Canada regarding key hepatitis policy issues in Canada:

Action Hepatitis Canada has been calling on Canadian federal, provincial and territorial governments to adopt measures that address the international and national viral hepatitis epidemic from a public health perspective. More specifically, the Coalition urges the Canadian government to adopt a fully-funded coordinated national strategy for both hepatitis B and hepatitis C by 2012 that:

- Promotes prevention of hepatitis B and C through expanded education, immunisation and harm reduction programmes all across Canada.
- Improves access to comprehensive care and treatment programmes in all areas of the country.
- Increases knowledge and innovation through interdisciplinary research and surveillance to reduce the burden of hepatitis B and hepatitis C on Canadians.
- Creates awareness about risk factors, stigma and the need for testing among the general population and at-risk groups.
- Builds capacity through training and recruitment of qualified health professionals.
- Supports communities and community-based groups in developing, delivering and evaluating peer-driven and focused initiatives.

As a way to obtain a snapshot of the state of the nation with respect to these “Six Asks,” the Coalition prepared a report card in July 2011 which identifies what is being successfully achieved as well as gaps that must be addressed and uses this information to develop a grade reflecting the current performance of the Canadian federal, provincial and territorial governments. The following year, updates were made to the report card. The report card can be consulted at: http://www.actionhepatitiscanada.ca/wp-content/uploads/2012/07/Hepatitis-Strategy-Report-Card.pdf.

Monitoring of government responses to our initial national Six Asks indicated that there remained much to be achieved as we approached the original 2012 deadline. In looking at the national situation just prior to the 2012 deadline, three priority areas were identified for which we asked that concrete measures be implemented before the end of 2012. These priority areas are:

- Increasing awareness and preventing hepatitis B and hepatitis C infections among at-risk populations.
- Improving access to health care and drug coverage.
- Supporting communities and groups through stable funding for prevention, education, care and support.

While new, very effective drugs have been developed, they are not yet available to all Canadians who desperately need them. In the United States, the Centers for Disease Control and Prevention urges people born between 1945 and 1965 to be tested, noting that roughly 75% of people with the disease are baby boomers. Canada has no plans to follow the lead of the United States and urge all baby boomers to be tested. The Public Health Agency of Canada is currently reviewing its options, and a report is to be completed that “will help shape our future hep C screening guidelines.” Canada should not drag its feet. Our baby boomers are no less at risk.

Action Hepatitis Canada produced a “Briefing Note: Hepatitis B & Hepatitis C” which provides a snapshot of the burden of hepatitis B and hepatitis C and the socio-economic costs in Canada.

To our knowledge, this information is not accurate.

(The briefing note can be consulted here: http://www.actionhepatitiscanada.ca/wp-content/uploads/2012/07/Briefing-Note-final-2.pdf) Effective medicines and control strategies are available to dramatically reduce suffering and deaths caused by these diseases and yet federal, provincial and territorial governments have not put forth concerted efforts to fight hepatitis B and hepatitis C by providing adequate funding and national policy to ensure success.

There are many factors that contribute to the burdens of hepatitis B and hepatitis C, and those living with and affected by hepatitis B and hepatitis C not only suffer from the disease but also stigmatisation, shame and anguish. The magnitude of the impact on human lives and to society can be minimised and/or avoided at lower costs with the correct management strategies initiated today. Healthy outcomes for individuals can be achieved as well as solutions to the key determinants through enhanced cross-sectorial collaborations, increased funding and prioritised spending.

In a July 2012 letter, we asked our elected government officials to provide leadership in addressing the issues and gaps identified in Action Hepatitis Canada’s briefing note and strengthen the delivery of hepatitis B and hepatitis C healthcare to reach the entire population, particularly the most vulnerable and difficult-to-reach. This leadership has yet to be seen. At the 3rd Canadian Symposium on Hepatitis C Virus held in Toronto February 7, 2014, the request to the federal government for a national strategy was once again made to the government of Canada’s representatives by attending participants from both the medical and civil society communities.

One national drug plan would be desirable.
The respondent reviewed 25 items of information that the government of Canada reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States. The government information was thought to be accurate for 96.0% of items.

Survey points marked “accurate”:
1.1, 1.3, 2.1, 2.2, 3.1, 3.2, 3.3, 3.4, 3.5, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, 4.10, 5.1, 5.2, 5.3, 5.4 and 5.5.

The government information was thought to not be accurate for 4.0% of items.

Survey points marked “not accurate”:
1.2.

The AIDS Kootenay Outreach Support Society did not provide any comments about survey items. The respondent also did not provide a statement regarding key hepatitis policy issues in Canada.
Canada

Hep C Support Group*
NGO – hepatitis patient group
Robson, British Columbia, Canada

SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Canada reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

✓ The government information was thought to be accurate for 56.0% of items.
  Survey points marked “accurate”: 1.1, 2.1, 2.2, 3.1, 3.3, 3.4, 4.3, 4.5, 4.7, 4.10, 5.1, 5.2, 5.3, and 5.4.

✗ The government information was thought to not be accurate for 36.0% of items.
  Survey points marked “not accurate”: 1.2, 1.3, 3.2, 3.5, 4.1, 4.2, 4.4, 4.6, and 4.9.

→ The respondent took no position on the government information for 8.0% of items.
  Survey points marked “take no position”: 4.8, and 5.5.

The Hep C Support Group did not provide any comments about survey items.

Statement from the Hep C Support Group regarding key hepatitis policy issues in Canada:

National coordination. Very poorly set up.

Awareness-raising, partnerships and resource mobilisation. Not enough done in this area.

Evidence-based policy and data for action. All governments are not doing enough or paying for treatment for those who were infected through the blood supply. We are left out in the cold, in hopes we soon all die off. Treatment options too expensive for most people who suffer, as stigma has put them in a bad financial situation. Put more funding into action rather than statistics.

Prevention of transmission. Local government should be involved and health workers need more training.

Screening, care and treatment. I cannot find any evidence that they are doing anything.
SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Mexico reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

- The government information was thought to be accurate for 24.0% of items.
  - Survey points marked “accurate”: 3.1, 3.3, 3.4, 3.5, 4.1 and 4.6.
- The government information was thought to not be accurate for 32.0% of items.
  - Survey points marked “not accurate”: 1.1, 1.2, 1.3, 2.1, 2.2, 4.2, 4.4 and 4.7.
- The respondent took no position on the government information for 8.0% of items.
  - Survey points marked “take no position”: 3.2 and 4.3.
- The respondent did not select an answer for 36.0% of items.
  - Survey points for which no answer was selected: 4.5, 4.8, 4.9, 4.10, 5.1, 5.2, 5.3, 5.4 and 5.5.

Survey comments from Fundación Mexicana para la Salud Hepática:

<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 There is routine surveillance for viral hepatitis. There is a national surveillance system for the following types of acute hepatitis: A, B, C and D, but not for any type of chronic hepatitis.</td>
<td>The Mexican government does not have specific programmes dedicated exclusively to the prevention and control of viral hepatitis. The government does vaccinate against Hepatitis B and screens blood in blood banks, but those measures are not part of comprehensive strategies.</td>
</tr>
<tr>
<td>3.3 Information was not provided on whether liver cancer cases are registered nationally. Cases with HIV/hepatitis coinfection are not registered nationally. The government publishes hepatitis disease reports annually.</td>
<td>The Mexican health system cannot provide those as a whole. Their different institutions (Instituto Mexicano del Seguro Social, Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado, Secretaría de Salud, Seguro Popular) can provide separate data. There is no specific report for hepatitis.</td>
</tr>
<tr>
<td>3.4 Hepatitis outbreaks are required to be reported to the government and are further investigated. Information was not provided on whether there is adequate laboratory capacity nationally to support investigation of viral hepatitis outbreaks and other surveillance activities.</td>
<td>The outbreaks reported area basically hepatitis A. There is a national network of laboratories.</td>
</tr>
<tr>
<td>4.1 Information was not provided on whether there is a national policy on hepatitis A vaccination.</td>
<td>Vaccination for Hepatitis A is not a public policy in Mexico.</td>
</tr>
<tr>
<td>4.6 Information was not provided on whether there is a national policy on injection safety in health-care settings, or whether single-use or auto-disable syringes, needles and cannulas are always available in all health-care facilities.</td>
<td>There is a policy about injection safety and biologics disposal for the whole health system.</td>
</tr>
</tbody>
</table>

* World Hepatitis Alliance member.
### Mexico

**Fundación Mexicana para la Salud Hepática continued**

<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Information was not provided on whether there is a written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis.</td>
<td>The Mexican Government does not have a written national strategy or plan focused on any aspect of viral hepatitis.</td>
</tr>
<tr>
<td>1.2 Information was not provided on whether there is a designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities, or how many people work full-time on hepatitis-related activities in all government agencies/bodies.</td>
<td>The Mexican Government does not have a designated unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities.</td>
</tr>
<tr>
<td>1.3 Information was not provided on whether the government has a viral hepatitis prevention and control programme that includes activities targeting specific populations.</td>
<td>The Mexican government does not have specific programmes dedicated exclusively to the prevention and control of viral hepatitis. The government does vaccinate against Hepatitis B and screens blood in blood banks but those measures are not part of comprehensive strategies.</td>
</tr>
<tr>
<td>2.1 Information was not provided on whether the government held events for World Hepatitis Day 2012 or funded other viral hepatitis public awareness campaigns since January 2011.</td>
<td>In all World Hepatitis Day Events since 2011 the Government has not been present.</td>
</tr>
<tr>
<td>2.2 Information was not provided on whether the government collaborates within country civil society groups to develop and implement its viral hepatitis prevention and control programme.</td>
<td>There is no formal collaboration with civil society; some sporadic activities at the state level.</td>
</tr>
<tr>
<td>4.2 Information was not provided on whether the government has established the goal of eliminating hepatitis B.</td>
<td>Hepatitis B vaccination has been in place since 1998. In 2012 almost 18 million children were vaccinated. Fundación Mexicana para la Salud Hepática was the main force behind the approval of the vaccine in 1998.</td>
</tr>
<tr>
<td>4.4 Information was not provided on whether there is a national policy that specifically targets mother-to-child transmission of hepatitis B.</td>
<td>There is no specific programme.</td>
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<tr>
<td>Information reported by government (2012–2013)</td>
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<tr>
<td>3.2 There are standard case definitions for hepatitis. Deaths, including from hepatitis, are reported to a central registry. Of the hepatitis cases, 10.2% are reported as “undifferentiated” or “unclassified” hepatitis.</td>
<td>There is a classification but that category is mixed with hepatic diseases. All kinds of hepatitis viruses are mixed together.</td>
</tr>
<tr>
<td>4.5 Information was not provided on whether there is a specific national strategy and/or policy/guidelines for preventing hepatitis B and hepatitis C infection in health-care settings, or whether health-care workers are vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood.</td>
<td>There are initiatives for general precautions but not a specific programme dedicated to preventing hepatitis in health-care settings.</td>
</tr>
<tr>
<td>4.8 Information was not provided on whether there is a national infection control policy for blood banks and whether all donated blood units (including family donations) and blood products nationwide are screened for hepatitis B and hepatitis C.</td>
<td>The government does vaccinate against hepatitis B and screens blood for hepatitis B and hepatitis C in blood banks, but those measures are not part of comprehensive strategies.</td>
</tr>
<tr>
<td>4.9 Information was not provided on whether there is a national policy relating to the prevention of viral hepatitis among people who inject drugs.</td>
<td>There is no national policy regarding the issue.</td>
</tr>
<tr>
<td>4.10 Information was not provided on whether the government has guidelines that address how hepatitis A and hepatitis E can be prevented through food and water safety.</td>
<td>There are guidelines focused on hepatitis A.</td>
</tr>
<tr>
<td>5.1 Information was not provided on how health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis. Information was not provided on whether there are national clinical guidelines for the management of viral hepatitis and for the management of HIV, and whether the latter include recommendations for coinfection with viral hepatitis.</td>
<td>Health professionals specialised during their residence and attending to congresses. There are guidelines for hepatitis C and HIV; both include coinfection.</td>
</tr>
<tr>
<td>5.3 Information was not provided on whether people testing for hepatitis B or hepatitis C register by name, and whether hepatitis B or hepatitis C tests are free of charge for all individuals or compulsory for members of any specific group.</td>
<td>The tests are performed free only when you donate blood in blood banks (hepatitis B and hepatitis C). No name is captured and there is no compulsory testing for any group.</td>
</tr>
</tbody>
</table>
### Information reported by government (2012–2013)

| 5.4 | Information was not provided on whether publicly funded treatment is available for hepatitis B or hepatitis C and, if so, who is eligible for this. |
| 5.5 | Information was not provided on whether any drug for treating hepatitis B and hepatitis C is on the national essential medicines list or subsidised by the government. |

### Civil society respondent comments (2014)

- **Hepatitis B** is covered in Instituto Mexicano del Seguro Social and Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (50% of the population) with access to entecavir. Seguro popular (people without social security) does not cover hepatitis B.

- **Hepatitis C** is covered in Instituto Mexicano del Seguro Social and Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado with access to pegylated interferon, no access to boceprevir. Telaprevir has not been launched in Mexico.

- Seguro Popular formally included in 2012 hepatitis C as part of the coverage, but only one hospital is providing interferon treatment. Of course, no access to boceprevir or other new drugs.

- Seguro Popular only covers people under age 50.

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**Statement from Fundación Mexicana para la Salud Hepática regarding key hepatitis policy issues in Mexico:**

The Mexican health system works in silos – different parts do not communicate and do not coordinate. In the case of HIV/AIDS, there is a National Council against AIDS that helps as a governance body to coordinate activities. In this council, civil society organisations have representation.

Hepatitis C in Mexico should be treated in a similar fashion. We should have a national programme and a council making sure that the response against hepatitis is coordinated among different institutions in Mexico.

The role of Government would be to create this programme and council, making sure that the decisions taken by this body are mandatory. The Government should also provide high-level representatives for the discussions.

The role of civil society would be to monitor the implementation of public policy and collaborate to raise awareness among the general population. There is also a critical role to make sure patients adhere to treatment to make sure that investment is not wasted. This could be done by support groups backed by governments (federal and state) as well as pharmaceutical companies.
SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of the United States reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 76.0% of items.

Survey points marked “accurate”:
1.1, 1.2, 1.3, 2.1, 2.2, 3.2, 3.3, 3.5, 4.1,
4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 5.1,
5.4 and 5.5.

The government information was thought to not be accurate for 24.0% of items.

Survey points marked “not accurate”:
3.1, 3.4, 4.9, 4.10, 5.2 and 5.3.

Hep Free Hawaii did not provide any comments about survey items. The respondent also did not provide a statement regarding key hepatitis policy issues in the United States.
There is a national policy specifically targeting mother-to-child transmission of hepatitis B. All pregnant women in the United States are required to be tested for hepatitis B to ensure that appropriate post-exposure prophylaxis is provided to their newborns within the first 12 to 24 hours after delivery.

The government has national policies relating to screening and referral to care for hepatitis B and hepatitis C. All pregnant women in the United States are required to be tested for hepatitis B to ensure that appropriate post-exposure prophylaxis is provided to their newborns within the first 12 to 24 hours after delivery.

The respondent took no position on the government information for 12.0% of items. Survey points marked “take no position”: 3.4, 4.6 and 4.7.

Survey comments from the Hepatitis B Foundation:

- To our knowledge, this information is accurate.
  - 2.2 The government collaborates with the following in-country civil society groups to develop and implement its viral hepatitis prevention and control programme: Viral Hepatitis Action Coalition (VHAC), National Viral Hepatitis Roundtable and Asia and Pacific Alliance to Eliminate Viral Hepatitis.

- To our knowledge, this information is not accurate.
  - 3.1 There is routine surveillance for viral hepatitis. There is a national surveillance system for the following types of acute hepatitis: A, B, C and D. There is a national surveillance system for the following types of chronic hepatitis: B and C.
  - 4.4 There is a national policy specifically targeting mother-to-child transmission of hepatitis B.

The United States Centers for Disease Control and Prevention is officially working with Hep B United, a national coalition of community coalitions across the country working to reduce hepatitis B infection and liver cancer.

All pregnant women in the United States are required to be tested for hepatitis B to ensure that appropriate post-exposure prophylaxis is provided to their newborns within the first 12 to 24 hours after delivery.

To clarify, the government has national “recommendations” relating to screening and referral to care. They are not policies, in that they do not need to be followed — they are intended to guide practice.

To the best of our knowledge, there is no national surveillance system for chronic hepatitis B. There are smaller, targeted federally funded surveillance programmes for chronic hepatitis B in strategic areas of the country (i.e. New York City, Philadelphia, Massachusetts).
The government has established the goal of eliminating hepatitis B but information was not provided about a specific timeframe for this goal.

The government has responded to the viral hepatitis epidemic with the Viral Hepatitis Action Plan that was initiated in 2011 through 2013. A renewal of this three-year plan is currently underway with release expected in May 2014. The goal is to ultimately eliminate viral hepatitis, but the specific objectives for the next three years are to improve viral hepatitis prevention and ensure that infected persons are identified and provided care and treatment; and to improve coordination of viral hepatitis activities and promote collaborations.

Statement from the Hepatitis B Foundation regarding key hepatitis policy issues in the United States:

Viral hepatitis B and C continue to be seriously under-diagnosed and under-estimated diseases in the United States. Up to 70% of infected individuals remain undiagnosed. Less than 15% of people with chronic hepatitis B receive treatment. These lapses are due to a number of factors, including: translating policy into practice (reimbursement procedures, screening recommendations) which has led to a lack of routine screening at the primary care level; having a health care system that does not offer appropriate access to health care for the highest risk and most underserved communities; and disease-related stigmatisation. Having enforceable policies in place would help to improve routine viral hepatitis screening and linkage to care. Additionally, the government should be responsible for developing an enhanced, national surveillance system for chronic hepatitis B and hepatitis C, so that these diseases will not be underestimated. Other stakeholders, including those involved in health care, non-profit research and public health should collaborate to make hepatitis B and hepatitis C screening and linkage to care a priority – this should include improving infrastructure in high-risk communities, delivering education to providers and community members, and working to reduce socio-economic barriers to these services.
SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of the United States reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 100% of items.

Survey comments from Hep C Connection:

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<tbody>
<tr>
<td>3.1 There is routine surveillance for viral hepatitis. There is a national surveillance system for the following types of acute hepatitis: A, B, C and D. There is a national surveillance system for the following types of chronic hepatitis: B and C.</td>
<td>The chronic surveillance system is for a limited number of states and cities.</td>
</tr>
<tr>
<td>5.4 Publicly funded treatment is not available for hepatitis B or hepatitis C.</td>
<td>To an extent it is through Medicaid.</td>
</tr>
</tbody>
</table>

Statement from the Hep C Connection regarding key hepatitis policy issues in the United States:

The United States Health and Human Services agency has spent a lot of time and resources creating a viral hepatitis action plan and then updating it with results. The plan involves many federal agencies and specific activities that will help identify patients with the virus, provide linkage to care, increase providers who treat, and develop awareness about viral hepatitis. The plan is ambitious given that our federal budget does not provide a lot of financial resources to implement it. The federal government should increase funding; however, that is unlikely to happen. Other stakeholders, non-profits such as Hep C Connection, should continue to try to implement specific strategies in their own communities that have been identified in the Health and Human Services action plan. The United States Centers for Disease Control and Prevention viral hepatitis budget is roughly US$ 29,000,000, which is a pittance compared to HIV funding and the overall federal government budget.
### SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of the United States reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

<table>
<thead>
<tr>
<th>Survey comments from the San Francisco Hepatitis C Task Force:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Information reported by government (2012–2013)</strong></td>
</tr>
<tr>
<td><strong>Civil society respondent comments (2014)</strong></td>
</tr>
<tr>
<td><strong>To our knowledge, this information is accurate.</strong></td>
</tr>
<tr>
<td><strong>To our knowledge, this information is not accurate.</strong></td>
</tr>
<tr>
<td>2.1 The government held events for World Hepatitis Day 2012. It has funded other viral hepatitis public awareness campaigns since January 2011 (Annex A).</td>
</tr>
<tr>
<td>5.1 Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools of health professionals (pre-service education), on-the-job training, post-graduate training and continuing medical education. There are national clinical guidelines for the management of viral hepatitis. These guidelines include recommendations for cases of HIV coinfection.</td>
</tr>
</tbody>
</table>

* World Hepatitis Alliance member.
5.4 Publicly funded treatment is not available for hepatitis B or hepatitis C.

5.5 The following hepatitis B drugs are included on the national essential medicines list or are subsidised by the government: interferon alpha, pegylated interferon, lamivudine, adefovir dipivoxil, entecavir, telbivudine and tenofovir. The following hepatitis C drugs are included on the national essential medicines list or are subsidised by the government: interferon alpha, pegylated interferon, ribavirin, boceprevir and telaprevir.

To our knowledge, the United States does not have a national list.

5.4 Publicly funded treatment is not available for hepatitis B or hepatitis C.

Some types of public funding – generally at the state level – cover treatment.

To our knowledge, the United States does not have a national list.

We take no position regarding this statement.

3.1 There is routine surveillance for viral hepatitis. There is a national surveillance system for the following types of acute hepatitis: A, B, C and D. There is a national surveillance system for the following types of chronic hepatitis: B and C.

Surveillance in the United States is inadequate.

3.5 There is not a national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are conducted regularly; the target populations are children over the age of six and the general population. The last serosurvey was carried out in 2011.

No national public health research agenda is accurate.

Statement from the San Francisco Hepatitis C Task Force regarding key hepatitis policy issues in the United States:

The San Francisco Hepatitis C Task Force feels the United States does not adequately address any of the following topics:

- national coordination;
- awareness-raising, partnerships and resource mobilisation;
- evidence-based policy and data for action;
- prevention of transmission;
- screening, care and treatment

Services department does not even have a website maintained specifically for viral hepatitis.

Legislative action has been sorely lacking. State coordinators, who could play a vital role in the national response, also have tiny budgets. Other stakeholders such as task forces like ourselves are ready and willing to work on viral hepatitis issues at all levels.
Eastern Mediterranean Region
This chapter presents Eastern Mediterranean region findings from the World Hepatitis Alliance’s 2014 civil society survey in two sections.

The first section provides an overview of respondents. The second section describes the extent to which respondents agreed or disagreed with what their governments reported about hepatitis policies and programmes for the 2013 World Health Organization (WHO) Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States. It also notes the issues associated with the greatest amount of agreement and disagreement.

6.1. Respondents

Six organisations from five countries in the Eastern Mediterranean region responded to the World Hepatitis Alliance’s 2014 civil society survey. The governments of all of those countries provided information for the 2013 WHO global policy report, and thus all respondents were able to comment on the accuracy of their governments’ responses. Additional information about respondents is presented in Table 6.1.

Table 6.1 Eastern Mediterranean region respondents to the World Hepatitis Alliance’s 2014 civil society survey (N=6)

<table>
<thead>
<tr>
<th>Country</th>
<th>Civil society respondents (#)</th>
<th>Type of respondent (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NGO – hepatitis patient group</td>
<td>NGO – direct service provider</td>
</tr>
<tr>
<td>Egypt</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Jordan</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Lebanon</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Pakistan</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Yemen</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
Half of respondents identified themselves as nongovernmental organisations (Figure 6.1). Among the remaining respondents, one identified itself as a medical society and another as a private foundation. One-third of respondents were either voting or non-voting members of the World Hepatitis Alliance at the time they submitted their surveys (data not shown).

Two-thirds of respondents were based in lower-middle-income countries. The remainder were based in upper-middle-income countries (Figure 6.2).

6.2. Highlights relating to civil society agreement or disagreement with what governments reported

The civil society survey contained 25 items based on the information that governments provided for the 2013 WHO global policy report. For each item, civil society stakeholders were asked to consider the government response to one or more questions about national hepatitis policies and programmes, and to select one of the following three statements: To our knowledge, this information is accurate; To our knowledge, this information is not accurate; or We take no position regarding this statement.

Detailed findings for all civil society survey items are presented in Annex C. In sum, half of all civil society respondents thought that the information from their governments was accurate for 19 or more of the 25 items. Regarding the proportions of respondents who marked items as “not accurate,” one-third thought that the information from their governments was not accurate for at least 10 items.

The following survey items were most commonly identified as points on which civil society respondents in the Eastern Mediterranean region agreed with their governments’ responses: item 1.2, regarding the existence of a designated governmental unit/department responsible for viral hepatitis-related activities and the number of government staff working on hepatitis-related activities; item 3.2, regarding hepatitis case definitions and the reporting of deaths; item 3.3, regarding disease registration and reporting; item 3.4, regarding the reporting and investigation of hepatitis outbreaks; and item 3.5, regarding a national viral hepatitis research agenda and viral hepatitis serosurveys. Further details are presented in Table 6.2.

The following survey items were most commonly identified as points on which civil society respondents in the Eastern Mediterranean region disagreed with their governments’ responses: item 1.1, regarding the existence of a national strategy or plan for the prevention and control of viral hepatitis; item 2.1, regarding World Hepatitis Day activities and viral hepatitis awareness campaigns; item 2.2, regarding government collaboration with civil society groups; and item 3.1, regarding viral hepatitis surveillance. Further details are presented in Table 6.3.
Table 6.2. Survey items eliciting the highest levels of agreement from civil society respondents, Eastern Mediterranean region (N=6)

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Question(s) addressed by governments for 2013 WHO global policy report</th>
<th># (%) of respondents who indicated agreement with their governments’ response(s) by selecting “to our knowledge, this information is accurate”</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2</td>
<td>Is there a designated governmental unit/department responsible only for coordinating and/or carrying out viral hepatitis-related activities? If yes, what is its name? How many people work full-time (or how many full-time equivalent staff) on hepatitis-related activities in all government agencies/bodies?</td>
<td>6 (100%)</td>
</tr>
<tr>
<td>3.2</td>
<td>Are there standard case definitions for hepatitis infections? Are deaths, including from hepatitis, reported to a central registry? What percentage of hepatitis cases are reported as “undifferentiated” or “unclassified” hepatitis?</td>
<td>6 (100%)</td>
</tr>
<tr>
<td>3.3</td>
<td>Are liver cancer cases registered nationally? Are cases of HIV/hepatitis co-infection registered nationally? How often are hepatitis disease reports published?</td>
<td>6 (100%)</td>
</tr>
<tr>
<td>3.4</td>
<td>Are hepatitis outbreaks required to be reported to the government? If yes, are they further investigated? Is there adequate laboratory capacity nationally to support viral hepatitis outbreak investigations and other surveillance activities?</td>
<td>6 (100%)</td>
</tr>
<tr>
<td>3.5</td>
<td>Is there a national public health research agenda for viral hepatitis? Are viral hepatitis serosurveys conducted regularly? If yes, how often? When was the last one carried out? Please specify the target populations.</td>
<td>6 (100%)</td>
</tr>
</tbody>
</table>

Table 6.3. Survey items eliciting the highest levels of disagreement from civil society respondents, Eastern Mediterranean region (N=6)

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Question(s) addressed by governments for 2013 WHO global policy report</th>
<th># (%) of respondents who indicated disagreement with their governments’ response(s) by selecting “to our knowledge, this information is not accurate”</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>In your country, is there a written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis? If yes, is it exclusive for viral hepatitis or does it also address other diseases? Please indicate components of the strategy or plan.</td>
<td>2 (33.3%)</td>
</tr>
<tr>
<td>2.1</td>
<td>Did your government hold events for World Hepatitis Day 2012? Has your government funded any public viral hepatitis awareness campaigns since January 2011, other than World Hepatitis Day?</td>
<td>3 (50.0%)</td>
</tr>
<tr>
<td>2.2</td>
<td>Does your government collaborate with any civil society group within your country (such as patient groups or national or local nongovernmental organisations) to develop and implement its viral hepatitis prevention and control programme? If yes, please name major partners.</td>
<td>2 (33.3%)</td>
</tr>
<tr>
<td>3.1</td>
<td>Is there routine surveillance for viral hepatitis? If yes, is there a national surveillance system for the following types of acute hepatitis? A, B, C. Is there a national surveillance system for the following types of chronic hepatitis? B, C.</td>
<td>4 (66.7%)</td>
</tr>
</tbody>
</table>
The respondent reviewed 25 items of information that the government of Egypt reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

- The government information was thought to be accurate for 88.0% of items. Survey points marked “accurate”: 1.1, 1.2, 1.3, 2.1, 2.2, 3.2, 3.3, 3.4, 3.5, 4.1, 4.2, 4.3, 4.5, 4.6, 4.7, 4.8, 4.9, 4.10, 5.1, 5.3, 5.4 and 5.5.

- The government information was thought to not be accurate for 8.0% of items. Survey points marked “not accurate”: 3.1 and 5.2.

- The respondent took no position on the government information for 4.0% of items. Survey points marked “take no position”: 4.4.

The Egyptian Liver Research Institute and Hospital (ELRIAH) did not provide any comments about survey items.

Statement from ELRIAH regarding key hepatitis policy issues in Egypt:

Awareness-raising faces many obstacles, some of them due to social factors such as illiteracy, poverty, and ignorance spread in many rural areas in Egypt which leads to wrong practices causing the transmission of hepatitis and increasing its prevalence in Egypt. Other obstacles are governmental, like budgetary issues, and coordination among NGOs as partners in raising community awareness. On a national scale, lack of health awareness among people of rural areas, and their overestimating or underestimating such diseases, as many consequences such as the withdrawal of the patient, social trend to ignore the periodical examination, this resulting in the quick silent spread of infection.

What needs to change?

- Increasing the number of awareness campaigns all over Egypt, especially rural poor areas.
- Implementation of strict rules on health care units and practitioners not applying infection control guidelines, to eliminate infection prevalence.
- Increasing the budget for treatment and awareness.
- Establishing more partnerships with national NGOs under organised governmental coordination to share duties and responsibilities.

What should be the government’s role in bringing about these changes? What responsibilities should the government have?

- Increasing the budget set for prevention and treatment.
- Increasing the number of health care organisations providing awareness, treatment, screening, and care.
- Establishing more partnerships with NGO organisation and sharing duties and responsibilities with them.
- Focusing mainly on rural underserved communities.
- Improving awareness through all means of media and communications.

Evidence:

A study was conducted through a project titled “Changing Behavioural Aspects Leading to Hepatitis C Endemicity through Developing Educational and Multi-media Tools, Grant No. 1774,” that was supported financially by the Science and Technology Development Fund, Egypt.

This study aimed to assess the level of behavioural development in order to create a positive environment for the adoption of the recommended behaviours. The study was conducted over one year from Jan. 2011 until Jan. 2012. Knowledge, attitude and behaviour of 540 hepatitis C patients and 102 of their contacts were assessed and the level of behavioural development was determined. The study revealed that the majority of patients and contacts knew that hepatitis C infection is dangerous with perceived concern for early diagnosis and treatment. More than 75% knew the correct modes of transmission. The assessment showed positive attitudes towards the recommended practices with intention to adopt those practices. Strategies of creating opportunities to continue the recommended behaviours should be adopted together with the reinforcement of social support. (World Academy of Science, Engineering and Technology International Journal of Medical Science and Engineering Vol:7 No:12, 2013.)
SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Jordan reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 76.0% of items.

Survey points marked “accurate”: 1.1, 1.2, 3.2, 3.3, 3.4, 3.5, 4.1, 4.2, 4.3, 4.4, 4.6, 4.7, 4.8, 4.9, 4.10, 5.1, 5.2, 5.4 and 5.5.

The government information was thought to not be accurate for 16.0% of items.

Survey points marked “not accurate”: 2.1, 2.2, 3.1 and 4.5.

The respondent took no position on the government information for 8.0% of items.

Survey points marked “take no position”: 1.3 and 5.3.

The Friends of Liver Disease Patients Society did not provide any comments about survey items. The respondent also did not provide a statement regarding key hepatitis policy issues in Jordan.
**SURVEY HIGHLIGHTS**

The respondent reviewed 25 items of information that the government of Lebanon reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

<table>
<thead>
<tr>
<th>The government information was thought to be accurate for 68.0% of items.</th>
<th>The respondent took no position on the government information for 32.0% of items.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey points marked “accurate”: 1.2, 1.3, 2.2, 3.1, 3.2, 3.3, 3.5, 4.4, 4.5, 4.6, 4.8, 4.9, 5.2, 5.3, 5.4 and 5.5.</td>
<td>Survey points marked “take no position”: 1.1, 2.1, 3.4, 4.1, 4.2, 4.3, 4.7 and 5.1.</td>
</tr>
</tbody>
</table>

Survey comments from Soins Infirmiers et Développement Communautaire:

<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2 The government collaborates with the following in-country civil society groups to develop and implement its viral hepatitis prevention and control programme: the Lebanese Red Cross, SiDC, Hep B and Lebanese Scouts.</td>
<td>This collaboration needs to be strengthened.</td>
</tr>
<tr>
<td>4.6 There is a national policy on injection safety in health-care settings. It is not known what types of syringes the policy recommends for therapeutic injections. Single use or auto-disable syringes, needles and cannulas are always available in all healthcare facilities.</td>
<td>It is not only for hepatitis prevention. All hospitals and medical settings are implementing universal precautions.</td>
</tr>
<tr>
<td>5.3 People testing for both hepatitis B and hepatitis C register by name; the names are kept confidential within the system. Hepatitis B and hepatitis C tests are not free of charge and not compulsory for members of any specific group.</td>
<td>The names are confidential but the patient needs to go monthly to the Ministry of Health to take his medication. He has a card that indicates his status.</td>
</tr>
<tr>
<td>1.1 There is a written national strategy or plan that focuses exclusively on the prevention and control of viral hepatitis. It includes components for raising awareness, surveillance, vaccination, prevention in general, prevention of transmission via injecting drug use, prevention of transmission in health-care settings, treatment and care, and co infection with HIV.</td>
<td>There is a National Programme for hepatitis B and hepatitis C, but we do not have the strategic plan and details of it.</td>
</tr>
</tbody>
</table>
Statement from Soins Infirmiers et Développement Communautaire regarding key hepatitis policy issues in Lebanon:

National coordination. For us the coordination should be made differently and an advisory committee should be formed from NGOs and other sectors that are involved in the hepatitis B and hepatitis C field of work.

Awareness-raising, partnerships and resource mobilisation. More activities should be done including awareness-raising for the public and for specific groups and engagement to do activities for vulnerable populations.

Evidence-based policy and data for action. There is a need to conduct integrated bio-behavioural surveillance studies or any other study that can give a real context of hepatitis B and hepatitis C, especially among other hepatitis infections.

Prevention of transmission. We are noticing that among men who have sex with men (MSM) we have hepatitis B patients, and among drug users we have hepatitis C patients.

Screening, care and treatment. The treatment is available by the Ministry of Health however the regular tests PCR and other are not covered and this could be an obstacle for the adherence of the treatment.

Responses to questions:

What are the greatest problems with the national response to viral hepatitis?

› The national programme should be more active and the Ministry of Health should invest more to have a well-established national strategy.

What needs to change?

› An active participation of NGOs among other stakeholders in the response.

What evidence exists to support your organisation’s viewpoint?

› We do not have documents – what we have is that by observing our patients not able to be adherent to the medications, not able to receive the hepatitis B vaccine free of charge and not able to cover the fees of their CD4 and viral load. All of these issues for us are crucial for reporting and to take action.

Information reported by government (2012–2013)

2.1 The government did not hold events for World Hepatitis Day 2012 and has not funded other viral hepatitis public awareness campaigns since January 2011.

3.4 Hepatitis outbreaks are required to be reported to the government and are further investigated. There is adequate laboratory capacity nationally to support outbreak investigations and other surveillance activities for hepatitis A, hepatitis B and hepatitis C, but not for hepatitis E.

Civil society respondent comments (2014)

To our knowledge, the programme is implementing awareness-raising activities and training workshops. However we cannot tell to what extent it is active or not.

We have a concern about hepatitis C infection among drug users that is well known by the government even if there is no specific data on that but these cases are reported. However, we cannot say that there is a national response to prevent or to take action with this regards.

3.4 Hepatitis outbreaks are required to be reported to the government and are further investigated. There is adequate laboratory capacity nationally to support outbreak investigations and other surveillance activities for hepatitis A, hepatitis B and hepatitis C, but not for hepatitis E.

We take no position regarding this statement.

Chapter 6: Eastern Mediterranean Region

Global Community Hepatitis Policy Report
Liver cancer cases are not registered nationally, but cases with HIV/hepatitis coinfection are. The government has published one hepatitis disease report that described a national hepatitis prevalence study conducted in 2008.

People testing for both hepatitis B and hepatitis C register by name, and there is open access to their names. Hepatitis B and hepatitis C tests are not free of charge and not compulsory for members of any specific group.

There is routine surveillance for viral hepatitis. There is a national surveillance system for acute hepatitis A, but not for any type of chronic hepatitis.

Liver cancer cases are not registered nationally, but cases with HIV/hepatitis coinfection are. The government has published one hepatitis disease report that described a national hepatitis prevalence study conducted in 2008.

5.3 People testing for both hepatitis B and hepatitis C register by name, and there is open access to their names. Hepatitis B and hepatitis C tests are not free of charge and not compulsory for members of any specific group.

To our knowledge, this information is accurate.

3.1 There is routine surveillance for viral hepatitis. There is a national surveillance system for acute hepatitis A, but not for any type of chronic hepatitis.

3.3 Liver cancer cases are not registered nationally, but cases with HIV/hepatitis coinfection are. The government has published one hepatitis disease report that described a national hepatitis prevalence study conducted in 2008.

5.3 People testing for both hepatitis B and hepatitis C register by name, and there is open access to their names. Hepatitis B and hepatitis C tests are not free of charge and not compulsory for members of any specific group.

To our knowledge, this information is not accurate.

1.1 There is no written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis.

2.1 The government held events for World Hepatitis Day 2012 and has funded other viral hepatitis public awareness campaigns since January 2011 (Annex A).

The provincial government is working in collaboration with other NGOs and civil society organisations (CSOs) for the said activity. These NGOs/CSOs cater to different target groups including the ones mentioned in the statement.

The first statement is not correct but the government has published one hepatitis disease report that described a national hepatitis prevalence study conducted in 2008.

There is no open access to their names. The rest I agree with.

To our knowledge, this information is not accurate.

1.1 There is no written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis.

2.1 The government held events for World Hepatitis Day 2012 and has funded other viral hepatitis public awareness campaigns since January 2011 (Annex A).

The provincial hepatitis programmes do celebrate World Hepatitis Day but they do not fund any other viral hepatitis public awareness.
Statement from The Health Foundation regarding key hepatitis policy issues in Pakistan:

**National coordination.** There is no national coordination. NGOs/CSOs are not being recognised for the work being done in any field. There is always a factor of mistrust among us CSOs and the government.

**Awareness-raising, partnerships and resource mobilisation.** The media does not play any role in awareness-raising, even though it can be the best source to raise awareness among the masses.

**Evidence-based policy and data for action.** No such data exists.

**Screening, care and treatment.** Screening is not encouraged in public-sector hospitals due to a lack of funds. Our routine immunisation is well below the standard percentage. So many children miss their pentavalent vaccine which has hepatitis B vaccine in it. Birth dose and administration of HBIG (in case the mother has hepatitis B) at the time of birth is not given in public as well as many private hospitals. Treatment guidelines are not followed in the majority of the cases.

### Information reported by government (2012–2013)

- **2.2** The government does not collaborate with in-country civil society groups to develop and implement its viral hepatitis prevention and control programme.

- **4.8** There is a national infection control policy for blood banks. All donated blood units (including family donations) and blood products nationwide are screened for hepatitis C, but not for hepatitis B.

- **4.10** The government has guidelines that address how hepatitis A and hepatitis E can be prevented through food and water safety.

### Civil society respondent comments (2014)

- **Since we are working in Sindh at the moment the Hepatitis Chief Minister Programme has signed a memorandum of understanding to provide us with treatment for hepatitis C (conventional interferon 3MIU+ribavirin) and hepatitis B (tab entacavir 0.5mg) as well as hepatitis B vaccine (both adult and paediatric dose). We have a strong partnership with this provincial government initiative (the Hepatitis Prevention and Control Program, Sindh) since 2011 and every month we submit our reports to them regarding the stock provided.**

- **There are many small blood banks selling blood which has never been screened. Only reputable labs screen blood for both hepatitis B and hepatitis C.**

- **If there are guidelines, they have never been implemented and we have never heard of them.**

### Responses to questions:

**What are the greatest problems with the national response to viral hepatitis?**

- The greatest problem is the mind-set of the people. The majority of Pakistanis are from a low socio-economic background and they think that getting an injection will make them better at a fast pace and they can in turn not miss a single day as they are on daily wages.

**What needs to change?**

- Injection practices, the role of the media to create awareness, behaviour change communication of the general population.

**What should be the government’s role in bringing about these changes? What responsibilities should the government have?**

- The government can play a vital role by providing us with reliable data and conducting hepatitis surveys nationwide. It can also make a central hepatitis data repository that would be a good resource and free for all NGOs and civil society organisations (CSOs) to access.

**What should be the roles and responsibilities of other stakeholders at the community, national and international levels?**

- NGOs/CSOs can help in raising awareness and mobilisation of the communities.
- Government can ensure that standards are met for supply/demand for vaccination, treatment and cold-chain maintenance.
- Media can play a vital role in ensuring viral hepatitis awareness (small TVCs every few hours on all channels).

**What evidence exists to support your organisation’s viewpoint?**

- [WHO EMRO | Prevention and control of hepatitis](https://www.who.int/emro/)
- [A review of hepatitis viral infections in Pakistan](https://www.who.int/emro/)
- [A Silent Storm: Hepatitis C in Pakistan](https://www.who.int/emro/)
- [Prevalence of Hepatitis B & C In Pakistan](https://www.who.int/emro/)
### SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Pakistan reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4.5</strong> There is a specific national strategy and/or policy/guidelines for preventing hepatitis B and hepatitis C infection in health-care settings. Health-care workers are vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood.</td>
<td>There is vaccination of health workers, but not before starting work. Also, vaccination is not carried out uniformly.</td>
</tr>
<tr>
<td><strong>1.3</strong> The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific populations: health-care workers (including health-care waste handlers), people who inject drugs, prisoners and people living with HIV.</td>
<td>Special population groups like the ones mentioned are specifically not taken care of in the national hepatitis control programmes.</td>
</tr>
<tr>
<td><strong>2.1</strong> The government held events for World Hepatitis Day 2012 and has funded other viral hepatitis public awareness campaigns since January 2011 (Annex A).</td>
<td>In general such events are held and sponsored mostly by civil society organisations like medical societies.</td>
</tr>
<tr>
<td><strong>3.1</strong> There is routine surveillance for viral hepatitis. There is a national surveillance system for acute hepatitis A, but not for any type of chronic hepatitis.</td>
<td>There are some surveillance programs run by concerned organisations but not by the government itself.</td>
</tr>
<tr>
<td><strong>4.2</strong> The government has not established the goal of eliminating hepatitis B.</td>
<td>There has been a reasonably robust national programme for hepatitis B vaccination for many years.</td>
</tr>
<tr>
<td><strong>4.8</strong> There is a national infection control policy for blood banks. All donated blood units (including family donations) and blood products nationwide are screened for hepatitis C, but not for hepatitis B.</td>
<td>There is a national policy for blood banks, which is poorly implemented. There is more routine testing of blood donations for hepatitis B rather than hepatitis C.</td>
</tr>
</tbody>
</table>

To our knowledge, this information is **accurate** for 56.0% of items.

Survey points marked “accurate”: 1.2, 2.2, 3.1, 3.2, 3.3, 3.5, 4.1, 4.5, 4.6, 4.7, 4.9, 5.3, 5.4 and 5.5.

To our knowledge, this information is **not accurate** for 44.0% of items.

Survey points marked “not accurate”: 1.1, 1.3, 2.1, 3.4, 4.2, 4.3, 4.4, 4.8, 4.10, 5.1 and 5.2.

Survey comments from the Pakistan Society for Study of Liver Diseases:

Pakistan Society for Study of Liver Diseases

Medical society
Karachi, Pakistan
www.psssid.org.pk

**Chapter 6: Eastern Mediterranean Region**
Statement from the Pakistan Society for Study of Liver Diseases regarding key hepatitis policy issues in Pakistan:

National Coordination. With devolution of health as a provincial subject, the central coordination of programs has suffered. To some extent these issues of national coordination are being addressed by the formation of a technical advisory group for viral hepatitis at the national level, with the involvement of all provincial programme managers ensured.

Awareness-raising. Very little direct governmental effort and resource is being spent in public awareness. More governmental and NGO partnerships need to be developed.

Evidence-based policy. The need for further evidence is critical. There are very few surveillance programs to calculate the true ongoing impact of these infections.

Prevention of transmission. The area of hepatitis B vaccination is going well. However a birth dose needs to be introduced as soon as possible.

Screening, care and treatment. A good number of patients are being treated. However, record-keeping is poor and therefore outcomes of treatment are not accurately measured.
Yemen

Yemen Gastroenterology and Hepatology Society
Private foundation
Sanaa City, Yemen

SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Yemen reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 88.0% of items.
Survey points marked “accurate”:
1.1, 1.2, 1.3, 2.1, 2.2, 3.1, 3.2, 3.3, 3.4, 3.5, 4.2, 4.3, 4.4, 4.5, 4.8, 4.9, 4.10, 5.1, 5.2, 5.3, 5.4 and 5.5.

The government information was thought to not be accurate for 8.0% of items.
Survey points marked “not accurate”:
4.1 and 4.7.

The respondent took no position on the government information for 4.0% of items.
Survey points marked “take no position”:
4.6.

The Yemen Gastroenterology and Hepatology Society did not provide any comments about survey items. The respondent also did not provide a statement regarding key hepatitis policy issues in Yemen.
European Region
### European Region

<table>
<thead>
<tr>
<th>Country</th>
<th>Organizations/Networks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albania</td>
<td>• Aksion Plus</td>
</tr>
<tr>
<td>Austria</td>
<td>• Österreichische Gesellschaft für Gastroenterologie und Hepatologie</td>
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<tr>
<td>Belarus</td>
<td>• Together against Hepatitis</td>
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<td>Belgium</td>
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<td>• Vlaams Hepatitis Contactpunt</td>
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<tr>
<td>Bulgaria</td>
<td>• HepActive</td>
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<tr>
<td>• National Association for Fighting Hepatitis – Hepasist</td>
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<tr>
<td>Denmark</td>
<td>• CHIP</td>
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<td>• Roskilde Sygehus</td>
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<td>• Sex &amp; Samfund (Danish Family Planning Association)</td>
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<tr>
<td>Estonia</td>
<td>• Estonian Society of Gastroenterology</td>
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<tr>
<td>France</td>
<td>• Association Française pour l’Etude du Foie</td>
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<td>• Institut de Santé Publique, d’Epidémiologie et de Développement, Bordeaux School of Public Health</td>
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<td>Georgia</td>
<td>• Georgian Harm Reduction Network</td>
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<td>Germany</td>
<td>• Deutsche Leberhilfe e.V.</td>
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<td>• Deutsche Leberstiftung/German Liver Foundation</td>
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<tr>
<td>Greece</td>
<td>• Hellenic Foundation of Gastroenterology and Nutrition</td>
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<td>• Hellenic Liver Association “Prometheus”</td>
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<td>Latvia</td>
<td>• Hepatita Biedriba</td>
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<td>• De Regenboog Groep (The Rainbow Group)</td>
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<tr>
<td>Norway</td>
<td>• Norwegian Society for Infectious Diseases</td>
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<td>Poland</td>
<td>• Department of Infectious Diseases, Wroclaw Medical University</td>
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<td>• Polish Association for the Study of the Liver</td>
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<td>Romania</td>
<td>• Baylor Black Sea Foundation</td>
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<td>• United against Hepatitis</td>
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<td>• The Hepatitis C Trust</td>
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<td>• The Hepatitis C Trust (Scotland)</td>
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<td>• Waverley Care</td>
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</table>
This chapter presents European region findings from the World Hepatitis Alliance’s 2014 civil society survey in three sections. The first section provides an overview of respondents. The second section describes the extent to which respondents agreed or disagreed with what their governments reported about hepatitis policies and programmes for the 2013 World Health Organization (WHO) Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States. It also notes the issues associated with the greatest amount of agreement and disagreement. The third section highlights some of the qualitative findings from respondents based in countries where governments did not submit information for the 2013 WHO global policy report.

Table 7.1. European region respondents to the World Hepatitis Alliance’s 2014 civil society survey (N=40)

<table>
<thead>
<tr>
<th>Country</th>
<th>Civil society survey respondents (#)</th>
<th>NGO – hepatitis patient group</th>
<th>NGO – direct service provider</th>
<th>NGO – other</th>
<th>Medical society</th>
<th>Private foundation</th>
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<td>United Kingdom of Great Britain and Northern Ireland</td>
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</table>
7.1. Respondents

Forty organisations from 27 countries in the European region responded to the World Hepatitis Alliance’s 2014 civil society survey. The governments of 23 of those countries provided information for the 2013 WHO global policy report, and thus the 35 respondents based in those countries were able to comment on the accuracy of their governments’ responses. The governments of the other four countries did not provide information for the 2013 report; the five respondents based in those countries instead commented on their governments’ responses to viral hepatitis by writing short statements about key issues. Additional information about respondents is presented in Table 7.1.

Almost forty percent of respondents identified themselves as hepatitis patient groups, and another 18% identified themselves as nongovernmental direct service providers (Figure 7.1). Fifteen percent identified themselves as medical societies.

Forty-five percent of respondents were either voting or non-voting members of the World Hepatitis Alliance at the time they submitted their surveys (data not shown).

Almost two-thirds of respondents were based in high-income countries. Another 23% were based in upper-middle-income countries (Figure 7.2).

7.2. Highlights relating to civil society agreement or disagreement with what governments reported

The civil society survey contained 25 items based on the information that governments provided for the 2013 WHO global policy report. For each item, civil society stakeholders were asked to consider the government response to one or more questions about national hepatitis policies and programmes, and to select one of the following three statements:

To our knowledge, this information is accurate; To our knowledge, this information is not accurate; or We take no position regarding this statement.

Detailed findings for all civil society survey items are presented in Annex C. In sum, approximately half of all civil society respondents thought that the information from their governments was accurate for 18 or more of the 25 items. Regarding the proportions of respondents who marked items as “not accurate,” approximately half thought that the information from their governments was not accurate for at least five items.

The following survey items were most commonly identified as points on which civil society respondents in the European region agreed with their governments’ responses: item 1.1, regarding the existence of a national strategy or plan for the prevention and control of viral hepatitis; item 4.6, regarding injection safety in health care settings; item 4.8, regarding infection control for blood products; and item 5.5, regarding the inclusion of hepatitis B drugs and hepatitis C drugs on national essential medicines lists and in government-subsidised programmes. Further details are presented in Table 7.2 overleaf.

The following survey items were most commonly identified as points on which civil society respondents in the European region disagreed with their governments’ responses: item 3.1, regarding viral hepatitis surveillance; item 3.3 regarding disease registration and reporting; item 5.2, regarding screening and referral to care for hepatitis B and hepatitis C; item 5.3, regarding hepatitis B and hepatitis C testing; and item 5.4, regarding publicly funded treatment for hepatitis B and hepatitis C. Further details are presented in Table 7.3 overleaf.

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Figure 7.1. Types of organisations submitting survey responses, European region (N=40)

Figure 7.2. Responses received by income group, European region (N=40)
### Table 7.2. Survey items eliciting the highest levels of agreement from civil society respondents, European region (N=35)

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Question(s) addressed by governments for 2013 WHO global policy report</th>
<th># (%) of respondents who indicated agreement with their governments’ response(s) by selecting “to our knowledge, this information is accurate”</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>In your country, is there a written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis? If yes, is it exclusive for viral hepatitis or does it also address other diseases? Please indicate components of the strategy or plan.</td>
<td>29 (82.9%)</td>
</tr>
<tr>
<td>4.6</td>
<td>Is there a national policy on injection safety in health care settings? If yes, what type of syringes does the policy recommend for therapeutic injections? Are single-use or auto-disable syringes, needles and cannulas always available in all health care facilities?</td>
<td>29 (82.9%)</td>
</tr>
<tr>
<td>4.8</td>
<td>Is there a national infection control policy for blood banks? Are all donated blood units (including family donations) and blood products nationwide screened for hepatitis B? Are all donated blood units (including family donations) and blood products nationwide screened for hepatitis C?</td>
<td>32 (91.4%)</td>
</tr>
<tr>
<td>5.5</td>
<td>Which hepatitis B drugs and hepatitis C drugs are included on the national essential medicines list or are subsidised by the government?</td>
<td>29 (82.9%)</td>
</tr>
</tbody>
</table>

### Table 7.3. Survey items eliciting the highest levels of disagreement from civil society respondents, European region (N=35)

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Question(s) addressed by governments for 2013 WHO global policy report</th>
<th># (%) of respondents who indicated disagreement with their governments’ response(s) by selecting “to our knowledge, this information is not accurate”</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Is there routine surveillance for viral hepatitis? If yes, is there a national surveillance system for the following types of acute hepatitis? A, B, C. Is there a national surveillance system for the following types of chronic hepatitis? B, C.</td>
<td>11 (31.4%)</td>
</tr>
<tr>
<td>3.3</td>
<td>Are liver cancer cases registered nationally? Are cases of HIV/hepatitis co-infection registered nationally? How often are hepatitis disease reports published?</td>
<td>18 (51.4%)</td>
</tr>
<tr>
<td>5.2</td>
<td>Does your government have a national policy relating to screening and referral to care for hepatitis B? For hepatitis C?</td>
<td>11 (31.4%)</td>
</tr>
<tr>
<td>5.3</td>
<td>Please answer the following questions about hepatitis B and hepatitis C testing in your country. · When testing, do people register by name? · If people register by name, are their names kept confidential within the system, or is there open access to the names? · Is the test free of charge for all individuals? · Is the test compulsory for members of any specific group?</td>
<td>12 (34.3%)</td>
</tr>
<tr>
<td>5.4</td>
<td>Is publicly funded treatment available for hepatitis B? If yes, who is eligible? Is publicly funded treatment available for hepatitis C? If yes, who is eligible? How much does the government spend on publicly funded treatment for hepatitis B and hepatitis C?</td>
<td>11 (31.4%)</td>
</tr>
</tbody>
</table>
7.3. Qualitative findings from countries where government information is lacking

Civil society survey respondents based in countries where governments did not submit information for the 2013 WHO global policy report did not have any information to review and hence did not complete the component of the survey discussed in the preceding section. They only completed a survey component in which respondents were invited to write brief statements discussing the policy response to viral hepatitis in their countries. Respondents were encouraged to focus on one or more of five topics: national coordination; awareness-raising, partnerships and resource mobilisation; evidence-based policy and data for action; prevention of transmission; and screening, care and treatment.

The purpose of this section is to present some excerpts that are generally reflective of the concerns of respondents in the European region. The following data represent only the views of the five civil society survey respondents that did not have government information to review (two from Greece and each from Norway, Portugal and Romania). The full text of all respondents’ statements can be found later in this chapter.

Two respondents remarked on governmental failure to mount a comprehensive national response to viral hepatitis. The Portuguese Board of Hepatology wrote:

There is no national coordination. The Ministry of Health has no organisation to deal specifically with hepatitis.

The Baylor Black Sea Foundation wrote:

Presently, in Romania there is no comprehensive approach to tackling hepatitis B and hepatitis C. Existing efforts, especially financial efforts, go towards treatment and only treatment.

Respondents brought up different types of viral hepatitis prevention issues. The Hellenic Liver Association “Prometheus” (Greece) wrote:

The increase in prevalence among people who inject drugs is the result of underperforming harm reduction programmes. The government does not seem to invest in harm reduction programmes.

The Norwegian Society for Infectious Diseases commented on a lack of national screening policies for hepatitis B or hepatitis C, other than a policy addressing pregnancy. Even in this regard the respondent suggested that the existing approach is insufficient:

Testing of mothers belonging to defined risk groups is recommended. Unfortunately, there is not always adherence to this recommendation. Mothers with hepatitis B also exist outside of the defined risk groups. As a result, babies at risk of mother-to-child transmission may fail to receive vaccination and immunoglobulin, and subsequently may become infected. For the same reason, mothers with high-level hepatitis B viraemia may not receive recommended antiviral therapy in pregnancy to reduce risk of transmission to their children. The government should consider introducing a policy of routine hepatitis B testing for all pregnant women, as is already the case with HIV.

Barriers to viral hepatitis treatment also received attention. The Hellenic Foundation of Gastroenterology and Nutrition (Greece) expressed concern about the lack of reimbursement for laboratory tests that patients are advised to undergo after they have been diagnosed with hepatitis B or hepatitis C.

The respondent also wrote:

There is a delay in the availability and reimbursement of new [viral hepatitis treatment regimens]. Even when the new agents may be available, they are only reimbursed through a bureaucratic process based on approval for individual patients.

The Norwegian Society for Infectious Diseases wrote:

The government of Norway provides treatment for hepatitis B and hepatitis C free of charge, but does not have clear policies regarding when treatment is indicated.

The Baylor Black Sea Foundation (Romania) wrote:

Access to treatment has improved in the past few years. There is a clear referral system that patients need to follow in order to acquire access to treatment. Funding is not very transparent, nor is decision-making in regard to the choice of drug regimen, especially in hepatitis C cases.

Multiple respondents highlighted viral hepatitis screening issues. The Hellenic Foundation of Gastroenterology and Nutrition (Greece) wrote:

There is no national screening policy for viral hepatitis, not even official recommendations from any governmental body.

The Baylor Black Sea Foundation reported that in Romania, viral hepatitis screening is not “standardised, funded or [addressed] in special recommendations”.

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SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Albania reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 76.0% of items.

Survey points marked “accurate”: 1.1, 1.2, 1.3, 2.1, 3.1, 3.4, 4.1, 4.2, 4.3, 4.6, 4.7, 4.8, 4.9, 4.10, 5.1, 5.2, 5.3, 5.4 and 5.5.

The government information was thought to not be accurate for 20.0% of items.

Survey points marked “not accurate”: 2.2, 3.3, 3.5, 4.4 and 4.5.

The respondent took no position on the government information for 4.0% of items.

Survey points marked “take no position”: 3.2.

Aksion Plus did not provide any comments about survey items.

Statement from Aksion Plus regarding key hepatitis policy issues in Albania:

One of the key issues is to provide treatment for hepatitis B and hepatitis C to drug users and other vulnerable groups outside of the health insurance scheme. For those who are out of the health system, it is impossible to get free treatment.

At the same time, there is not a national strategy for hepatitis B vaccination. In collaboration with the Institute of Public Health, we were able to provide free vaccines for our opioid substitution therapy clients and staff at our centres.

The hepatitis approach is included as a co-infection with HIV/AIDS. National response/law/strategy.

We will organise a workshop with the governmental health structures in order to better address the hepatitis treatment and referral system.

Prisons are also part of this process but the situation seems a bit improved in terms of surveillance and treatment.

There is regular bio–behavioural surveillance conducted with the most vulnerable groups but it is mainly targeting the capital, Tirana. This practice should be extended to other cities as well. For instance, in the Aksion Plus opioid substitution therapy centre in Korca, a city in the south, half of the clients have hepatitis B and hepatitis C.

We are closely working with the Dutch NGO Correlation Network to address some of the most urgent issues related to the hepatitis threat among vulnerable groups: drug users, Roma individuals and sex workers.
1.2 There is no designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities. It is not known how many people work full-time on hepatitis-related activities in all government agencies/bodies.

To my knowledge, nobody works full-time on hepatitis-related activities in any government body.

1.3 The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific populations: health-care workers (including health-care waste handlers), people who inject drugs and people living with HIV.

Again, as above, this programme is not even known to specialists in the field in any detail but it could probably be found if one would be actively chasing it.

2.1 The government did not hold events for World Hepatitis Day 2012 and has not funded other viral hepatitis public awareness campaigns since January 2011.

This is probably true but it would also not be effective if they would, considering that World Hepatitis Day is in the middle of the Austrian holiday season with nobody around.

4.5 There is a specific national strategy and/or policy/guidelines for preventing hepatitis B and hepatitis C infection in health-care settings. Health-care workers are vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood.

But to my knowledge, this programme is only voluntary, not mandatory. No policy exists on what to do with infected healthcare workers.
## Austria

<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4.10</strong> Information was not provided on whether the government has guidelines that address how hepatitis A and hepatitis E can be prevented through food and water safety.</td>
<td>There are probably guidelines regarding food safety, which is very good in Austria. Also, infection control reporting in the past has been repeatedly successful in finding and controlling the rare outbreaks that have occurred.</td>
</tr>
<tr>
<td><strong>5.4</strong> Publicly funded treatment is available for hepatitis B and hepatitis C. Information was not provided on who is eligible for this. The amount spent by the government on publicly funded treatment for hepatitis B and hepatitis C is not known.</td>
<td>Every Austrian resident who is insured (and even the ones who are not insured) is eligible for treatment including reimbursement.</td>
</tr>
<tr>
<td><strong>3.1</strong> There is routine surveillance for viral hepatitis. There is a national surveillance system for the following types of acute hepatitis: A, B, C, D and E, and for the following types of chronic hepatitis: B, C and D.</td>
<td>There is an inefficient system, which has been improved recently by shifting the reporting from the physicians to the Virology Laboratories. There is, however, no information on the clinical scenario available and no distinction between acute or chronic hepatitis possible. Also, this is not routine surveillance in a strict sense but just opportunistic surveillance, finding cases by chance if the treating physician decides to order a test.</td>
</tr>
<tr>
<td><strong>3.3</strong> Liver cancer cases and cases with HIV/hepatitis coinfection are registered nationally. The government publishes hepatitis disease reports monthly.</td>
<td>Cancer in general and HIV infections are registered nationally. I have never in the last 22 years in my practice seen a single monthly hepatitis disease report. If they are published, nobody of interest gets to see them.</td>
</tr>
<tr>
<td><strong>5.1</strong> Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools for health professionals (pre-service education). There are national clinical guidelines for the management of viral hepatitis, but they do not include recommendations for cases with HIV coinfection. There are national clinical guidelines for the management of HIV, which include recommendations for coinfection with viral hepatitis.</td>
<td>The Austrian Guidelines are joint guidelines with the Germans as well as the Swiss and they do of course contain recommendations about how to treat HIV/hepatitis C coinfection.</td>
</tr>
</tbody>
</table>
5.5 The following drugs for treating hepatitis B are on the national essential medicines list or subsidised by the government: interferon alpha, lamivudine and tenofovir. The following drugs for treating hepatitis C are on the national essential medicines list or subsidised by the government: interferon alpha and ribavirin.

2.2 The government collaborates with in country civil society groups to develop and implement its viral hepatitis prevention and control programme. Information was not provided about the identity of civil society partners.

4.2 The government has not established the goal of eliminating hepatitis B.

Information reported by government (2012–2013)

Civil society respondent comments (2014)

We have all treatment options available, which in addition to the ones listed also include peginterferon, telbivudine, entecavir, telaprevir, boceprevir. Sofosbuvir is available in Austria but reimbursement is currently negotiated, so it is at the moment only reimbursed for the most urgent cases (approved on a case-by-case basis).

There might be a collaboration with the Austrian branch of the European Liver Patients Association but there is definitely no collaboration with the Austrian Society of Gastroenterology and Hepatology, the only professional medical association dealing with viral hepatitis. I have been Secretary General (4 years) and head of the liver disease working party (4 years) of this society and never had any contact with the Austrian government regarding viral hepatitis prevention and control.

That I do not know, but they offer nationwide hepatitis B vaccination to children and adolescents at least born after 1997, and screening for all mother-to-be, so there is a good programme that comes close to eradicating hepatitis B in native Austrians. This does not cover screening of immigrants, which is the true population at risk for hepatitis B in Austria.

Statement from ÖGGH regarding key hepatitis policy issues in Austria:

Prevention of transmission is taken care of quite well in Austria: screening of blood products is universal and well controlled, transmission in the hospital or other health care settings is rare. Hepatitis B vaccination is performed in all children since 1997 (unless they actively refuse). The biggest source of transmission is intravenous drug use, but also here information campaigns and generous needle exchange programmes are available. In addition, screening is offered at several low-barrier contact points for people who inject drugs (PWID). Since awareness campaigns for safe sex are being conducted in the context of HIV transmission, this is also taking care of hepatitis B transmission.

In Austria, we do not have universal screening for hepatitis C but there is opportunistic screening in many hospitals at admission. Screening for elevated liver enzymes is done for all male citizens at age 18 when examined for eligibility for the military service and followed up if enzymes are elevated. For female residents, hepatitis B screening is carried out during any pregnancy in the “mother-child-pass” examinations, which are coupled to financial incentives (child support after birth). No screening of any organised sort is available for female residents who never become pregnant. In a low-prevalence country for chronic viral hepatitis like Austria (prevalence may be 0.5%), universal screening does not seem to be cost-effective but screening of risk groups would be advisable.

Since the largest number of infected people in Austria belongs to the immigrant communities, at least voluntary screening for these people should be offered together with awareness campaigns specifically targeting these groups. Screening of prison inmates (even short-term inmates) should be universally applied.

Once detected, laboratories are mandated to transmit positive results of hepatitis B and hepatitis C testing to a central state agency that makes sure individuals are informed of their diagnosis: so once infection is detected, loss to follow-up is rare.
Belarus

Together against Hepatitis*

NGO – hepatitis patient group
Minsk, Belarus
http://by-hepatit.net/ http://www.antihep.by/

SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Belarus reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 36.0% of items.

Survey points marked “accurate”: 1.1, 3.1, 3.3, 4.1, 4.2, 4.5, 4.10, 5.2 and 5.5.

The government information was thought to not be accurate for 12.0% of items.

Survey points marked “not accurate”: 5.1, 5.3 and 5.4.

The respondent took no position on the government information for 52.0% of items.

Survey points marked “take no position”: 1.2, 1.3, 2.1, 2.2, 2.3, 3.4, 3.5, 4.3, 4.4, 4.6, 4.7, 4.8 and 4.9.

Survey comments from Together against Hepatitis:

**To our knowledge, this information is accurate.**

### Information reported by government (2012–2013)

3.3 Liver cancer cases and cases with HIV/hepatitis coinfection are registered nationally. The government publishes hepatitis disease reports monthly and annually.

Statistics on viral hepatitis are not publicly available.

### Civil society respondent comments (2014)

Awareness about viral hepatitis, especially about hepatitis C and modern approaches to treatment, can be described as insufficient. Often health professionals (even infectious disease doctors) do not know that hepatitis C can be treated and advise their patients incorrectly about the cost, success of treatment and the therapy itself. This situation is typical for the provinces and small towns. Specialists from related health areas (maternity staff, dentists, therapists etc.) are very poorly informed about viral hepatitis. Despite the existence of well-designed and strict regulations, their implementation is weak.

Confidentiality is alleged. Patients report cases when infectionists call at home or at work and provide information to the family, colleagues and third parties without their knowledge. To get tested for hepatitis free of charge (PCR), a doctor’s referral is needed.

Patients with chronic hepatitis B and chronic hepatitis C need to pay for the treatment from their own resources. Public medicine provides two first injections of pegylated interferon (dual therapy), doctor consultations and free blood tests during the therapy time (on doctor’s referral).

To our knowledge, this information is not accurate.

5.1 Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools of health professionals (pre-service education), on-the-job training and post-graduate training. There are national clinical guidelines for the management of viral hepatitis. These guidelines include recommendations for cases of HIV coinfection.

Confidentiality is alleged. Patients report cases when infectionists call at home or at work and provide information to the family, colleagues and third parties without their knowledge. To get tested for hepatitis free of charge (PCR), a doctor’s referral is needed.

To our knowledge, this information is not accurate.

5.3 People testing for both hepatitis B and hepatitis C register by name; the names are kept confidential within the system. Hepatitis B and hepatitis C tests are free of charge for all individuals and are compulsory for members of some specific groups but these groups were not identified.

5.4 Publicly funded treatment is available for hepatitis B and C. Information was not provided on who is eligible for publicly funded treatment for hepatitis B. Publicly funded treatment for hepatitis C is available only to people with acute infection (not those with chronic infection). Information was not provided on the amount spent by the government on such treatment for hepatitis B and hepatitis C.

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* World Hepatitis Alliance member.
<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
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<tbody>
<tr>
<td>2.1 The government held events for World Hepatitis Day 2012. It has funded other viral hepatitis public awareness campaigns since January 2011 (Annex A).</td>
<td>In Belarus, in 2012, the action took place mostly on the Internet. General information about viral hepatitis was presented on the website of the Centre for Hygiene and Epidemiology and some other medical institutions. Information was given about all viral hepatitis, without separating into A, B, C, D and E and without specific instructions for health workers and patients.</td>
</tr>
<tr>
<td>2.2 The government collaborates with the following in-country civil society groups to develop and implement its viral hepatitis prevention and control programme: NGO “Positive Movement” and Belarusian Red Cross.</td>
<td>The target groups of the NGO Positive Movement are people living with HIV and people who use drugs. The organisation’s activities are not targeted specifically for hepatitis and do not cover other groups of patients. Belarusian Red Cross has no special programme for viral hepatitis either. In Belarus, hepatitis is captured only partially in the framework of HIV/AIDS programmes. Until April 2014, there were no NGOs in Belarus that dedicated their activities specifically to viral hepatitis.</td>
</tr>
<tr>
<td>3.5 Information was not provided on whether there is a national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are conducted regularly: the target populations are people who inject drugs, men who have sex with men, pregnant women, people living with HIV, health-care workers, members of the military and prisoners. Information was not provided on when the last serosurvey was carried out.</td>
<td>To our knowledge, there is no national public health research agenda for viral hepatitis.</td>
</tr>
<tr>
<td>4.6 There is a national policy on injection safety in health-care settings. The policy recommends single-use syringes for therapeutic injections. Single-use or auto-disable syringes, needles and cannulas are always available in all health-care facilities.</td>
<td>We have no information on the implementation of this policy.</td>
</tr>
<tr>
<td>4.8 There is a national infection control policy for blood banks. All donated blood units (including family donations) and blood products nationwide are screened for hepatitis B and hepatitis C.</td>
<td>This requirement exists, but there is no freely available information on its implementation.</td>
</tr>
</tbody>
</table>
Statement from Together against Hepatitis regarding key hepatitis policy issues in Belarus:

There is no national strategy for viral hepatitis prevention. State regulations are badly implemented in the health care system. More informational work with health care professionals, especially in the regions, is required. Ways to increase the availability of hepatitis treatment should be found. Officials of the Ministry of Health should be better informed about the viral hepatitis situation in the country.

Officials should recognise the scale of the epidemic in the country. A national programme should be developed with the participation of patient NGOs. Patient education about hepatitis is needed.

Regarding prevention of transmission, stronger measures should be taken in this field to implement legal requirements. Providing materials in sufficient quantities (disposable gloves and instruments, sterilisers) to all medical institutions is required, especially in regions.

Evidence:

Patients during three years (survey), reports from the patient web-forum, research reports, materials from the infection specialists’ conference.
Belgium

Carrefour Hépatites*
NGO – hepatitis patient group
Vaux-sur-Sûre, Belgium
www.hepatites.be

SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Belgium reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 64.0% of items.

Survey points marked “accurate”:
1.1, 1.2, 1.3, 2.1, 2.2, 3.4, 4.1, 4.2, 4.3, 4.6, 4.7, 4.8, 4.10, 5.1, 5.2 and 5.5.

The government information was thought to not be accurate for 36.0% of items.

Survey points marked “not accurate”:
3.1, 3.2, 3.3, 3.5, 4.4, 4.5, 4.9, 5.3 and 5.4.

Survey comments from Carrefour Hépatites:

Information reported by government (2012–2013)

1.3 The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific populations: health-care workers (including health-care waste handlers), newborns and unvaccinated adolescents.

5.1 Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools of health professionals (pre-service education), on-the-job training and post-graduate training. There are national clinical guidelines for the management of viral hepatitis. These guidelines include recommendations for cases of HIV coinfection.

5.5 The following drugs for treating hepatitis B are on the national essential medicines list or subsidised by the government: interferon alpha, pegylated interferon, lamivudine, adefovir dipivoxil, entecavir and tenofovir. The following drugs for treating hepatitis C are on the national essential medicines list or subsidised by the government: interferon alpha, pegylated interferon, ribavirin, boceprevir and telaprevir.

But no guidelines!

But refunds/reimbursements are limited and restrictive – discriminatory.

Hepatitis A and hepatitis B vaccination is free but not compulsory for those aged 0–13 since 1992.

* World Hepatitis Alliance member.
<table>
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<tbody>
<tr>
<td>3.5 There is no national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are conducted regularly; the target population is the general population. The last serosurvey was carried out in 2006.</td>
<td>There is never any “public” investigation in Belgium! There has been one initiative from Schering-Plough (MSD) and two from the CHAC!</td>
</tr>
<tr>
<td>4.5 There is a specific national strategy and/or policy/guidelines for preventing hepatitis B and hepatitis C infection in health-care settings. Health-care workers are vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood.</td>
<td>The second sentence is accurate.</td>
</tr>
</tbody>
</table>

*Carrefour Hépatites did not provide a statement regarding key hepatitis policy issues in Belgium.*
**Belgium**

**Vlaams Hepatitis Contactpunt**

* NGO – hepatitis patient group

Sint Truiden, Belgium

[www.hepatitisc.be](http://www.hepatitisc.be)

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### Survey Highlights

The respondent reviewed 25 items of information that the government of Belgium reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

- **The government information was thought to be accurate for 84.0% of items.**
- **The government information was thought to not be accurate for 12.0% of items.**
- The respondent took no position on the government information for 4.0% of items.

#### Survey points marked “accurate”:

1.1, 1.2, 1.3, 2.1, 2.2, 3.2, 3.3, 3.4, 3.5, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 4.10, 5.1, 5.2, 5.4 and 5.5.

#### Survey points marked “not accurate”:

3.1, 4.1 and 5.3.

#### Survey points marked “take no position”:

4.9.

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### Information reported by government (2012–2013)

- **1.1** There is no written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis.
- **1.2** There is no designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities. It is not known how many people work full-time on hepatitis-related activities in all government agencies/bodies.
- **3.3** Liver cancer cases and cases with HIV/hepatitis coinfection are registered nationally. The government publishes hepatitis disease reports annually.
- **4.10** It is not known whether the government has guidelines that address how hepatitis A and hepatitis E can be prevented through food and water safety.

### Civil society respondent comments (2014)

- **A national strategy/plan is in progress.**
- **A national reference centre is available ([https://nrchm.wiv-isp.be](https://nrchm.wiv-isp.be)) for laboratory activities.**
- **We have a national register of HIV containing hepatitis C coinfection information.**
- **The KCE (federal competence centre for healthcare) developed a study on Hepatitis A transmission. Guidelines are thus available for this pathogen [https://kce.fgov.be/sites/default/files/page_documents/d20081027388.pdf](https://kce.fgov.be/sites/default/files/page_documents/d20081027388.pdf).**
- **The information in the first sentence is accurate. Regarding the second sentence, the information is accurate for hepatitis B through the notification system. The notification system also includes hepatitis A but not hepatitis C.**

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* World Hepatitis Alliance member.

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**Chapter 7: European Region**

Global Community Hepatitis Policy Report

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Statement from Vlaams Hepatitis Contactpunt regarding key hepatitis policy issues in Belgium:

The Belgian federal government has written a national plan for 2014-2018 in collaboration with a group of hepatologists and governmental organisations. The involvement of patients’ associations was asked to read the proposals and this offered us an opportunity for feedback and suggestions. The hepatitis C plan had shortcomings in the Belgian policy that needed to be solved. On the one hand, it provided a thorough screening of the risk groups, on the other hand it also had to approve make new medicines for the Belgian patients. Unfortunately, the plan still needs approval from the different authorities (regional and federal). This is a slowly progressing step which requires to convince different authorities. The coming elections restrain these activities.

We hope that the national hepatitis C plan will be put into action this year anyway and we will be here on a regular basis to remind the Ministers of Social Affairs (federal government) of this urgent matter.

To our knowledge, this information is not accurate.

5.3 People testing for both hepatitis B and hepatitis C register by name; the names are kept confidential within the system. Hepatitis B and hepatitis C tests are free of charge for all individuals and are not compulsory for members of any specific group.

This is a question with multiple answers. HBV and HCV tests are free of charge. The register is not by name.
Statement from HepActive regarding key hepatitis policy issues in Bulgaria:

First of all, Bulgaria health policy is not including ALT/AST in annual screening tests. This is a cheap but effective tool to determine people with liver problems. Also, there are no free screening laboratories, no long-term screening programmes, most of the general practitioners are not familiar with hepatitis – we need educational programmes for them.

During the treatment, the patient needs to stay in hospital for three days only for blood tests – we need some serious changes in our hospital policies, especially for chronic hepatitis patients. And last but not least – Bulgaria is on the bottom when it comes to new treatments. We get those three or four years after other European countries.

Survey Highlights

The respondent reviewed 25 items of information that the government of Bulgaria reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

- The government information was thought to be accurate for 36.0% of items.
- The government information was thought to not be accurate for 40.0% of items.
- The respondent took no position on the government information for 24.0% of items.

Survey comments from HepActive:

Information reported by government (2012–2013)

- ✅ The vaccination with vaccine against hepatitis B has been mandatory since 1992.
- ✗ As far as we know, until now there is not any government activity dedicated to World Hepatitis Day in any year.
- ✗ There is no routine surveillance of any type of viral hepatitis (neither chronic nor acute).
- ✗ The vaccination is mandatory but we cannot say whether the given percentages are valid or not.

Civil society respondent comments (2014)

- ✅ The government has established the goal of eliminating hepatitis B but does not have a specific timeframe for this.
- ✗ To our knowledge, this information is not accurate.
- ✗ 2.1 The government held events for World Hepatitis Day 2012 but has not funded other viral hepatitis public awareness campaigns since January 2011.
- ✗ 3.1 There is routine surveillance for viral hepatitis. There is a national surveillance system for the following types of acute hepatitis: A, B, C, D and E, but not for any type of chronic hepatitis.
- ✗ 4.3 Nationally, 98.6% of newborn infants in a given recent year received the first dose of hepatitis B vaccine within 24 hours of birth and 96% of one-year-olds (ages 12–23 months) in a given recent year received three doses of hepatitis B vaccine.
- ✗ We take no position regarding this statement.
- ✗ Statement from HepActive regarding key hepatitis policy issues in Bulgaria:

We take no position regarding this statement.
Though there is no strategy thus far, there is already a written proposal and it is submitted to the Ministry of Health for adoption. There is such an activity written in the hepatitis plan submitted to the Ministry of Health.

To our knowledge only Hepasist is involved in the working group. We do not know how and whether Hepactive is involved in the work.

There is monitoring of cases, but there is no register where this information is officially stored.

It is possible to screen the population in a case of an epidemic outbreak, but this only applies for hepatitis A.

The respondent reviewed 25 items of information that the government of Bulgaria reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 64.0% of items. Survey points marked “accurate”: 1.1, 1.2, 1.3, 2.1, 2.2, 2.3, 3.1, 3.4, 3.5, 4.3, 4.5, 4.6, 4.7, 4.8, 5.1, 5.2, 5.4 and 5.5.

The government information was thought to not be accurate for 32.0% of items. Survey points marked “not accurate”: 3.2, 3.3, 3.5, 4.1, 4.4, 4.9, 4.10 and 5.3.

The respondent took no position on the government information for 4.0% of items. Survey points marked “take no position”: 4.2.

**Survey comments from National Association for Fighting Hepatitis – Hepasist:**

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<tr>
<th>Information reported by government (2012–2013)</th>
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</thead>
<tbody>
<tr>
<td>1.1 There is no written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis.</td>
<td>Though there is no strategy thus far, there is already a written proposal and it is submitted to the Ministry of Health for adoption.</td>
</tr>
<tr>
<td>1.3 The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific population: health-care workers (including health-care waste handlers).</td>
<td>There is such an activity written in the hepatitis plan submitted to the Ministry of Health.</td>
</tr>
<tr>
<td>2.2 The government collaborates with the following in-country civil society groups to develop and implement its viral hepatitis prevention and control programme: Hepasist National Association to Fight Hepatitis and Hepactive Association to Fight Hepatitis.</td>
<td>To our knowledge only Hepasist is involved in the working group. We do not know how and whether Hepactive is involved in the work.</td>
</tr>
<tr>
<td>3.1 There is routine surveillance for viral hepatitis. There is a national surveillance system for the following types of acute hepatitis: A, B, C, D and E, but not for any type of chronic hepatitis.</td>
<td>There is monitoring of cases, but there is no register where this information is officially stored.</td>
</tr>
<tr>
<td>3.4 Hepatitis outbreaks are required to be reported to the government and are further investigated. There is adequate laboratory capacity nationally to support outbreak investigations and other surveillance activities for hepatitis A, hepatitis B, and hepatitis C, but not for hepatitis E.</td>
<td>It is possible to screen the population in a case of an epidemic outbreak, but this only applies for hepatitis A.</td>
</tr>
<tr>
<td>Information reported by government (2012–2013)</td>
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<tr>
<td>4.3 Nationally, 98.6% of newborn infants in a given recent year received the first dose of hepatitis B vaccine within 24 hours of birth and 96% of one-year-olds (ages 12–23 months) in a given recent year received three doses of hepatitis B vaccine.</td>
<td>The programme is since 1992.</td>
</tr>
<tr>
<td>4.5 There is a specific national strategy and/or policy/guidelines for preventing hepatitis B and hepatitis C infection in health-care settings. Health-care workers are vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood.</td>
<td>This is specially marked in the proposal for the national hepatitis plan.</td>
</tr>
<tr>
<td>5.2 The government does not have national policies relating to screening and referral to care for hepatitis B or hepatitis C.</td>
<td>This is also included and stressed in the hepatitis plan.</td>
</tr>
<tr>
<td>5.4 Publicly funded treatment for hepatitis B and hepatitis C is available to all people with health insurance. Information was not provided on the amount spent by the government on such treatment.</td>
<td>The drugs are available and the National Health Insurance Fund should have outlined their expenditures on them in their annual budget. There is a fiscal report, but it is not accessible for everyone.</td>
</tr>
<tr>
<td>3.2 There are standard case definitions for hepatitis. Deaths, including from hepatitis, are reported to a central registry. Less than 5% of hepatitis cases are reported as “undifferentiated” or “unclassified” hepatitis.</td>
<td>In a case when someone died from cirrhosis the autopsy says “death from cirrhosis” but it is never specified whether it was caused by hepatitis and what kind.</td>
</tr>
<tr>
<td>4.1 There is a national hepatitis A vaccination policy.</td>
<td>In the case of an outbreak the government does not have the capacities to react. Should there be a crisis situation, they tend to turn to NGOs for assistance.</td>
</tr>
<tr>
<td>4.4 There is a national policy specifically targeting mother-to-child transmission of hepatitis B (Annex B).</td>
<td>Since 2014, there is no more testing for pregnant women for hepatitis B.</td>
</tr>
</tbody>
</table>
People testing for both hepatitis B and hepatitis C register by name; the names are kept confidential within the system. Hepatitis B and hepatitis C tests are not free of charge for all individuals, but are free of charge for injecting drug users, men who have sex with men, prisoners and sex workers. Hepatitis B and hepatitis C tests are not compulsory for members of any specific group.

The Ministry of Health only gives 500 tests for free, though there is a lot more demand. There are centres where these tests are administered but they end quickly and it is not clear why.

Statement from National Association for Fighting Hepatitis – Hepasist regarding key hepatitis policy issues in Bulgaria:

National coordination is missing in Bulgaria. The governmental structures receive partial information on acute hepatitis, and the information is spread by word-of-mouth. There are no follow-up data on what happens to those diagnosed with acute hepatitis and whether they receive treatment. There are no specific data on mortality from acute or chronic hepatitis. The responsibilities for conducting screenings, diagnostics, treatment and continuous care services need to be clearly distributed among the relevant stakeholders. The government needs to take the leading role as a unifier of all the stakeholders and needs to adopt and support the national hepatitis plan. Regardless of the political majority and leadership in the country, the essence of the plan should be preserved as a long-term investment in social health. The roles of the stakeholders are (as we see them):

- **Institutions** supporting the development and implementation of the proposed national hepatitis plans; work on improving access to treatment for hepatitis and revaccination for hepatitis B; introducing plans for hepatitis A vaccination for children and high-risk groups.
- **Doctors** conducting diagnostics and treatment; put pressure on the government to develop a hepatitis register and later register new patients in the system; raise awareness among their patients of the disease and the need and benefits of early testing.
- **Patient organisations** informal support for patients; presenting useful information in a user-friendly manner to the general public; advocating for the rights and interests of patients in regards to access to treatment and care; collating and sharing best-practice case examples from the international scene.
- **Industry** to deliver new therapies to the Bulgarian market; to make treatment and medicines financially accessible for the patients; to support the patient and professional organisations.
- **Media** to provide unbiased coverage of the developments in the field and to raise awareness among the general public of the dangers of hepatitis and benefits of early screening.

Altogether, we stress the lack of adequate data on hepatitis in Bulgaria and access to quality and timely treatment and care. As mentioned above, information is mainly spread by word-of-mouth, which is based on one’s perceptions of the environment. At any given moment there is no certainty of how many people are diagnosed, how many are in critical condition, how many are on treatment and what type of treatment, and so on. We observe and learn from the good experiences and practices of the international community and do our best to bring those good examples to Bulgaria.
There is a specific national strategy and/or policy/guidelines for preventing hepatitis B and hepatitis C infection in health-care settings. Health-care workers are vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood.

Sundhedsstyrelsen (Danish Health and Medicines Authority) recommends vaccination against HBV in healthcare workers with a significant risk of HBV exposure, but to my knowledge few (if any?) offer free HBV vaccination. For example, at the largest hospital in Denmark HBV vaccination is not offered to all who are at risk of HBV infection.
4.10 The government has guidelines addressing how hepatitis A and hepatitis E can be prevented through food and water safety.

4.3 Nationally, 90% of newborn infants in a given recent year received the first dose of hepatitis B vaccine within 24 hours of birth and 64% of one-year-olds (ages 12–23 months) in a given recent year received three doses of hepatitis B vaccine.

4.6 There is a national policy on injection safety in health-care settings, but it is not known what type of syringes it recommends for therapeutic injections. Single-use or auto-disable syringes, needles and cannulas are always available in all healthcare facilities.

5.1 Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools of health professionals (pre-service education), on-the-job training and post-graduate training. There are national clinical guidelines for the management of viral hepatitis, which include recommendations for cases with HIV coinfection.

5.2 The government does not have national policies relating to screening and referral to care for hepatitis B or hepatitis C.

Statement from CHIP regarding key hepatitis policy issues in Denmark:

In Denmark, most people are diagnosed with hepatitis C by the general practitioners or in the municipal centres for drug users. Further evaluation of the infection and possibly HCV treatment is the responsibility of hospital infectious disease or gastroenterology departments. This physical barrier is often difficult to overcome especially for former or current drug users. It is estimated that fewer than half of all drug users diagnosed with hepatitis C are followed by a specialist hospital department. Studies from other countries have shown that decentralised (in the centres for drug abusers) evaluation and treatment of hepatitis C have in general been positive. It is recommended that similar research based initiatives are developed in Denmark and supported economically by national and municipal funds.

The Danish Ministry of Health (via Sundhedsstyrelsen) has for many years published guidelines on who and how to screen for viral hepatitis, but there has been no evaluation of awareness, adherence and cost-effectiveness of these recommendations. This is pertinent since it is estimated that only about half all HBV and HCV infected in Denmark have been diagnosed. Again, nationally funded research based studies should further investigate this.
SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Denmark reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 96.0% of items.

Survey points marked “accurate”:
1.1, 1.2, 1.3, 2.1, 2.2, 3.1, 3.2, 3.3, 3.4, 3.5, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, 4.10, 5.1, 5.3, 5.4 and 5.5.

The government information was thought to not be accurate for 4.0% of items.

Survey points marked “not accurate”:
5.2.

Roskilde Sygehus did not provide any comments about survey items.

Statement from Roskilde Sygehus regarding key hepatitis policy issues in Denmark:

Our government should do more to support vulnerable youth, e.g. children who lose one or both of their parents, so that they do not become criminals, drug abusers and hepatitis-C infected. This should be done in Denmark, but we should also support this work in other countries.
Denmark

Sex & Samfund (Danish Family Planning Association)

NGO – Sexual and reproductive health and rights advocacy organisation
Copenhagen, Denmark
www.sexogsamfund.dk

SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Denmark reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 68.0% of items.
Survey points marked “accurate”: 1.1, 1.3, 2.1, 2.2, 3.1, 3.3, 3.4, 4.1, 4.2, 4.4, 4.5, 4.6, 4.9, 4.10, 5.1, 5.3 and 5.4.

The government information was thought to not be accurate for 4.0% of items.
Survey points marked “not accurate”: 4.3.

The respondent took no position on the government information for 28.0% of items.
Survey points marked “take no position”: 1.2, 3.2, 3.5, 4.6, 4.7, 5.1 and 5.5.

Survey comments from Sex & Samfund (Danish Family Planning Association):

4.3 Nationally, 90% of newborn infants in a given recent year received the first dose of hepatitis B vaccine within 24 hours of birth and 64% of one-year-olds (ages 12–23 months) in a given recent year received three doses of hepatitis B vaccine.

To our knowledge, this information is not accurate.

Only as a temporary change in the national children’s vaccination programme because of a shortage in the original DiTeKiPolHib vaccine. Otherwise it is only children of women in specific target groups that are offered the hepatitis B vaccine.

Sex & Samfund did not provide a statement regarding key hepatitis policy issues in Denmark.
Estonia


The government information was thought to be accurate for 68.0% of items.

Survey points marked “accurate”:
1.1, 1.2, 1.3, 2.1, 2.2, 3.2, 3.5, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, 4.1 and 5.3.

The government information was thought to not be accurate for 28.0% of items.

Survey points marked “not accurate”:
3.1, 3.3, 3.4, 5.1, 5.2, 5.4 and 5.5.

The respondent took no position on the government information for 4.0% of items.

Survey points marked “take no position”:
4.1.

To our knowledge, this information is not accurate.

To our knowledge, this information is not accurate.

Survey comments from the Estonian Society of Gastroenterology:

Information reported by government (2012–2013)

3.1 There is routine surveillance for viral hepatitis. There is a national surveillance system for the following types of acute hepatitis: A, B, C, D and E, and for the following types of chronic hepatitis: B, C and D.

3.3 Liver cancer cases are not registered nationally, but cases with HIV/hepatitis coinfection are. The government publishes hepatitis disease reports monthly and annually.

3.4 Hepatitis outbreaks are required to be reported to the government and are further investigated. There is adequate laboratory capacity nationally to support outbreak investigations and other surveillance activities for hepatitis A, hepatitis B and hepatitis C, but not for hepatitis E.

5.1 Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools of health professionals (pre-service education). There are national clinical guidelines for the management of viral hepatitis, but it is not known whether they include recommendations for cases with HIV coinfection.

5.2 The government has national policies relating to screening and referral to care for hepatitis B and hepatitis C.

Civil society respondent comments (2014)

Chronic viral hepatitis B and hepatitis C surveillance only specific population groups (for example pregnant women, prisoners, etc.), blood donors screening for hepatitis B and hepatitis C.

Hepatocellular cancer cases are registered nationally.

Hepatitis E surveillance is possible also.

National clinical guidelines for the management of hepatitis B and hepatitis C include recommendations for coinfection cases (HCV/HIV, HBV/HCV, HBV/HIV).

Only for screening for hepatitis B.
5.4 Publicly funded treatment for hepatitis B and hepatitis C is available to people covered by the Estonian Health Insurance Fund. Information was not provided on the amount spent by the government on such treatment.

5.5 The following drugs for treating hepatitis B are on the national essential medicines list or subsidised by the government: interferon alpha and pegylated interferon. The following drugs for treating hepatitis C are on the national essential medicines list or subsidised by the government: interferon alpha, pegylated interferon and ribavirin. With limitations for hepatitis B and hepatitis C, not all available drugs are 100% reimbursed. For hepatitis B, peginterferon alpha2a is 100% reimbursed, entecavir is only 50% reimbursed. For hepatitis C, peginterferon alpha 2a and 2b, and ribavirin 100% reimbursed. Telaprevir and boceprevir are reimbursed 100% only for patients with advanced fibrosis (F3-F4).

To our knowledge, this information is not accurate.

The Estonian Society of Gastroenterology did not provide a statement regarding key hepatitis policy issues in Estonia.
SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of France reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 76.0% of items.

Survey points marked “accurate”:
1.1, 1.2, 1.3, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 2.9, 2.10, 3.1, 3.2, 3.4, 3.5, 3.6, 3.7, 3.8, 3.9, 3.10, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, 4.10, 5.1, 5.2, 5.3, 5.4 and 5.5.

The government information was thought to not be accurate for 24.0% of items.

Survey points marked “not accurate”:
2.1, 3.1, 3.3, 3.4, 3.5 and 5.3.

Association Française pour l’Etude du Foie (AFEF) did not provide any comments about survey items.

Statement from Association Française pour l’Etude regarding key hepatitis policy issues in France:

Waiting for the first national report on hepatitis B and hepatitis C published on 19 May 2014 by ANRS-AFEF.
SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of France reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 76.0% of items.
Survey points marked “accurate”: 1.1, 1.2, 1.3, 2.2, 3.1, 3.2, 3.4, 3.5, 4.2, 4.4, 4.5, 4.6, 4.8, 4.9, 4.10, 5.1, 5.2, 5.4 and 5.5.

The government information was thought to not be accurate for 20.0% of items.
Survey points marked “not accurate”: 3.3, 4.1, 4.3, 4.7 and 5.3.

The respondent took no position on the government information for 4.0% of items.
Survey points marked “take no position”: 2.1.

The Institut de Santé Publique, d’Épidémiologie et de Développement (ISPED) did not provide any comments about survey items.

Statement from ISPED regarding viral hepatitis screening, care and treatment in France:

What are the greatest problems with this component of the national response to viral hepatitis?
› Lack of data and evidence in the field.

What needs to change?
› Organisation of information system (ongoing with HEAPTE study cohort).

What should be the government’s role in bringing about these changes?
What responsibilities should the government have?
› Co-funding within a public/private partnership.

What should be the roles and responsibilities of other stakeholders at the community, national and international levels?
› Collaboration (see above).

What evidence exists to support your organisation’s viewpoint?
› ANRS website.
There is no written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis.

The government does not have a viral hepatitis prevention and control programme that includes activities targeting specific populations.

The government held events for World Hepatitis Day 2012 but has not funded other viral hepatitis public awareness campaigns since January 2011.

The government collaborates with the following in-country civil society groups to develop and implement its viral hepatitis prevention and control programme: Bemoni Public Union, Centre for Information and Counseling on Reproductive Health Tanadgoma, and Curatio International Foundation.

Hepatitis outbreaks are required to be reported to the government and are further investigated. There is adequate laboratory capacity nationally to support investigation of viral hepatitis outbreaks and other surveillance activities.

There is no national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are not conducted regularly.

Written national programme has been submitted to the Ministry of Health in August 2013. In March 2014, three-day workshop was dedicated to elaboration of the action plan.

Control programme (including treatment) running in prison system since March 1 2014 (adopted in June 2013).

This is Georgian Harm Reduction Network campaign that runs since 2011. We do not know of government-organised events.

Formal partners of government are not the organisations mentioned in the governmental account but: Georgian Harm Reduction Network, Georgian Community Advisory Board, Health Research Union, Medecins du Monde–France, Open Society Foundations.

There might be a capacity, but this is not what government is doing. We also doubt that reported cases are further investigated.

Georgian National Centre for Disease Control and Public Health together with US Centres for Disease Control (CDC) and CDC Foundation are putting together study design for updated prevalence study.
Statement from the Georgian Harm Reduction Network regarding viral hepatitis screening, care and treatment in Georgia:

What are the greatest problems with this component of the national response to viral hepatitis?

- Treatment programme is drafted, budgeted, management is modelled, and costs are calculated. Only thing left is to adopt and fund this programme. Instead the Georgian government talks about international response and donor money investments in elimination programme.

What needs to change?

- The Georgian government needs to allocate around EUR 5 million in order to screen 5,000 people and treat 2,400 patients during the first year. And then scale up the treatment.

Information reported by government (2012–2013)

5.2 The government has national policies relating to screening and referral to care for hepatitis B and hepatitis C.

5.3 People testing for both hepatitis B and hepatitis C register by name; the names are kept confidential within the system. Hepatitis B and hepatitis C tests are not free of charge for all individuals, but they are free of charge for pregnant women and blood donors. Hepatitis B and hepatitis C tests are compulsory for blood donors.

5.4 Publicly funded treatment is not available for hepatitis B or hepatitis C.

5.5 The following drugs for treating hepatitis B are on the national essential medicines list or subsidised by the government: interferon alpha, pegylated interferon, lamivudine, adefovir dipivoxil and tenofovir. The following drugs for treating hepatitis C are on the national essential medicines list or subsidised by the government: interferon alpha, pegylated interferon, ribavirin, boceprevir and telaprevir.

Civil society respondent comments (2014)

In 2011–2012, national screening centre conducted HCV screening and no referral was practiced. Even PCR tests were not conducted. Which means that those screened are not diagnosed.

Anti-HCV tests are available in army screening programme. Global Fund-funded interventions offer free anti-HCV to people who inject drugs. Médecins du Monde–France also covers people who inject drugs.

Global Fund funding is incorporated in state programmes. Therefore we can conclude that HIV coinfected patients are treated (110 per year). Also prison treatment programme will treat 1,000 prisoners in two years.

We have inquired about the Essential Medicines List but did not get it from the Georgian National Centre for Disease Control and Public Health or from the Ministry of Health. They say there is a list, but we cannot find it. Even if there were, at the moment nothing is subsidised by government.

What should be the government’s role in bringing about these changes? What responsibilities should the government have?

- Everything is written and developed. There should be commitment from the government that they will make relevant budget allocations for treatment of patients with pegylated interferon alpha 2A and alpha 2B and direct engagement in new direct-acting antiviral price negotiations.

What roles and responsibilities of other stakeholders at the community, national and international levels?

- Patient groups and NGOs collaborate with international counterparts to ensure non-discrimination inclusion of the patients in treatment programmes. These stakeholders also conduct treatment literacy activities.

What evidence exists to support your organisation’s viewpoint?

- National treatment programme document
- Studies
- Accounts in media, when government commits to universal access of HCV treatment etc.
- Public procurement tender documentations and decision minutes

× To our knowledge, this information is not accurate.
SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Germany reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

[✓] The government information was thought to be accurate for 92.0% of items.

Survey points marked “accurate”:
1.1, 1.2, 1.3, 2.1, 2.2, 3.1, 3.2, 3.4, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, 4.10, 5.1, 5.3, 5.4 and 5.5.

[✗] The government information was thought to not be accurate for 8.0% of items.

Survey points marked “not accurate”:
3.3 and 5.2.

Survey comments from Deutsche Leberhilfe e.V.:

Information reported by government (2012–2013)

2.2 The government does not collaborate with in-country civil society groups to develop and implement its viral hepatitis prevention and control programme.

Civil society respondent comments (2014)

The government has started after we have produced a national strategy paper. We are now in first discussion with representatives of the Ministry of Health.

3.2 There are standard case definitions for hepatitis. Deaths, including from hepatitis, are reported to a central registry. Information was not provided on the percentage of hepatitis cases reported as “undifferentiated” or “unknown” hepatitis.

It is true that there is a central registry but in real life it is not working well. So we do not have in Germany a very correct overview of hepatitis-related mortality.

4.5 There is a specific national strategy and/or policy/guidelines for preventing hepatitis B and hepatitis C infection in health-care settings. Health-care workers are vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood. Hepatitis B vaccination is also recommended for health-care waste handlers.

Yes, for those who are employed by a hospital, vaccination is reimbursed but not very often proactively offered. Those who are not hospital employees (e.g., cleaning staff) have difficulties to get vaccination reimbursed or to be informed.

5.1 Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools of health professionals (pre-service education) and on-the-job training. There are national clinical guidelines for the management of viral hepatitis, which include recommendations for cases with HIV coinfection.

But hepatitis is only a minor little part in the education in university.

* World Hepatitis Alliance member.
Statement from Deutsche Leberhilfe e.V. regarding key hepatitis policy issues in Germany:

National coordination. At this time, national coordination is not good. The German national hepatitis action group initiative (including the leading physicians and NGOs but not government representatives) has developed an action strategy paper which was launched in 2013 and presented to the Ministry of Health. One of the recommendations is to create a national hepatitis task force to coordinate hepatitis-related activities and implement needed strategies.

Awareness-raising, partnerships and resource mobilisation. Awareness strategies in the different hepatitis risk groups is key but not been started by the government. In vain we have discussed several times with the Ministry of Health that there is a high need of individualised awareness strategies for better prevention and better diagnosis.

Evidence-based policy and data for action. The Robert Koch Institute (a central scientific institution serving the Federal Ministry of Health) has started several minor projects to have better data. But although the first publications appeared in 2013, there have been no follow-up efforts to initiate programmes, which are especially needed for high-risk groups.

Prevention of transmission. The highest incidence groups in Germany for hepatitis C are people who inject drugs and men who have sex with men. However, no prevention programmes have been established for either group (e.g., harm reduction in prison). Also, regarding hepatitis B, there are no specific programmes for e.g. migrants coming from highly endemic countries. The BzGA (Bundeszentrale für gesundheitliche Aufklärung) claims they run programmes but in fact NGOs like Deutsche Leberhilfe, Aidshilfe or Leberstiftung are the only ones who roll out prevention programmes. Everything is paid by private donations and with no financial support from the government.

Screening, care and treatment. Of all hepatitis cases in Germany, a maximum of 25% are diagnosed. Out of this only 20% have received treatment. The total treatment rate is less than 5%. Because as mentioned above only private initiatives care for more screening there is no expectation to increase this number. On the other hand we have excellent physicians in clinic and private sector for all hepatitis cases. The treatment success rate is close to pivotal clinical studies.
The Deutsche Leberstiftung/German Liver Foundation did not provide a statement regarding key hepatitis policy issues in Germany.

5.5 The following drugs for treating hepatitis B are on the national essential medicines list or subsidised by the government: interferon alpha, pegylated interferon, lamivudine, adefovir dipivoxil, entecavir, telbivudine and tenofovir.

The following drugs for treating hepatitis C are on the national essential medicines list or subsidised by the government: interferon alpha, pegylated interferon, ribavirin, boceprevir and telaprevir.

Outdated – Sofosbuvir is available.

The Deutsche Leberstiftung/German Liver Foundation did not provide a statement regarding key hepatitis policy issues in Germany.
The Government of Greece did not respond to the World Health Organization survey for the 2013 Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States, and therefore the Hellenic Foundation of Gastroenterology and Nutrition could not comment on government information for this report.

The organisation provided the following general statement regarding hepatitis screening, care and treatment in Greece:

There is no national screening policy for viral hepatitis, not even official recommendations from any governmental body.

There are barriers not only to screening, but also to patients’ initial evaluation, as no PCR tests for hepatitis B or hepatitis C (HBV DNA, HCV RNA, HCV genotype) are reimbursed.

There is a delay in the availability and reimbursement of new [viral hepatitis treatment regimens]. Even when the new agents may be available, they are only reimbursed through a bureaucratic process based on approval for individual patients.
SURVEY HIGHLIGHTS

The Government of Greece did not respond to the World Health Organization survey for the 2013 Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States, and therefore the Hellenic Liver Association “Prometheus” could not comment on government information for this report.

The organisation provided the following general statement regarding key hepatitis policy issues in Greece:

Prevention of transmission. Unfortunately, in Greece there is an increase in the prevalence of viral hepatitis, especially among vulnerable groups. The only effective measure was the establishment of compulsory vaccination in newborns in 1987. Furthermore, since 1992 there has been (screening of blood products) which has prevented the transmission of hepatitis C through transfusions.

In addition, according to the annual report of the National Centre for Documentation and Information on Drugs, there has been an increase in the prevalence of Hepatitis C among people who inject drugs (69.3% in 2011 to 73.4% in 2012). In addition, according to the same report, in 2012 only 81 people who inject drugs (PWID) got vaccinated for Hepatitis A, and 173 for hepatitis B.

Also, the increase of HIV prevalence in 2010 among PWID added an extra problem, since 99% of the newly infected HIV cases had already been diagnosed with hepatitis C.

Unfortunately, the increase in prevalence among PWID is the result of underperforming harm reduction programmes. The government does not seem to “invest” in harm reduction programmes. Waiting lists in substitution programmes remain extremely high – 2.5 years in Athens. Needle exchange is very poor. Approximately, 400,000 syringes have been distributed during the past year, whereas the actual need is approximately 2,000,000.

There are no drug consumption rooms in Athens or other facilities that promote safe injection.

Evidence-based policy and data for action. In Greece, unlike other countries of the European Union, there are no representative epidemiological studies of the population that could give us valid information about the state of health of citizens.

During the last three months, the National Organization of Health Services in Greece in cooperation with the National Technical University of Athens and the University of Peloponnesse started a registry project. They will create a register tracing all patients living with hepatitis B and C, and will try to calculate the cost of their treatment.

Furthermore, the Medical School of Athens in collaboration with all of the medical schools of Greece and Panteion University will start a national epidemiological study of hepatitis B and hepatitis C. The study will be conducted on a random sample of 6,000 people aged 18.

Awareness-raising, partnerships and resource mobilisation. Activities focused on increasing awareness about viral hepatitis among policy-makers, health professionals, and the public have only been conducted by NGOs. Unfortunately, government has not implemented awareness campaigns or other similar actions.

Disappointing is the fact that the department of hepatitis within the Greek Centre for Disease Control (CDC) (KEELPNO) lacks funding. The Greek CDC, which is the most acceptable and well-known institution, and the one responsible for implementing national awareness campaigns for hepatitis, has not carried out any related activities.

On the other hand, the Greek CDC has implemented awareness campaigns for HIV. Unfortunately, hepatitis has been neglected as a disease.

There should be an annual effort to have NGOs work in cooperation with the Greek CDC. All related institutions should implement awareness campaigns so as during the whole year media should constantly broadcast hepatitis awareness messages.

Hellenic Liver Association ‘Prometheus’*
NGO – hepatitis patient group
Athens, Greece
http://helpa-prometheus.gr/

* World Hepatitis Alliance member.
### Hungary

**Májbetegekért Alapítvány**

**Foundation**

Budapest, Hungary

www.majbeteg.hu

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**SURVEY HIGHLIGHTS**

The respondent reviewed 25 items of information that the government of Hungary reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for **88.0%** of items.

- **Survey points marked “accurate”:** 1.1, 1.2, 1.3, 2.2, 3.1, 3.2, 3.3, 3.4, 3.5, 4.1, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, 4.10, 5.1, 5.2, 5.3 and 5.4

The government information was thought to not be accurate for **12.0%** of items.

- **Survey points marked “not accurate”:** 2.1, 4.2 and 5.5.

**Survey comments from the Májbetegekért Alapítvány:**

<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.2</strong> There is no designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities. It is not known how many people work full-time on hepatitis-related activities in all government agencies/bodies.</td>
<td><strong>There are 30 hepatitis centrums in Hungary, where hepatitis-infected patients are being treated.</strong></td>
</tr>
<tr>
<td><strong>2.2</strong> The government collaborates with the following in-country civil society group to develop and implement its viral hepatitis prevention and control programme: Májmoly Foundation.</td>
<td><strong>The correct name of the foundation is Májbetegekért Alapítvány (Foundation for Patients with Liver Disease).</strong></td>
</tr>
<tr>
<td><strong>3.3</strong> Liver cancer cases are registered nationally, but cases with HIV/hepatitis coinfection are not. The government publishes hepatitis disease reports weekly.</td>
<td><strong>The government does not publish hepatitis disease reports weekly.</strong></td>
</tr>
<tr>
<td><strong>4.9</strong> It is not known whether there is a national policy relating to the prevention of viral hepatitis among people who inject drugs.</td>
<td><strong>There is not a national policy relating to the prevention of viral hepatitis among people who inject drugs.</strong></td>
</tr>
<tr>
<td><strong>5.2</strong> It is not known whether the government has national policies relating to screening and referral to care for hepatitis B or hepatitis C.</td>
<td><strong>The government does not have national policies relating to screening and referral to care for hepatitis B or hepatitis C.</strong></td>
</tr>
</tbody>
</table>

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* World Hepatitis Alliance member.
<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>2.1 It is not known whether the government held events for World Hepatitis Day 2012 or has funded other viral hepatitis public awareness campaigns since January 2011.</td>
<td>The government had not held events for World Hepatitis Day, but in Budapest three organisations, Májbetegekért Alapítvány, ÖVEM and VIMOR (one foundation and two patient associations) have organised the Hungarian Hepatitis Day together since 2011.</td>
</tr>
<tr>
<td>4.2 The government has not established the goal of eliminating hepatitis B</td>
<td>There is a hepatitis B vaccination policy. Every child born after 1986 gets the vaccination at age 14.</td>
</tr>
<tr>
<td>5.4 Publicly funded treatment is available for hepatitis B and hepatitis C, but information was not provided on who is eligible for such treatment. The amount spent by the government on publicly funded treatment for hepatitis B and hepatitis C is not known.</td>
<td>Treatment for hepatitis B is available for everybody, pegilated interferon + ribavirin. Treatment for hepatitis C is available for almost everybody. Direct-acting antiviral treatment for hepatitis C is based on Priority Index which counted in the National Hepatitis Registry (<a href="http://www.hepreg.hu">www.hepreg.hu</a>).</td>
</tr>
<tr>
<td>5.5 It is not known whether any drug for treating hepatitis B or hepatitis C is on the national essential medicines list or subsidised by the government.</td>
<td>National health insurance is financing the treatment.</td>
</tr>
</tbody>
</table>

Májbetegekért Alapítvány did not provide a statement regarding key hepatitis policy issues in Hungary.
Hetz – Israel Association for the Health of the Liver

NGO – hepatitis patient group
Kibbutz Tzora, Israel
www.hetzliver.org

Statement from Hetz – Israel Association for the Health of the Liver regarding key hepatitis policy issues in Israel:

The greatest problem is the lack of a national plan for the eradication of hepatitis, which includes a national screening programme that focuses on screening at-risk populations.

What needs to change?

The adoption and funding for implementation of a national plan for eradicating hepatitis by the Israeli government, which should mainly include: (1) the establishment of a national hepatitis registry, (2) screening programme, (3) programme for eradicating hepatitis in prisons, (4) programme focusing on people who inject drugs, (5) clear measures of success such as increasing the number of diagnosed patients and increasing the number of patients receiving treatment.

The government’s role is to adopt, fund and implement a national plan for eradication of hepatitis. The government should (1) appropriately fund the implementation of the plan, starting with screening of at-risk populations, (2) formally appoint a person whose role will be to lead coordination of the implementation, (3) work closely with the patient association and the physician association in drafting the plan and implementing it, (4) formally support World Hepatitis Day by initiating activities and campaigns to raise awareness about the importance of being tested and treated, (5) financially support the patient association.

Physicians should agree on the optimal care path for patients, including what the role of the family physician is, and other health professionals.

Evidence supporting our viewpoint:

New local analysis proves hepatitis C screening is cost-effective.

The viral time-bomb: Local hepatologists agree that hepatitis C complications will increase steeply in the next five to ten years, which will lead to a steep increase in health expenditure on cirrhosis, liver cancer and liver transplants.

New parliamentary research report supports compensation of patients who acquired the virus in government health facilities.

Free testing offered during World Hepatitis Day 2013 resulted in many newly diagnosed patients – proving the value of media campaigns and accessible testing services.

SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Israel reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 48.0% of items.

Survey points marked “accurate”:
1.2, 3.5, 4.1, 4.2, 4.3, 4.5, 4.6, 4.7, 4.8, 5.1, 5.2 and 5.5.

The government information was thought not to be accurate for 52.0% of items.

Survey points marked “not accurate”:
1.1, 1.3, 2.1, 2.2, 3.1, 3.2, 3.3, 4.4, 4.9, 4.10, 5.3 and 5.4.

Survey comments from Hetz – Israel Association for the Health of the Liver:

To our knowledge, this information is accurate.

4.2 The government has not established the goal of eliminating hepatitis B.

4.4 There is a national policy specifically targeting mother-to-child transmission of hepatitis B (Annex B).

4.9 There is a national policy relating to the prevention of viral hepatitis among people who inject drugs.

To our knowledge, this information is not accurate.

There is a vaccination plan for hepatitis B but not a screening plan.

The Hetz Association is struggling for this in the parliament.

The Hetz Association is working on this issue.

Information reported by government (2012–2013)

Civil society respondent comments (2014)
SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Italy reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️ The government information was thought to be accurate for <strong>72.0%</strong> of items.</td>
<td>There is just a department taking care of prevention of infectious diseases.</td>
</tr>
<tr>
<td>Survey points marked “accurate”: 1.2, 2.1, 3.1, 3.4, 3.5, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 4.10, 5.1, 5.2, 5.4 and 5.5.</td>
<td></td>
</tr>
<tr>
<td>✗ The government information was thought to not be accurate for <strong>28.0%</strong> of items.</td>
<td>To be more clear and honest, the government never take any hepatitis public awareness activity and they held events for World Hepatitis Day just under pressure of patient association and scientific associations. Also because World Hepatitis Day has not yet been officially approved by any Italian government although we have asked for this several times.</td>
</tr>
<tr>
<td>Survey points marked “not accurate”: 1.1, 1.3, 2.2, 3.2, 3.3, 4.9 and 5.3.</td>
<td></td>
</tr>
</tbody>
</table>

Survey comments from Associazione EpaC:

1.2 There is no designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities. Information was not provided on how many people work full-time on hepatitis-related activities in all government agencies/bodies. To our knowledge, this information is accurate.

2.1 The government held events for World Hepatitis Day 2012 but has not funded other viral hepatitis public awareness campaigns since January 2011. To be more clear and honest, the government never take any hepatitis public awareness activity and they held events for World Hepatitis Day just under pressure of patient association and scientific associations. Also because World Hepatitis Day has not yet been officially approved by any Italian government although we have asked for this several times.

3.1 There is routine surveillance for viral hepatitis. There is a national surveillance system for the following types of acute hepatitis: **A, B, C, D and E**, but not for any type of chronic hepatitis. Yes there is only a registry for acute hepatitis, but not all local health district departments adhere to this system. In any case, this surveillance do not provide any information on the real number of patients we have with hepatitis B and hepatitis C, how many new diagnoses each year, and so on. It is a very limited source of information.

4.2 The government has not established the goal of eliminating hepatitis B. But we have a good vaccination programme.

4.10 The government has guidelines that address how hepatitis A and hepatitis E can be prevented through food and water safety. Maybe they have, but we should consider whether those guidelines are known by citizens. To our knowledge, there are no active efforts to circulate the information.

* World Hepatitis Alliance member.
### Italy

**Associazione EpaC continued**

<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5.1</strong> Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools of health professionals (pre-service education) and postgraduate training. Information was not provided on whether there are national clinical guidelines for the management of HIV, which include recommendations for co-infection with viral hepatitis.</td>
<td>Skill and competence are also provided by the scientific associations.</td>
</tr>
<tr>
<td><strong>5.4</strong> Publicly funded treatment is available for hepatitis B and hepatitis C. Information was not provided regarding who is eligible for this. Information was not provided on the amount spent by the government on publicly funded treatment for hepatitis B and hepatitis C.</td>
<td>We confirm, but of course access to treatment is another story.</td>
</tr>
<tr>
<td><strong>5.5</strong> The following drugs for treating hepatitis B are on the national essential medicines list or subsidised by the government: interferon alpha, pegylated interferon, lamivudine, adefovir dipivoxil, entecavir, telbivudine and tenofovir. The following drugs for treating hepatitis C are on the national essential medicines list or subsidised by the government: interferon alpha, pegylated interferon, ribavirin, boceprevir and telaprevir.</td>
<td>It is time to add sofosbuvir.</td>
</tr>
<tr>
<td><strong>1.1</strong> There is no written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis.</td>
<td>Partially true. In fact there is a strategy/plan ready, written by a selected group of stakeholders, but not yet approved by the Minister of Health. We have been waiting for approval for several months.</td>
</tr>
<tr>
<td><strong>1.3</strong> The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific populations: health-care workers (including health-care waste handlers), people who inject drugs, prisoners, partners of carriers of HBsAg and hepatitis C virus, people cohabiting with carriers of HBsAg or hepatitis C virus, people undergoing multiple blood transfusions, people with haemophilia, people undergoing haemodialysis, people with chronic skin lesions of the hands (eczema, psoriasis), travellers to hepatitis B-endemic areas, police officers, firefighters, public officials and garbage disposal workers.</td>
<td>Government does not have a unique hepatitis control programme. However, many of the activity mentioned are included in other plans and specific laws, i.e., the drug users strategy, vaccination strategy, travellers to hepatitis B endemic areas, people with haemophilia. But some time are not systematic activities if we look at the local level (regions) and in any case are not included in a unique hepatitis control programme.</td>
</tr>
<tr>
<td>Information reported by government (2012–2013)</td>
<td>Civil society respondent comments (2014)</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td><strong>2.2</strong> The government does not collaborate with in-country civil society groups to develop and implement its viral hepatitis prevention and control programme.</td>
<td>They started to collaborate beginning last year. But the impression is that they cooperate in everything that does not imply costs (like to have a strategic plan) that have no cost for government because it is a piece of paper. They stop the cooperation when it is time to put money into the plan and/or approve everything have a cost.</td>
</tr>
<tr>
<td><strong>3.2</strong> There are standard case definitions for hepatitis. Deaths, including from hepatitis, are reported to a central registry. In response to a question asking what percentage of hepatitis cases are reported as “undifferentiated” or “unclassified”, the following information was provided: incidence rate/100,000 of unclassified hepatitis: 0.1.</td>
<td>This is unclear. By the way, hepatitis deaths are not well calculated because we need to sum up the deaths from hepatocellular carcinoma, cirrhosis, post-transplant, that means the consequences and complications of hepatitis. And from our calculation, we have at least 10,000 deaths per year just for hepatitis C.</td>
</tr>
<tr>
<td><strong>3.3</strong> Liver cancer cases and cases with HIV/hepatitis coinfection are not registered nationally. The government publishes hepatitis disease reports annually.</td>
<td>To my knowledge, new cases of liver cancer and coinfection are not reported (there are just estimations) but are reported the death each four years of the liver cancer mortality. I have never seen a hepatitis disease report from government. Very curious to see what this means regarding a “hepatitis disease report.”</td>
</tr>
<tr>
<td><strong>4.9</strong> There is a national policy relating to the prevention of viral hepatitis among people who inject drugs.</td>
<td>This is a very vague statement. Which prevention policy? If we refer to the screening they forgot to say that at local level the screening is not done properly and systematically. I mean that whatever is written in a strategy, then you need to see the implementation at the local level. We have 21 different regional systems, and many times things are done differently region by region and district by district.</td>
</tr>
</tbody>
</table>
To our knowledge, this information is not accurate.

5.3 People testing for hepatitis B and hepatitis C do not register by name. Hepatitis B and hepatitis C tests are free of charge for all individuals. Information was not provided on whether hepatitis B or hepatitis C tests are compulsory for members of any specific group.

This point is not clear as formulated. It is true that there is a strong policy on maintaining patient privacy with nondisclosure systems. Not true that tests are free of charge for all individuals, just some specific groups. In most cases, a regular citizen must co-pay the test, especially hepatitis C (EUR 8 through a doctor’s prescription, or EUR 15–20 privately.) In some cities, there are free anonymous testing services for special categories of people (for example, sex workers, men who have sex with men). But these are local initiatives.

Information reported by government (2012–2013)

Statement from Associazione EpaC regarding key hepatitis policy issues in Italy:

In Italy nothing exists regarding the topics [in the civil society survey]. I do not think there will be any national coordination, awareness, screening mobilisation or whatever in viral hepatitis without a specific directive from the European Parliament and support statements to World Health Assembly resolution 63.18.

Civil society respondent comments (2014)

Our government does not listen to patient associations, but listens a lot to the European directives. So we should put any possible efforts into convincing the European Parliament to introduce hepatitis into the health agenda.
Hepatīta Biedrība
NGO – hepatitis patient group
Riga, Latvia
www.hepatitis.lv

Statement from Hepatīta Biedrība regarding key hepatitis policy issues in Latvia:

The biggest problem is reimbursement for hepatitis C treatment. The state compensates only 75% of drug treatment costs. As the costs are high, the co-payment adds up to EUR 300 per month, which creates a very high barrier for many patients to be cured and further increases risks for virus transfer to other individuals. Untreated patients thus are under great risk of further complications of cirrhosis and liver cancer. Information from the Infectology Centre of Latvia shows that almost half of patients cannot afford the treatment because of the co-payment. Also, the new generation medicine is not reimbursed and only few patients can afford to pay for themselves and be cured. The reimbursement level should be increased to 100% to prevent the further spread of the disease and cure patients.

SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Latvia reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

- The government information was thought to be accurate for 64.0% of items.
  - Survey points marked “accurate”: 1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 2.1, 2.2, 2.3, and 2.4.

- The government information was thought to not be accurate for 12.0% of items.
  - Survey points marked “not accurate”: 3.1, 3.2, 3.3, 3.4, 3.5, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, and 4.8.

- The respondent took no position on the government information for 24.0% of items.
  - Survey points marked “take no position”: 1.6, 1.8, 1.9, 1.10, 2.4, 2.5, 3.6, 3.7, 3.8, 3.9, 4.9, 4.10.

Survey comments from Hepatīta Biedrība:

1.1 There is no written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis. To our knowledge, this information is accurate.

A common strategy for hepatitis C, HIV and sexually transmitted diseases is in development; to be approved this year.
SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of the Netherlands reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

- The government information was thought to be accurate for 60.0% of items. Survey points marked “accurate”: 1.1, 1.2, 1.3, 3.3, 3.5, 4.1, 4.2, 4.5, 4.6, 4.7, 4.8, 4.9, 5.2 and 5.4.

- The government information was thought to not be accurate for 4.0% of items. Survey points marked “not accurate”: 2.2.

- The respondent took no position on the government information for 36.0% of items. Survey points marked “take no position”: 2.1, 3.1, 3.2, 4.3, 4.4, 4.10, 5.1, 5.3 and 5.5.

Survey comments from The Rainbow Group:

- To our knowledge, this information is not accurate.

- We take no position regarding this statement.

Information reported by government (2012–2013) Civil society respondent comments (2014)

2.2 The government collaborates with the following in-country civil society group to develop and implement its viral hepatitis prevention and control programme: National Hepatitis Centrum. The National Hepatitis C Centre closed down their activities in January 2013. I am not aware of any other civil society agency with whom they collaborate.

2.1 The government held events for World Hepatitis Day 2012 and has funded other viral hepatitis public awareness campaigns since January 2011. It might well be accurate, but I am not aware of any detail.

Statement from The Rainbow Group regarding viral hepatitis screening, care and treatment issues in the Netherlands:

Although there is no formal guideline in the Netherlands that active drug users are not eligible for hepatitis C treatment, there is limited influx of people who inject drugs towards hepatitis C screening and treatment. The bottleneck seems to be at the level of drug treatment agencies. They show varied levels of awareness and priority in getting people into treatment. On city levels, this policy – often in the hands of one or two addiction specialists – is decisive in the municipal availability of screening and treatment.

There are big differences throughout the country. Some cities have an active drug treatment agency resulting in substantial numbers of people being treated for hepatitis C, while in other cities there is way more limited awareness, screening, and hepatitis C treatment. This was reported in a recent report from the Ministry of Health, conducted by the Trimbos Institute, on “Estimated Number of Opiate Users in the Netherlands” (2013).

Recommended change: the Ministry of Health needs to provide more coordination and prioritise hepatitis C as an urgent health issue.
The organisation provided the following general statement regarding key hepatitis policy issues in Norway:

**Screening, care and treatment.** The Norwegian government does not have national screening policies for hepatitis B and hepatitis C, except for in pregnancy, where testing of mothers belonging to defined risk groups is recommended. Unfortunately, there is not always adherence to this recommendation. Mothers with hepatitis B also exist outside of the defined risk groups. As a result, babies at risk of mother-to-child transmission may fail to receive vaccination and immunoglobulin, and subsequently may become infected. For the same reason, mothers with high-level hepatitis B viraemia may not receive recommended antiviral therapy in pregnancy to reduce risk of transmission to their children. The government should consider introducing a policy of routine hepatitis B testing for all pregnant women, as is already the case with HIV. The government of Norway provides treatment for hepatitis B and hepatitis C free of charge, but does not have clear policies regarding when treatment is indicated. Treatment guidelines are available from the Norwegian Society for Infectious Diseases and the Norwegian Society for Gastroenterology. With the introduction of new and costly hepatitis C drugs, the above societies have begun to prepare guidelines regarding their use.

**Prevention of transmission.** The Norwegian government has only included hepatitis B vaccination in the child vaccination programme for children born into families in which at least one parent is not from a low-prevalence country. The most important measure for prevention of transmission of hepatitis B would be to include hepatitis B vaccination in the child vaccination programme for all children. Of 53 countries in the WHO European region, only five other countries besides Norway have not included hepatitis B vaccination in the child vaccination programme for all children.

**SURVEY HIGHLIGHTS**

The Government of Norway did not respond to the World Health Organization survey for the 2013 Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States, and therefore the Norwegian Society for Infectious Diseases could not comment on government information for this report.
## SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Poland reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

<table>
<thead>
<tr>
<th>Survey points marked “accurate”:</th>
<th>Survey points marked “not accurate”:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1, 2.1, 3.1, 3.2, 3.3, 3.4, 4.1, 4.2, 4.4, 4.5, 4.6, 4.7, 4.8, 4.10, 5.3 and 5.5.</td>
<td>1.1, 1.2, 2.2, 3.5, 4.3, 4.9, 5.1, 5.2 and 5.4.</td>
</tr>
</tbody>
</table>

To our knowledge, this information is accurate.

- **4.2** The government has not established the goal of eliminating hepatitis B.
- **4.10** The government does not have guidelines that address how hepatitis A and hepatitis E can be prevented through food and water safety.
- **1.1** There is no written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis.

To our knowledge, this information is not accurate.

- **4.9** There is a national policy relating to the prevention of viral hepatitis among people who inject drugs.
- **5.1** Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools for health professionals (pre-service education), on-the-job training and postgraduate training. There are national clinical guidelines for the management of viral hepatitis, but they do not include recommendations for cases with HIV coinfection. There are national clinical guidelines for the management of HIV, which include recommendations for coinfection with viral hepatitis.

### Survey comments from the Department of Infectious Diseases, Wroclaw Medical University:

<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Vaccination of all newborns and pregnant women is done, but people with hepatitis B do not have sufficient access to treatment.</td>
<td>Vaccination of all newborns and pregnant women is done, but people with hepatitis B do not have sufficient access to treatment.</td>
</tr>
<tr>
<td>There are no guidelines regarding hepatitis E.</td>
<td>There are no guidelines regarding hepatitis E.</td>
</tr>
<tr>
<td>Panel of experts is preparing the national strategy – Polish Experts Group.</td>
<td>Panel of experts is preparing the national strategy – Polish Experts Group.</td>
</tr>
<tr>
<td>Only NGOs carry out needle exchange programmes. There are not enough methadone programmes. Methadone is financed by national authorities – the National Health Fund.</td>
<td>Only NGOs carry out needle exchange programmes. There are not enough methadone programmes. Methadone is financed by national authorities – the National Health Fund.</td>
</tr>
<tr>
<td>There are national guidelines regarding coinfections.</td>
<td>There are national guidelines regarding coinfections.</td>
</tr>
</tbody>
</table>

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**Department of Infectious Diseases, Wroclaw Medical University**

**Medical school**

**Wroclaw, Poland**

**www.umed.wroc.pl**

**Survey comments from the Department of Infectious Diseases, Wroclaw Medical University:**
Information reported by government (2012–2013)

5.4 Publicly funded treatment is available for hepatitis B and hepatitis C. Publicly insured patients are eligible for this based on medical indications. The government spent Zl 65.5 million (US$ 20.1 million) on publicly funded treatment for hepatitis B in 2011. The amount spent by the government on such treatment for hepatitis C is not known.

Civil society respondent comments (2014)

The amount spent is low and does not cover the needs. People get drugs (pills) for hepatitis B infection for one to two years and it is not prolonged. People with hepatitis C are treated inadequately. Only a minority get protease inhibitors.

Statement from the Department of Infectious Diseases, Wroclaw Medical University regarding key hepatitis policy issues in Poland:

There are financial problems — there is not enough money in the “Kranken Kasse” to cover treatment for all who need it.

People need to wait for therapy. Or for hepatitis B the treatment is limited to one or two years. Increase the number of people in whom preventive procedures should be introduced. The government needs to take more responsibility for preventive procedures.
Survey highlights

The respondent reviewed 25 items of information that the government of Poland reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 68.0% of items.

Survey points marked “accurate”:
1.1, 1.2, 2.1, 2.2, 3.2, 3.4, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 4.10, 5.1 and 5.5.

The government information was thought to not be accurate for 32.0% of items.

Survey points marked “not accurate”:
1.3, 3.1, 3.3, 4.1, 4.9, 5.2, 5.3 and 5.4.

Survey comments from the Polish Association for the Study of the Liver:

1.1 There is no written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis.

A plan for the prevention and eradication of hepatitis C infection in Poland was prepared several years ago and annually updated by the Polish Group of Experts which is a joint initiative of experts from the Polish Association for the Study of the Liver and the Polish Association of Infectiologists and Epidemiologists. Unfortunately this initiative is constantly ignored by the Ministry of Health.

1.2 There is no designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities. It is not known how many people work full-time on hepatitis-related activities in all government agencies/bodies.

As a matter of fact there is no government institution which work on the hepatitis issue. All activities are carried out by medical societies and patient advocacy groups. The only epidemiological studies which provide information on the prevalence of hepatitis B and hepatitis C were carried out by medical societies.

2.2 The government does not collaborate with in-country civil society groups to develop and implement its viral hepatitis prevention and control programme.

It is definitely true.

3.2 There are standard case definitions for hepatitis. Deaths, including from hepatitis, are reported to a central registry. Of hepatitis cases, 2% are reported as “undifferentiated” or “unclassified” hepatitis.

This reporting is within the regular system of the reporting of deaths from all causes.
5.5 The following drugs for treating hepatitis B are on the national essential medicines list or subsidised by the government: interferon alpha, pegylated interferon, lamivudine, adefovir dipivoxil, entecavir and tenofovir. The following drugs for treating hepatitis C are included on the national essential medicines list or subsidised by the government: interferon alpha, pegylated interferon and ribavirin.

This is true, but it should be mentioned that access to these drugs is limited by an annually limited reimbursement.

1.3 The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific populations: health-care workers (including health-care waste handlers); people who inject drugs; people living with HIV; household contacts and other contacts of hepatitis B-infected persons; pre-surgical patients; and people at risk due to lifestyle, occupation, age and chronic diseases.

Definitely there are no such programmes supported financially by the government or the National Health Fund (responsible for the national insurance programme). Of course these groups receive assistance from health care providers, but the majority of these activities are not reimbursed or reimbursement is limited.

3.1 There is routine surveillance for viral hepatitis. There is a national surveillance system for the following types of acute hepatitis: A, B, C, D and E. There is a national surveillance system for the following types of chronic hepatitis: B, C and D.

This is a misunderstanding. Government recognises as “surveillance system” voluntary reporting of hepatitis cases by physicians. So this is passive system. There is no active surveillance programme based on the screening of high-risk populations. As a result, for example according to studies carried out by the Polish Group of Experts, there have now been up to 30,000 cases of hepatitis C diagnosed, whereas up to 700,000 people are antibody-positive for hepatitis C and about 200,000 are actively viremic (HCV RNA-positive) (0.6% of the population). These data were published in the European Journal of Gastroenterology & Hepatology. For other hepatotropic viruses there are no such data. The data collected by the National Institute of Health – recognised as a surveillance system – provide just a reporting rate and not a prevalence rate.

3.3 Liver cancer cases are registered nationally, but cases with HIV/hepatitis coinfection are not. The government publishes hepatitis disease reports. Information was not provided on how often these are published.

Definitely there is no national registry for hepatocellular cancer. The information provided is misunderstanding, because it looks like the government representative who completed the survey confused the voluntary reporting system that exists in Poland with a register which contains all crucial data about particular patients. Of course data on hepatocellular carcinoma and hepatitis patients are collected by the National Health Fund but they are not analysed and not provided upon the request of medical societies or even pharmaco-economic agencies. Hepatitis reports mentioned by the government are compilations of reporting (not surveillance) system described in our previous comment for point 3.1.
## Poland

### Polish Association for the Study of the Liver continued

<table>
<thead>
<tr>
<th>Chapter 7: European Region</th>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>There is a national hepatitis A vaccination policy.</td>
<td>There is definitely no such policy. Somebody probably mixed a national policy with the so-called “recommended vaccination programme” that includes hepatitis A vaccination as recommended.</td>
</tr>
<tr>
<td>4.9</td>
<td>There is a national policy relating to the prevention of viral hepatitis among people who inject drugs.</td>
<td>There is definitely false information. There is no government-reimbursed programme for hepatitis C prevention among people who use drugs.</td>
</tr>
<tr>
<td>5.2</td>
<td>The government has national policies relating to screening and referral to care for hepatitis B and hepatitis C.</td>
<td>This is definitely false information. There is no policy for screening and referral for hepatitis B and hepatitis C.</td>
</tr>
<tr>
<td>5.3</td>
<td>People testing for both hepatitis B and hepatitis C register by name; the names are kept confidential within the system. Hepatitis B and hepatitis C tests are not free of charge for all individuals, but they are free of charge for blood and organ donors, pregnant women, and everyone who has public health insurance and is referred by a doctor. Hepatitis B and hepatitis C tests are compulsory for blood and organ donors.</td>
<td>The first sentence is false — there is no named registry for HBV and HCV. Also false is: “Hepatitis B and hepatitis C ... are free of charge for ... everyone who has public health insurance and is referred by a doctor.” It is the mayor problem — There is no reimbursement for hepatitis B or hepatitis C testing by family doctors or specialities other than infectious diseases. It can be reimbursed only for outpatients and hospitals specialising in infectious diseases.</td>
</tr>
<tr>
<td>5.4</td>
<td>Publicly funded treatment is available for hepatitis B and hepatitis C. Publicly insured patients are eligible for this based on medical indications. The government spent Zł 65.5 million (US$ 20.1 million) on publicly funded treatment for hepatitis B in 2011. The amount spent by the government on such treatment for hepatitis C is not known.</td>
<td>Very false information provided. Reimbursement of hepatitis B and C treatment is limited annually. As a result in some centres patients must wait one to two years to start medication. Government spent on hepatitis C treatment about PLN 130 million (about EUR 30 million). Due to complicated and non-evidence-based therapeutic programme for hepatitis C, only 20% of hepatitis C-infected patients are eligible to receive reimbursed triple therapy based on protease inhibitors, whereas according to expert recommendation it should be 80%. The Ministry of Health implemented “worldwide unique” system of patient exclusion based on genetic discrimination (among treatment-naïve, only genotype TT for IL28B patients are eligible for triple therapy). Therapeutic programme for HBV medication is based on using lamivudine as a first-line nucleoside analogue. This is off-label and contrary to expert recommendation (Polish, EASL and AASLD).</td>
</tr>
</tbody>
</table>
Statement from the Polish Association for the Study of the Liver regarding key hepatitis policy issues in Poland:

National coordination. There is no national coordination, just because of lack of goodwill for collaboration between the Ministry of Health and medical societies, experts and patients organisations.

Awareness-raising, partnerships and resource mobilisation. Partnership exists between medical societies, experts and patients organisations. Resources for awareness-raising are not released by the Government at all.

Evidence-based policy and data for action. No evidence-based policy is visible on the government site, which usually is interested in short-term economic issues, even if long-term pharmaco-economical analysis supports the need to finance viral hepatitis screening and medication.

Prevention of transmission. There is an urgent need for a screening policy to be implemented. At this moment, the Ministry of Health is not interested in supporting any surveillance programme because recent data demonstrated that more than 200,000 people could need immediate medication for hepatitis C, whereas reimbursement is provided for only about 3,000 annually.

Screening, care and treatment. A screening programme should be implemented immediately according to the ready programme created by the Polish Group of Experts, and it could cost no more than EUR 10 million. The reimbursement for hepatitis C medication needs increased by at least 50% immediately and up to 100% by the next year.
The organisation provided the following general statement regarding key hepatitis policy issues in Portugal:

**National coordination.** There is no national coordination. The Ministry of Health has no organisation to deal specifically with hepatitis. The need for a strategy and plan has been recognised.

**Awareness-raising, partnerships and resource mobilisation.** There has been a lot of situations of social and national awareness pushing the government to deal with the problem of hepatitis: the Portuguese Parliament has issued a national resolution, all the media, national scientific liver associations, patient NGOs, etc.

**Evidence-based policy and data for action.** There are sufficient data to call action (see sources below). Several national and international publications with Portuguese data. Hepatitis C is killing around 1,000 persons per year, versus around 500 for HIV. The investment of medication for HIV is 50 times more than for hepatitis C. Government has taken three years to approve only boceprevir. Telaprevir is not approved. Some hospitals have paid the treatments, others not.

**Prevention of transmission.** Good programme for reducing the sharing of needles and for drug addiction at national level, but with problems due to budget reductions.

**Screening, care and treatment.** There is a national and governmental barrier to treatment access.

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**References:**

The organisation provided the following general statement regarding key hepatitis policy issues in Romania:

Baylor Black Sea Foundation’s programmes are focused on providing:

- Screening for hepatitis B and hepatitis C (voluntary counselling and testing programme for hepatitis B and hepatitis C)
- Comprehensive psychosocial and medical care for those diagnosed through the counselling and testing programme or already diagnosed and requesting psychosocial assistance

Considering that Baylor’s programme is developed only in one region of Romania, Dobrogea, this short assessment is limited to the difficulties experienced while rolling out our programmes locally and it might not contain information relevant from a national point of view.

Presently in Romania there is no comprehensive approach to tackling hepatitis B and hepatitis C. Existing efforts, especially financial efforts, go towards treatment and only treatment.

In the absence of a national strategic plan and a national programme for viral hepatitis, there are many aspects that are not funded, not monitored, and of course not implemented:

- There are no long-term national prevention campaigns or programmes.
- Screening activities are not standardised, funded or included in special recommendations. The referral of patients depends heavily on the specialist/family practitioner and is, on a smaller scale, also influenced by the resources available in the community. The Baylor Romania Voluntary, Free, Counseling and Testing Programme, which also includes rapid testing for hepatitis B and hepatitis C, is the only one in the country. Between 2010 and 2013, among the 32,000 people tested, only 2.1% were referred by a family practitioner and 1.3% by other specialists.
- Access to treatment has improved in the past few years. There is a clear referral system that patients need to follow in order to acquire access to treatment. Funding is not very transparent, nor is decision-making in regard to the choice of drug regimen, especially in hepatitis C cases.

The results obtained at the national level for all patients treated for hepatitis B and hepatitis C are not known. In a context where clear goals and objectives are lacking, the reporting/monitoring system is not well established. Only in 2014 did the Ministry of Health elaborate a reporting system for cases treated for hepatitis C, but the proposal after being criticised is still under discussion.

The psychosocial aspects of living with hepatitis B and hepatitis C are completely ignored. The initiatives that we are aware of were short-term, scattered, underfunded and lacking in continuity. The programmes developed by Baylor Romania target the psychosocial needs of patients living with hepatitis C at various points: after diagnosis, while preparing to access treatment, during treatment, etc.

There are no real data about the situation of hepatitis B and hepatitis C in Romania. The only study that has some information about the prevalence of Hepatitis B, C, D and E in Romania is from 2008 and is geographically limited (http://www.balkanhep.eu/Romania.htm).

SURVEY HIGHLIGHTS

The Government of Romania did not respond to the World Health Organization survey for the 2013 Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States, and therefore the Baylor Black Sea Foundation could not comment on government information for this report.

* World Hepatitis Alliance member.
**SURVEY HIGHLIGHTS**


<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.1</strong> There is a written national strategy or plan that focuses primarily on the prevention and control of viral hepatitis, and also integrates other diseases. It includes components for raising awareness, surveillance, vaccination, prevention in general, prevention of transmission via injecting drug use, prevention of transmission in health-care settings, treatment and care, and coinfection with HIV.</td>
<td><strong>This strategy does not include a national programme for hepatitis C treatment.</strong></td>
</tr>
<tr>
<td><strong>5.1</strong> Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools for health professionals (pre-service education), on-the-job training and postgraduate training. It is not known whether there are national clinical guidelines for the management of viral hepatitis, but there are for the management of HIV, which include recommendations for coinfection with viral hepatitis.</td>
<td><strong>The national clinical guidelines for hepatitis C are already available (since 2013).</strong></td>
</tr>
<tr>
<td><strong>5.4</strong> Publicly funded treatment is available for hepatitis B and hepatitis C. The amount spent by the government on such treatment is not known.</td>
<td><strong>Only patients coinfected with HIV and hepatitis C receive treatment.</strong></td>
</tr>
</tbody>
</table>

**Survey comments from United against Hepatitis:**

*United against Hepatitis* did not provide a statement regarding key hepatitis policy issues in the Russian Federation.

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*World Hepatitis Alliance member.*
SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Serbia reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

- The government information was thought to be accurate for 84.0% of items.
  Survey points marked “accurate”:
  1.1, 1.2, 1.3, 2.1, 2.2, 3.1, 3.2, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, 5.1, 5.2, 5.3, 5.4 and 5.5.

- The government information was thought to not be accurate for 12.0% of items.
  Survey points marked “not accurate”:
  3.3, 3.4 and 3.5.

- The respondent took no position on the government information for 4.0% of items.
  Survey points marked “take no position”:
  4.10.

Survey comments from Association HRONOS:

3.5 There is a national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are conducted regularly; the target populations are men who have sex with men, sex workers and Roma youth. The last serosurvey was carried out in 2010.

× To our knowledge, this information is not accurate.

5.1 Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools for health professionals (pre-service education), on-the-job training and postgraduate specialisation. There are national clinical guidelines for the management of viral hepatitis, which include recommendations for cases with HIV coinfection. There are national clinical guidelines for the management of HIV, which include recommendations for coinfection with viral hepatitis.

× To our knowledge, this information is not accurate.

2.2 The government collaborates with the following in-country civil society group to develop and implement its viral hepatitis prevention and control programme: NGO HRONOS.

Since this year.

5.4 Publicly funded treatment for hepatitis B and hepatitis C is available to all people with health insurance. Information was not provided on the amount spent by the government on such treatment.

Treatment is available to a limited number of patients. In 2013, the treated patients are less than 300.

× To our knowledge, this information is not accurate.

3.5 There is a national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are conducted regularly; the target populations are men who have sex with men, sex workers and Roma youth. The last serosurvey was carried out in 2010.

The last serosurvey was carried out in 2013.
Statement from Association HRONOS regarding key hepatitis policy issues in Serbia:

**National coordination.** Official documents which regulate this field exist, but their application is more than doubtful.

**Prevention of transmission.** At the level of prevention in counselling for voluntary, anonymous and confidential testing, there is no basic tests.

**Screening, care and treatment.** A lot of time is lost by the time of diagnosis and then to the point of starting treatment. From time to time occur acute shortage of medicines, and diagnostic tests (PCR) is not enough in relation to the needs.

Other comments:
- The lack of a national strategy to combat hepatitis, poor communication between the parts of the health system (primary, secondary and tertiary).
- Statistics are not reliable (often inadequately reported new cases, sometimes absent, sometimes repeatedly applying the same case).
- Republic Health Insurance Fund of delaying the introduction of new therapeutic options trying to save money, which is directly harmful to patients.
- In just four referral clinical centres, patients can receive treatment, which exposes them to additional effort and costs, as well as frequent travel.
SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Spain reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

- The government information was thought to be accurate for 68.0% of items.
  - Survey points marked “accurate”: 1.1, 1.2, 1.2, 2.1, 2.2, 3.3, 3.5, 4.1, 4.2, 4.4, 4.6, 4.7, 4.8, 4.9, 4.10, 5.1, 5.3 and 5.5.

- The government information was thought to not be accurate for 20.0% of items.
  - Survey points marked “not accurate”: 1.3, 3.1, 4.5, 5.2 and 5.4.

- The respondent took no position on the government information for 12.0% of items.
  - Survey points marked “take no position”: 3.2, 3.4 and 4.3.

Survey comments from ASSCAT:

<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.5 There is a national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are not conducted regularly.</td>
<td>First statement is not true; second one is.</td>
</tr>
<tr>
<td>4.9 There is a national policy relating to the prevention of viral hepatitis among people who inject drugs.</td>
<td>Only among people who inject drugs and attend to medical services.</td>
</tr>
<tr>
<td>4.5 There is a specific national strategy and/or policy/guidelines for preventing hepatitis B and hepatitis C infection in health-care settings. Health-care workers are vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood.</td>
<td>Some workers need to ask to be vaccinated; otherwise they are not.</td>
</tr>
<tr>
<td>5.4 Publicly funded treatment for hepatitis B and hepatitis C is available to all people with health insurance. The government spends €13,329 (US$17,140) on such treatment for hepatitis B per patient per year, and €39,940 (US$51,359) for hepatitis C per patient per year.</td>
<td>Spanish government relies on budget reasons to reduce the number of patients receiving treatment.</td>
</tr>
<tr>
<td>4.3 Nationally, 96.6% of newborn infants in a given recent year received the first dose of hepatitis B vaccine within 24 hours of birth and 96.6% of one-year-olds (ages 12–23 months) in a given recent year received three doses of hepatitis B vaccine.</td>
<td>This is the way it is supposed to be, but we cannot be sure.</td>
</tr>
</tbody>
</table>
Statement from ASSCAT regarding key hepatitis policy issues in Spain:

The Spanish government considers viral hepatitis treatment to be “too expensive,” especially for new treatments (e.g., sofosbuvir, simeprevir), and even for those already approved (e.g., boceprevir, telaprevir). Only patients with a mild or severe fibrosis score receive antiviral treatment. The rest are called to “wait” until government finds a way to pay for these treatments. Government ignores cost-effectiveness studies that state treating is better than waiting, also because they think on very short-term policies. The Spanish government should negotiate with the pharmaceutical industry regarding pricing and accessibility to ensure that every patient who needs treatment will have it, and will have it soon, instead of telling him/her, “You can wait because your situation is not severe enough yet.”

Patient associations should be part of decision-making boards on prevention, screening and treatment policies, as they receive claims, questions and concerns from the patients. It would also be good for these patient associations to receive some grants to do the job that government doesn’t achieve. We realise that governments cannot do everything at every time, but we need support to carry out our work.
Statement from SEVHep regarding key hepatitis policy issues in Switzerland:

In Switzerland a major challenge towards a national hepatitis strategy is the low awareness of the disease and its future public health, social and economic impact. Awareness is low on all levels: health care professionals, people at risk, politicians and the general public. In our decentralised, federalist country not only national but also cantonal authorities must be motivated in order to have a future national strategy implemented.

All key stakeholders need to be involved in the elaboration and implementation of such a national strategy. A key first step is to obtain a political mandate.

The targeted strategy should primarily focus on the low detection rates (an estimated 33% of all infected people are tested) and on the poor awareness, but also cover improved surveillance, prevention and access to care for most-at-risk populations.

The government needs to declare hepatitis as a relevant public health issue and accordingly to mandate and finance a national strategy. A close coordination between national and cantonal bodies from the beginning is essential to achieve adequate coverage at implementation.

Stakeholders are asked to contribute to and take part in a nationally coordinated action. They need to assure acceptance and implementation to enhance awareness and knowledge in their communities.

SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Switzerland reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 96.0% of items.

Survey points marked “accurate”:
1.1, 1.2, 1.3, 2.1, 2.2, 3.1, 3.2, 3.3, 3.4, 3.5, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, 4.10, 5.1, 5.2, 5.4 and 5.5.

The government information was thought to not be accurate for 4.0% of items.

Survey points marked “not accurate”:
5.3.

Survey comments from Swiss Experts in Viral Hepatitis (SEVHep):

To our knowledge, this information is accurate.

1.1 There is no written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis.

SEVHep is currently intending to bring together a task force of all relevant stakeholders in order to elaborate and implement such a national hepatitis strategy.

To our knowledge, this information is not accurate.

5.3 People testing for both hepatitis B and hepatitis C register by name; the names are kept confidential within the system. Hepatitis B and hepatitis C tests are not free of charge for all individuals, but they are free of charge for health-care workers, and organ and blood donors. Hepatitis B and hepatitis C tests are not compulsory for members of any specific group.

People testing for hepatitis B and hepatitis C are no longer registered by name since 2013 due to data protection issues. The rest is still accurate.

There are data from the mandatory national notification system. In addition there is evidence on prevalence in some risk groups and very soon a study on a mathematical model calculation of the future disease burden will be published. At a first kick-off meeting towards a national strategy, all key stakeholders supported the need of such a strategy.
The respondent reviewed 25 items of information that the government of The former Yugoslav Republic of Macedonia reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

- The government information was thought to be accurate for 72.0% of items.
  - Survey points marked “accurate”: 1.1, 1.2, 1.3, 2.1, 3.4, 3.5, 4.1, 4.3, 4.4, 4.5, 4.6, 4.8, 4.10, 5.1, 5.2, 5.3, 5.4 and 5.5.

- The government information was thought to not be accurate for 16.0% of items.
  - Survey points marked “not accurate”: 2.2, 3.1, 3.3 and 4.9.

- The respondent took no position on the government information for 12.0% of items.
  - Survey points marked “take no position”: 3.2, 4.2 and 4.7.

Survey comments from Healthy Options Project Skopje (HOPS):

- 3.5 There is no national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are not conducted regularly.
- 4.1 There is no national policy on hepatitis A vaccination.
- 4.4 There is a national policy specifically targeting mother-to-child transmission of hepatitis B.
- 5.2 The government has national policies relating to screening and referral to care for hepatitis B and hepatitis C.
- 5.4 Publicly funded treatment is available for hepatitis B and hepatitis C, but information was not provided on who is eligible for this, or on the amount spent by the government on such treatment.

The Institute for Public Health conducts biobehavioural studies for hepatitis C prevalence among people who inject drugs in a period of 2–3 years.

Hepatitis A vaccination is recommended when travelling abroad.

In the recommendations for evidence-based medicine, it is recommended that pregnant women be counselled for screening for hepatitis B. Unfortunately this is not done in practice.

There is consensus for prevention, diagnosis, treatment and monitoring of patients with hepatitis B and hepatitis C, and also in the recommendations for evidence-based medicine, where these questions are addressed.

There are sums of money provided by the Global Fund for treatment of 47 people who use drugs annually. In the previously mentioned documents there is no specific information regarding eligibility for treatment, but for these 47 patients there is a consensus between the Global Fund, the Country Coordinating Mechanism and the Clinic for Infectious Diseases, where people who use drugs must be 12 months on substitution therapy or abstaining for 12 months in order to be eligible for treatment. Active drug users are not eligible.
Statement from HOPS regarding key hepatitis policy issues in The former Yugoslav Republic of Macedonia:

National coordination. In March 2014, HOPS organised a conference regarding hepatitis C treatment among drug users. Representatives from the clinics, civil society organisations and pharmaceutical companies took part. At the conference, best practices and challenges in treatment were discussed and one of the conclusions was that there is a lack of national coordination regarding this issue.

There is need to create a national strategy for prevention, treatment and care for hepatitis C, where all stakeholders will take part. Currently every stakeholder is implementing its own tasks, dealing with the challenges independently. Creating a national strategy will mean that the Ministry of Health will allocate funds for dealing with the issue. Currently every clinic allocates funds for this treatment on their own decision (calculating with the money they receive as a clinic for treating all of the health issues under their responsibility). Treatment for hepatitis C is very expensive, so the allocation of national funds with support of the current fund by the clinics will allow more people to have access to treatment.

Evidence-based policy and data for action. The latest recommendations by the World Health Organization (WHO) are that active injecting drug users should be eligible for treatment and are an important population regarding prevention. The Ministry of Health has a recommendation for evidence-based medicine but it does not include eligibility criteria regarding hepatitis treatment. The latest WHO recommendations should be included in this document so that active injecting drug users are eligible for treatment.
Regarding this issue, there is a negative attitude by health workers which is confirmed with the consensus for treatment between the Global Fund, the Country Coordinating Mechanism and the Clinic for Infectious Diseases. According to this consensus, only drug users on substitution therapy or those who are abstaining for 12 months are eligible for treatment. Health workers consider that treating active injecting drug users is not cost-effective because of the risk of reinfection.

This is a very important issue to be discussed. It was discussed at the conference HOPS organised but this question should be discussed by broader involvement of stakeholders, and the Ministry of Health has a central role since it has a mandate to require health care institutions to implement recommendations.

**Screening, care and treatment.** Regarding treatment, another major issue in addition to eligibility is the cost of hepatitis C treatment. In Macedonia, there are only two pegylated interferons registered, and the clinics are procuring only one of them. There are very few clinics that procure both medicines. Because of the non-competitive way of procuring these medicines, the prices stay high. The cost of the medicine has a direct effect on the number of people on treatment. If the prices are lowered, more people will be able to undergo treatment. This issue was also discussed at the conference organised by HOPS. There is will for negotiation by the pharmaceutical companies but for lowering the prices on a national level, decision-makers must take part in the negotiation process (the Ministry of Health and the Health Insurance Fund).
The greatest problem is that there is no screening programme in the field, organised by the government and NGOs. The screening works only if an NGO is active in the field.

The first needed change is to improve communication between the government (Ministry of Health) and NGOs.

Working together for care of patients means treating, providing social assistance, a place to live and so on.

Fast diagnosis and fast treatment, no waiting for therapy (often several months).

Working together to introduce the new drug therapy in the treatment of viral hepatitis.

All of these changes are the responsibility of the government: the responsibility of government is to make these changes available to the patients.

The roles and responsibilities of other stakeholders at the community, national and international levels will be to work together (not separately) to make plans for health prevention, education, treatment, implementation of the plan, and to analyse the results.

According to the results, adjust the plan to the appropriate situation.

We conducted research in the field and carried out statistical analyses. We used anonymous questionnaires where free screening was offered.

SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of The Former Yugoslav Republic of Macedonia reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 72.0% of items.

Survey points marked “accurate”: 1.1, 1.2, 1.3, 2.1, 2.2, 3.1, 3.2, 3.4, 3.5, 4.1, 4.2, 4.3, 4.6, 4.8, 5.1, 5.3, 5.4 and 5.5.

The government information was thought not to be accurate for 12.0% of items.

Survey points marked “not accurate”: 3.3, 4.10 and 5.2.

The respondent took no position on the government information for 16.0% of items.

Survey points marked “take no position”: 4.4, 4.5, 4.7 and 4.9.

HEPTA did not provide any comments about survey items.
The respondent reviewed 25 items of information that the government of Ukraine reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 68.0% of items.

Survey points marked “accurate”: 2.1, 3.1, 3.2, 3.3, 3.4, 3.5, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 5.1, 5.2, 5.3, 5.4 and 5.5.

The government information was thought to not be accurate for 20.0% of items.

Survey points marked “not accurate”: 1.1, 1.2, 1.3, 4.1 and 4.2.

The respondent took no position on the government information for 12.0% of items.

Survey points marked “take no position”: 2.2, 4.9 and 4.10.

Survey comments from Government Institution “L.T. Malaya Therapy, National Institute of the National Academy of Medical Sciences of Ukraine”:

To our knowledge, this information is not accurate.

1.1 There is no written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis.

The Ukrainian Ministry of Healthcare recently outlined the new areas of state funding for the current year. Given the social importance of viral hepatitis, the Cabinet of Ministers of Ukraine adopted the № 637 resolution on April 29, 2013, entitled “Approval of the National Programme for prevention, diagnosis and treatment of viral hepatitis for the period until 2016.”

1.3 The government does not have a viral hepatitis prevention and control programme that includes activities targeting specific populations.

№ 672 resolution from December 30, 2004, regulates vaccination of blood donors.
Statement from Government Institution “L.T. Malaya Therapy, National Institute of the National Academy of Medical Sciences of Ukraine” regarding key hepatitis policy issues in Ukraine:

Screening, care and treatment. The Ukrainian Ministry of Healthcare recently outlined the new areas of state funding for the current year. Given the social importance of viral hepatitis, the Cabinet of Ministers of Ukraine adopted the № 637 resolution on April 29, 2013, entitled “Approval of the National Programme for prevention, diagnosis and treatment of viral hepatitis for the period until 2016.” To date, the programme has received no additional funding.

Additional dedicated funds would provide means to at least partially satisfy patients’ needs. The programme objectives originally included the development of care for patients with viral hepatitis B and C. This effort would include diagnostics, therapeutics, scientific research, and prevention, all aimed at significantly reducing prevalence and mortality, and increasing patients’ survival and quality of life.

According to the Centre for Medical Statistics of the Ukrainian Ministry of Healthcare, the following information is available:

- Prevalence of chronic viral hepatitis in the general population: 356,907 people (782.7 per 100 thousand of the relevant population).
- Incidence: 28,949 (63.5 per 100,000 of the relevant population).
- Prevalence in children: 1,999 persons (0.25 per 1,000 relevant population).
- Incidence in children: 299 (0.04 per 1,000 relevant population).

Given the information above, the leading specialists in infectious diseases highlighted the issue of lack of funding at a workshop on 7 December 2013. They also quoted high antiviral treatment cost, noting that resolving this issue should remain a priority. Finally, it was stressed that new antiviral drug production will allow to significantly reduce the per-patient cost of treatment of hepatitis C.

The strategy of approaching the current situation is therefore suggested as follows:

- Strong stimulation of scientific research on viral hepatitis, aimed at the development of new diagnostics tools and drugs, providing funding grants and information support for research groups.
- Support of educational programmes for healthcare professionals and patients, aimed at providing actual information about current state-of-the-art in prevention, diagnostics and treatment of viral hepatitis.
- Support of clinical trials for assessing new antiviral drugs, especially boceprevir, telaprevir etc., while maintaining internationally recognised ethical standards and satisfying GCP requirements.
- Strong increase of strictly controlled financial investment in implementing the social initiative; dissemination of successes to the general public.
- Close collaboration with international research centres, aimed at stimulating the exchange of scientific ideas.
The respondent reviewed 25 items of information that the government of Ukraine reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 48.0% of items.

Survey points marked “accurate”:
1.1, 1.2, 1.3, 3.2, 4.2, 4.3, 4.4, 4.5, 4.6, 4.9 and 5.5.

The government information was thought to not be accurate for 52.0% of items.

Survey points marked “not accurate”:
2.1, 2.2, 3.1, 3.3, 3.4, 3.5, 4.7, 4.8, 4.10, 5.1, 5.2, 5.3 and 5.4.

Survey comments from the International HIV/AIDS Alliance in Ukraine:

**1.1** There is no written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis.

**1.2** There is no designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities. It is not known how many people work full-time on hepatitis-related activities in all government agencies/bodies.

Alliance-Ukraine initiated developing the group at the Ministry of Health of Ukraine on controlling/coordinating implementation of the State Hepatitis programme at all levels – national and local.

**1.3** The government does not have a viral hepatitis prevention and control programme that includes activities targeting specific populations.

Vulnerable populations are not even mentioned in the State hepatitis Programme.

**4.4** There is a national policy that specifically targets mother-to-child transmission of hepatitis B (Annex B).

It is not a separate plan or strategy; it’s part of the State hepatitis programme.

**4.9** There is no national policy relating to the prevention of viral hepatitis among people who inject drugs.

Alliance-Ukraine presses the Ministry of Health of Ukraine to develop the guidelines and suggested to provide its technical and expertise support on that. Alliance-Ukraine plans to provide the MoH with detailed recommendations in this regard.
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>2.2 It is not known whether the government held events for World Hepatitis Day 2012. It has not funded other viral hepatitis public awareness campaigns since January 2011.</td>
<td>The Government has never held events on World Hepatitis Day, nor funded awareness campaigns. Alliance-Ukraine launched the all-Ukrainian HCV awareness and advocacy campaigns in 2011, which are still on-going.</td>
</tr>
<tr>
<td>2.2 The government collaborates with the following in-country civil society groups to develop and implement its viral hepatitis prevention and control programme: NGO “Stop Hepatitis” and Office IRF in Ukraine.</td>
<td>Alliance-Ukraine is the key organisation in Ukraine working in HCV area, and also cooperating with many international organisations in the EECA region and internationally on holding joint events and developing joint campaigns. In Ukraine, Alliance-Ukraine developed the whole network of NGOs working in hepatitis in all Ukrainian regions. Alliance reduced the price for HCV diagnostics and treatment by 2.5 times for the Alliance’s and governmental procurements. Alliance launched the first HCV treatment programmes in 10 Ukrainian regions and works not only with the Ministry of Health of Ukraine, but local administrations as well on developing and approving hepatitis treatment programmes and allocating funding. Alliance also works with the CDC (USA), the WHO country office and other stakeholders in Ukraine. Alliance implements HCV treatment programmes as a principal recipient of the Global Fund and implements hepatitis advocacy with the support of Open Society Foundation and its local office, IRF.</td>
</tr>
<tr>
<td>3.1 There is routine surveillance for viral hepatitis. There is a national surveillance system for the following types of acute hepatitis: A, B and C, and for the following types of chronic hepatitis: B and C.</td>
<td>There is no proper surveillance system in place. This is why there are no realistic hepatitis B and C statistics in Ukraine. Alliance-Ukraine plans to involve the CDC (USA) and MoH in developing a proper national surveillance system.</td>
</tr>
<tr>
<td>3.3 Liver cancer cases are registered nationally, but cases with HIV/hepatitis coinfection are not. The government does not publish hepatitis disease reports.</td>
<td>Both cases are not registered properly.</td>
</tr>
<tr>
<td>3.4 Hepatitis outbreaks are required to be reported to the government and are further investigated. There is adequate laboratory capacity nationally to support outbreak investigations and other surveillance activities for hepatitis A, hepatitis B and hepatitis C, but information was not provided on whether this is the case for hepatitis E.</td>
<td>It is not true. There is NO adequate laboratory capacity nationally to support outbreak investigations and other surveillance activities for hepatitis</td>
</tr>
</tbody>
</table>
Ukraine

International HIV/AIDS Alliance in Ukraine continued

3.5 There is no national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are conducted regularly; the target population is people who inject drugs. The last serosurvey was carried out in 2011.

3.5 Viral hepatitis serosurveys are conducted regularly by Alliance-Ukraine, not the Government. Alliance-Ukraine provides the Government and all the stakeholders with data on a regular basis.

4.7 Official government estimates of the number and percentage of unnecessary injections administered annually in health-care settings were not known.

4.7 The Government does not estimate the number and percentage of unnecessary injections.

4.8 There is a national infection control policy for blood banks. All donated blood units (including family donations) and blood products nationwide are screened for hepatitis B and hepatitis C.

4.8 The Ministry of Health usually claims that all donated blood units (including family donations) and blood products nationwide are screened for hepatitis B and hepatitis C. In reality, it is not true. Many people become infected with HepB or HepC as the blood is not properly screened everywhere.

4.10 The government has guidelines that address how hepatitis A and hepatitis E can be prevented through food and water safety.

4.10 Not guidelines (which is stronger) but recommendations.

5.1 Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools for health professionals (pre-service education), on-the-job training and postgraduate training. There are no national clinical guidelines for the management of viral hepatitis, but there are for the management of HIV, which include recommendations for coinfection with viral hepatitis.

5.1 One of the barriers to access to hepatitis B and C treatment in Ukraine is the lack of knowledge of medical/health professionals. In many regions health professionals still treat patients with linean/non-pegylated interferon and there is a lack knowledge and skills on treating with peg-Inf-riba treatment and DAAs. Alliance-Ukraine started training health care professionals for its already launched treatment programmes, which will be extended soon as well as involve more health professionals in education and training activities in 2014–2015 for more treatment programmes including state and local treatment programmes.

5.2 The government has national policies relating to screening and referral to care for hepatitis B and hepatitis C.

5.2 It is not reflected in the state/national hepatitis programme or diagnostics and treatment guidelines. There are no other official documents containing that information which can be named “national policies”. The State/National programme and treatment guidelines leave much to be desired. Alliance-Ukraine plans to develop recommendations to the MoH of Ukraine and push the Ministry of Health to improving the state programme and treatment guidelines in accordance with WHO’s recommendations.
5.3 People testing for both hepatitis B and hepatitis C register by name; the names are kept confidential within the system. Hepatitis B and hepatitis C tests are not free of charge for all individuals, but they are free of charge for pregnant women, blood donors and military conscripts. Hepatitis B and hepatitis C tests are compulsory for pregnant women, blood donors and military conscripts.

Confidentiality is not often observed. Hep B and Hep C screening tests are free, but not the full diagnostics package.

5.4 Publicly funded treatment is not available for hepatitis B or hepatitis C.

The Government approved its state target hepatitis programme in 2013 with US $4 million allocated for treatment. Around 600 patients started receiving treatment but no funding was allocated in 2014 from state budget. In response to the pressure of civil society, the Government promises to allocate more funding already in 2014, but this has not yet happened.

Statement from the International HIV/AIDS Alliance in Ukraine regarding key hepatitis policy issues in Ukraine:

We lack commitment from the Government to the hepatitis problems in Ukraine. The quality of the recently approved State/National Target Programme on Hepatitis and HCV treatment guidelines leaves much to be desired.

One of the main problems is that vulnerable groups are not even mentioned in the State hepatitis Programme, which provides the grounds for our health professionals to exclude HIV-positive and people who inject drugs (PWID) from treatment programmes/ refuse to provide them with treatment services. The other problem is that the State hepatitis programme was 10 times underfinanced in 2013 and no funding was allocated for 2014. One more problem is corruption. It took much of the Alliance’s time and effort to convince the MoH to procure HCV treatment at a reduced price, the price that the Alliance reduced for its procurements (Alliance’s treatment programmes). Currently, the Alliance tries to involve the MoH in its further price negotiations for pegylated interferon and sofosbuvir. Alliance also develops recommendations for the MoH to improve the State Hepatitis Programme and HCV treatment guidelines in accordance with WHO’s recommendations as well as develop HCV treatment guidelines for PWID.

One more problem is a lack of knowledge and skills of health professionals. The Alliance, with the support of some international donors, plans to hold a series of education trainings and awareness campaigns for health professionals and decision-makers at national and local levels. Alliance-Ukraine also conducts regular awareness, mobilisation and advocacy campaigns, which include screening for the general population and vulnerable groups, providing information on HBV and HCV, re-addressing patients for diagnostics and treatment, schools for patients and health professionals, work with authorities and national and local levels, public events with wide mass media coverage etc. These activities included in the Alliance’s campaigns are targeted at HCV and HBV awareness raising among the mentioned groups, generating treatment demand, allocating funds for treatment for the State hepatitis and local programmes, including vulnerable groups in treatment programmes and extending treatment programmes at national and local levels, further price reduction for diagnostics and treatment, launch of treatment with DAAs etc. Ideally, MoH should lead on all that.

In our situation, we/Alliance and partners need to press our MoH at least get involved in all of the above mentioned activities initiated and implemented by Alliance-Ukraine and partner NGOs. Together with the US CDC, Alliance-Ukraine plans to develop the hepatitis surveillance system for Ukraine. Together with WHO country office, US CDC and other stakeholders, Alliance-Ukraine plans to provide support to the MoH on improving and implementing the state hepatitis programmes.
**SURVEY HIGHLIGHTS**

The respondent reviewed 25 items of information that the government of Ukraine reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To our knowledge, this information is accurate.</strong></td>
<td></td>
</tr>
<tr>
<td>2.1 It is not known whether the government held events for World Hepatitis Day 2012. It has not funded other viral hepatitis public awareness campaigns since January 2011.</td>
<td>The World Hepatitis Day in 2011, 2012, 2013 was carried out exclusively with the support of foreign donors (IRF in Ukraine, Global Fund to Fight AIDS, Tuberculosis and Malaria).</td>
</tr>
<tr>
<td>2.2 The government collaborates with the following in-country civil society groups to develop and implement its viral hepatitis prevention and control programme: NGO “Stop Hepatitis” and the office of IRF in Ukraine.</td>
<td>The Government is also working with the International HIV/AIDS Alliance in Ukraine.</td>
</tr>
<tr>
<td>3.5 There is no national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are conducted regularly; the target population is people who inject drugs. The last serosurvey was carried out in 2011.</td>
<td>The last serosurvey was carried out for people who inject drugs in 2013 (International HIV/AIDS Alliance in Ukraine).</td>
</tr>
<tr>
<td><strong>To our knowledge, this information is not accurate.</strong></td>
<td></td>
</tr>
<tr>
<td>1.1 There is no written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis.</td>
<td>September 4, 2014, the Ukrainian government approved the state programme to combat hepatitis in Ukraine in 2014–2016.</td>
</tr>
<tr>
<td>1.3 The government does not have a viral hepatitis prevention and control programme that includes activities targeting specific populations.</td>
<td>September 4, 2014 the Cabinet of Ministers of Ukraine approved the State programme to combat hepatitis in Ukraine in 2014–2016 years.</td>
</tr>
<tr>
<td>5.4 Publicly funded treatment is not available for hepatitis B or hepatitis C.</td>
<td>According to the approved (in September 2013) national programme to combat hepatitis in Ukraine in 2014–2016, at the end of 2013 the Government allocated limited funding for the treatment of hepatitis C.</td>
</tr>
</tbody>
</table>

* World Hepatitis Alliance member.
Statement from Public Organisation “Gay-Alliance” regarding key hepatitis policy issues in Ukraine:

National coordination. In September 2014, the State programme came into force to combat viral hepatitis from 2014–2016. While in 2013 the government allocated 33.2 million hryvna (about 2,075 million euros).

Problem

➤ Despite the fact that in the fourth quarter of 2013 a certain amount of money was allocated for the treatment of hepatitis C, the majority of patients who need treatment cannot take advantage because of low awareness of available treatments and corruption schemes at the national and local levels, which affect the proper distribution of drugs. Further, in early 2014 in connection with the change of power in Ukraine and the economic crisis the additional allocation of funds for the Programme is not yet possible.

What needs to change?

➤ Need for concerted and coordinated advocacy work of the public sector (of patient and public organisations) at all levels to control the allocation of money and the proper distribution of funds for the diagnosis and treatment of hepatitis B in order to obtain them from the government of the State programme and reduce morbidity and mortality.

Prevention of transmission

Problem

➤ Currently, many non-profit community organisations in Ukraine are involved with prevention, diagnosis and informing about HIV, STIs and viral hepatitis among the groups most at risk, with financial support from the Global Fund and other donors. Not now, nor earlier did the Ukrainian government allocate money for prevention activities and awareness for the general population or the most vulnerable groups. In a situation of gradual reduction of funding for prevention programmes from the Global Fund, this situation is very worrying because the hepatitis C epidemic in Ukraine is growing rapidly.

What needs to change?

➤ Need to change the state’s attitude to the problem of viral hepatitis because, in spite of the state programme, the reach was very limited. Non-profit organisations together with officials need to work together on the allocation of funds from the state and local budgets for the prevention of hepatitis and monitor the implementation of the government programme to combat viral hepatitis. There needs to be developed a set of advocacy activities for the successful performance of tasks. A driving force for change must be public organisations and patients. Thanks to them, previous advocacy work on the allocation of budget funding for the treatment of hepatitis C has been the most successful.
**SURVEY HIGHLIGHTS**

The respondent reviewed 25 items of information that the government of the United Kingdom of Great Britain and Northern Ireland reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

- **The government information was thought to be accurate for 96.0% of items.**
  - Survey points marked “accurate”: 1.1, 1.2, 1.3, 2.1, 2.2, 3.1, 3.2, 3.3, 3.4, 3.5, 4.1, 4.2, 4.3, 4.4, 4.5, 4.7, 4.8, 4.9, 4.10, 5.1, 5.2, 5.3, 5.4 and 5.5.

- **The government information was thought to not be accurate for 4.0% of items.**
  - Survey points marked “not accurate”: 4.6.

**Survey comments from The Hepatitis C Trust:**

<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
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</thead>
<tbody>
<tr>
<td><strong>2.1</strong> The government did not hold events for World Hepatitis Day 2012, but has funded other viral hepatitis public awareness campaigns since January 2011 (Annex A).</td>
<td>But these were far from large scale, comprehensive public awareness events.</td>
</tr>
<tr>
<td><strong>4.3</strong> Information was not provided on the percentage of newborn infants nationally in a given recent year who received the first dose of hepatitis B vaccine within 24 hours of birth or the percentage of one-year-olds nationally (ages 12–23 months) in a given recent year who received three doses of hepatitis B vaccine.</td>
<td>This is because there is no universal infant vaccination programme.</td>
</tr>
<tr>
<td><strong>4.5</strong> There is a specific national strategy and/or policy/guidelines for preventing hepatitis B and hepatitis C infection in health-care settings. Health-care workers are vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood.</td>
<td>Health care workers doing EPP have been tested for blood-borne viruses since 2007 but not if they started practising before then. This was the cause of a recent hepatitis C outbreak in Wales.</td>
</tr>
<tr>
<td><strong>5.2</strong> The government has national policies relating to screening and referral to care for hepatitis B and hepatitis C.</td>
<td>They are infrequently followed.</td>
</tr>
<tr>
<td><strong>4.6</strong> There is a national policy on injection safety in health-care settings, but it is not known what type of syringes it recommends for therapeutic injections. It is not known whether single-use or auto-disable syringes, needles and cannulas are always available in all health-care facilities.</td>
<td>This is extraordinary that what syringes are recommended for is unknown.</td>
</tr>
</tbody>
</table>

*World Hepatitis Alliance member.*
Respondent statement regarding key hepatitis policy issues in the United Kingdom of Great Britain and Northern Ireland:

National coordination. All four countries of the United Kingdom have national plans for hepatitis C or viral hepatitis of varying quality. The English plan is only for hepatitis C and has no-one in charge, no monitoring, no targets and no money and has not been updated since 2004. A liver strategy was promised (with a large section on viral hepatitis) but this was abandoned in 2013. There is a pressing need for a new plan with robust oversight. In Northern Ireland, viral hepatitis is of relatively minor significance. In Wales there is a recent Blood Borne Viral Hepatitis Action Plan and in Scotland an excellent Hepatitis C Action Plan now rolled into a BBV and Sexual Health Framework but in both Wales and Scotland there is uncertainty over continued funding and questions over the scope of future ambitions. What is needed is strong cross-party political support for a determination to eliminate hepatitis C and to introduce universal HBV infant vaccination.

Awareness-raising, partnerships and resource mobilisation. World Hepatitis Day has been almost entirely left to civil society in the UK, this despite the fact that the majority of viral hepatitis patients remain undiagnosed. Even in Scotland only half of HCV patients have been diagnosed.

Evidence-based policy and data for action. The Scottish and Welsh responses to viral hepatitis have been excellent in their use of evidence (although they do not have the detail available for HIV). In England, no-one knows how many people are treated each year for HCV or HBV or what the outcomes are, an extraordinary situation given the cost. Much better data is required in England.

Prevention of transmission. The UK is one of the only countries in the world not to universally vaccinate its infants against HBV. The argument has been that it is not cost-effective because there is little native infection and all pregnant women are screened and risk groups are vaccinated. Instead, the Joint Committee on Vaccination and Immunisation should have been looking at how to make it cost-effective in the UK because vaccination amongst risk groups is often inadequate.

Apart from in Scotland, very few PWID are treated for HCV and this method of prevention has been essentially ignored. In addition, drug services have been inadequately trained and commissioners have put little or no emphasis on HCV so prevention messages have been inadequately transmitted to PWID with too much reliance placed on NSPs with little effort to explain that HCV is different from HIV and can be transmitted through drug paraphernalia and not just through needles and syringes.

Screening, care and treatment. Even in Scotland there has been inadequate diagnosis with too little effort put into finding the diagnosed. Broad-based awareness campaigns coupled with screening programmes are urgently required (as in the US for example with their baby-boomer screening programme) but not enough work has been done into how to do this cost-effectively. In England an agreement has just been put in place for universal opt-out blood-borne virus testing of all newly arrived in prison.
SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of the United Kingdom of Great Britain and Northern Ireland reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States:

- The government information was thought to be accurate for 84.0% of items.
- Survey points marked “accurate”: 1.1, 1.3, 2.1, 2.2, 3.1, 3.3, 3.4, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, 4.10, 5.2, 5.3, 5.4 and 5.5.

- The government information was thought not to be accurate for 8.0% of items.
- Survey points marked “not accurate”: 1.2 and 5.1.

- The respondent took no position on the government information for 8.0% of items.
- Survey points marked “take no position”: 3.2 and 3.5.

Survey comments from **The Hepatitis C Trust (Scotland):**

**Information reported by government (2012–2013)**

1.3 The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific populations: health-care workers (including health-care waste handlers), people who inject drugs, migrants, prisoners, the homeless, people living with HIV, people at risk for STI and pregnant women (antenatal screening).

2.1 The government did not hold events for World Hepatitis Day 2012, but has funded other viral hepatitis public awareness campaigns since January 2011 (Annex A).

2.2 The government collaborates with the following in-country civil society groups to develop and implement its viral hepatitis prevention and control programme: Hepatitis C Trust, Addaction, British Liver Trust, Exchange Supplies, Needle Exchange Forum and Injecting Advice.

5.2 The government has national policies relating to screening and referral to care for hepatitis B and hepatitis C.

**Civil society respondent comments (2014)**


The Scottish Government has made a contribution to World Hepatitis Day events organised and partly funded by charities, volunteer organisations and community organisations, as well as some regional National Health Service Boards.

Also in Scotland: Hepatitis Scotland, Waverley Care Gay Men’s Health, Terence Higgins Trust, Drugscope Aberdeen and Caledonia Youth and HIV Scotland.

Although screening is carried out in Harm Reduction/Needle Exchange Services.
There is no designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities. It is not known how many people work full-time on hepatitis-related activities in all government agencies/bodies.

In Scotland we have government civil servants who co-ordinate the viral hepatitis network. I do not know the numbers involved.

Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools for health professionals (pre-service education), on-the-job training and postgraduate training. There are no national clinical guidelines for the management of viral hepatitis, but there are for the management of HIV, which include recommendations for coinfection with viral hepatitis.

In Scotland we have the Scottish Intercollegiate Guidelines Network (SIGN 133) guideline on the management of hepatitis C. http://goo.gl/pOQmzl


Health Improvement Scotland have also produced a set of quality indicators for HCV. http://goo.gl/VtYJkN

We take no position regarding this statement.

There are standard case definitions for hepatitis. Deaths, including from hepatitis, are reported to a central registry. No hepatitis case is reported as “undifferentiated” or “unclassified” hepatitis.

Not sure.

There is no national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are conducted regularly; the target populations are people who inject drugs, female sex workers and men who have sex with men. The last serosurvey was carried out in 2011.

In the Tayside region of Scotland research into Vitamin D deficiency and how this affects treatment outcomes is being carried out as is a project into treating those who are currently continuing to inject drugs.

The Medical Research Council are conducting an investigation into genetic factors affecting treatment outcomes.
Statement from The Hepatitis C Trust (Scotland) regarding key hepatitis policy issues in the United Kingdom of Great Britain and Northern Ireland:

**Awareness-raising, partnerships and resource mobilisation.** The Scottish Government public awareness campaign lasted for 2 weeks and messaging was targeted at high prevalence areas. This was unsatisfactory bit like a damp squib.

In recent years the emphasis has been on injecting drug use with the campaign slogan (ever injected; get tested).

No government awareness targeting those who received blood / blood products before screening was introduced or awareness campaigns directed at ethnic minority populations.

**Evidence-based policy and data for action.** The Scottish SHBBV Framework is too wide ranging and includes HIV and teenage pregnancy, the outputs are not clearly measurable. There are no clear target dates set. The Scottish Government intends to roll over the existing outputs into the next incarnation of the framework. The 3rd sector feedback on the outputs is unsupportive of simply repeating the same format. There are no clearly defined dates or actions. The 3rd sector is also unhappy at how funding is provided, with services having to compete with each other in each area. In light of the advances in HCV therapy the entire structure of the services need to be redesigned with much more emphasis on the patient. The Scottish patients have not been surveyed on the framework that will be in place post-2015.

**Prevention of transmission.** As part of the action plan / framework the Scottish Government has increased outlets and access to needle exchange. All paraphernalia is provided including sterile water. Foil is also being introduced to persuade people to stop injecting and begin smoking heroin. Needle exchange is not provided in the Scottish Prisons.

The reliance on harm reduction does not capture recreational drug injectors who may not access these services. There is no universal screening for HCV for expectant mothers only for HIV and HBV. There is no national policy to find people who have been infected for decades.

Tattooing in unlicensed premises is not considered to be a risk factor in Scotland as we have a low prevalence. There is no routine vaccination for all infants in respect of HBV. Our blood supply is screened and universal precaution procedures are in place within health care settings to minimise the risk.

**Screening, care and treatment.** There is no national screening policy. The first new therapies for HCV have been approved but for restricted use. My opinion is that there will be a two-tier treatment schedule with the majority of Scottish patients continuing to be treated with Peg and Riba.

Just over half of those estimated to be infected have been diagnosed and 3% of those have been initiated onto therapy for HCV.
UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND

Waverley Care*
NGO – direct service provider
Edinburgh, United Kingdom of Great Britain and Northern Ireland
www.waverleycare.org

SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of the United Kingdom of Great Britain and Northern Ireland reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 60.0% of items.
Survey points marked “accurate”:
1.1, 1.3, 2.2, 3.1, 3.2, 4.1, 4.5, 4.6, 4.8, 4.9, 4.10, 5.2, 5.3, 5.4 and 5.5.

The government information was thought to not be accurate for 32.0% of items.
Survey points marked “not accurate”:
1.2, 2.1, 3.3, 3.4, 3.5, 4.2, 4.4 and 5.1.

The respondent took no position on the government information for 8.0% of items.
Survey points marked “take no position”:
4.3 and 4.7.

Survey comments from Waverley Care:

<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1.1 There is a written national strategy or plan that focuses exclusively on the prevention and control of hepatitis C. It includes components for raising awareness, surveillance, prevention in general, prevention of transmission via injecting drug use, prevention of transmission in health-care settings, treatment and care, and coinfection with HIV.</td>
<td>Scotland has its own national strategy around Hepatitis C as health is devolved to the Scottish Government and we are not governed by the UK Government on this issue. The Scottish Government’s Strategy is called ‘Sexual Health and Blood Borne Virus Framework 2011–15.</td>
</tr>
<tr>
<td>1.3 The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific populations: health-care workers (including health-care waste handlers), people who inject drugs, migrants, prisoners, the homeless, people living with HIV, people at risk for STI and pregnant women (antenatal screening).</td>
<td>Again accurate for Scotland.</td>
</tr>
<tr>
<td>2.2 The government collaborates with the following in-country civil society groups to develop and implement its viral hepatitis prevention and control programme: Hepatitis C Trust, Addaction, British Liver Trust, Exchange Supplies, Needle Exchange Forum and Injecting Advice.</td>
<td>This is indeed accurate; however, in Scotland the main NGOs involved are: Hepatitis Scotland, Waverley Care, Addaction and Positive Help.</td>
</tr>
<tr>
<td>3.1 There is routine surveillance for viral hepatitis. There is a national surveillance system for the following types of acute hepatitis: A, B, C and E, and for the following types of chronic hepatitis: B and C.</td>
<td>Surveillance is coordinated nationally in Scotland by Health Protection Scotland.</td>
</tr>
</tbody>
</table>

* World Hepatitis Alliance member.
<table>
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<tr>
<th>Information reported by government (2012–2013)</th>
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</thead>
<tbody>
<tr>
<td><strong>3.2</strong> There are standard case definitions for hepatitis. Deaths, including from hepatitis, are reported to a central registry. No hepatitis case is reported as “undiifferentiated” or “unclassified” hepatitis.</td>
<td>To our knowledge, this information is accurate.</td>
</tr>
<tr>
<td><strong>4.6</strong> There is a national policy on injection safety in health-care settings, but it is not known what type of syringes it recommends for therapeutic injections. It is not known whether single-use or auto-disable syringes, needles and cannulas are always available in all health-care facilities.</td>
<td>To our knowledge, this information is not accurate.</td>
</tr>
<tr>
<td><strong>4.9</strong> There is a national policy relating to the prevention of viral hepatitis among people who inject drugs.</td>
<td>Covered in the Scottish Government national framework cited above.</td>
</tr>
<tr>
<td><strong>5.4</strong> Publicly funded treatment for hepatitis B and hepatitis C is available to the entire population. The amount spent by the government on such treatment is not known.</td>
<td>The amount of money spent by Government is known.</td>
</tr>
<tr>
<td><strong>1.2</strong> There is no designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities. It is not known how many people work full-time on hepatitis-related activities in all government agencies/bodies.</td>
<td>The Scottish Government has a dedicated team working on all blood-borne virus issues including hepatitis C and are responsible for the strategy cited in 1.1 They work in partnership with Health Protection Scotland, NHS Boards and BBV NGOs.</td>
</tr>
<tr>
<td><strong>2.1</strong> The government did not hold events for World Hepatitis Day 2012, but has funded other viral hepatitis public awareness campaigns since January 2011 (Annex A).</td>
<td>The Scottish Government has always encouraged activities around World Hepatitis Day, through their funding of the national NGO – Hepatitis Scotland’. Waverley Care and all health boards across Scotland works in partnership with Hepatitis Scotland to ensure that these activities are coordinated and joined up.</td>
</tr>
<tr>
<td><strong>3.3</strong> Liver cancer cases are registered nationally, but cases with HIV/hepatitis coinfection are not. The government publishes hepatitis disease reports quarterly and annually.</td>
<td>Again all cases of coinfection are also collated by Health Protection Scotland and local health boards.</td>
</tr>
</tbody>
</table>
### Information reported by government (2012–2013)

<table>
<thead>
<tr>
<th>Section</th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4</td>
<td>Hepatitis outbreaks are not required to be reported to the government. There is adequate laboratory capacity nationally to support investigation of outbreaks and other surveillance activities.</td>
</tr>
<tr>
<td>3.5</td>
<td>There is no national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are conducted regularly; the target populations are people who inject drugs, female sex workers and men who have sex with men. The last serosurvey was carried out in 2011.</td>
</tr>
<tr>
<td>4.2</td>
<td>The government has not established the goal of eliminating hepatitis B.</td>
</tr>
<tr>
<td>4.4</td>
<td>There is a national policy that specifically targets mother-to-child transmission of hepatitis B (Annex B).</td>
</tr>
<tr>
<td>5.1</td>
<td>Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools for health professionals (pre-service education), on-the-job training and postgraduate training. There are no national clinical guidelines for the management of viral hepatitis, but there are for the management of HIV, which include recommendations for coinfection with viral hepatitis.</td>
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### Civil society respondent comments (2014)

<table>
<thead>
<tr>
<th>Section</th>
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</tr>
</thead>
<tbody>
<tr>
<td>3.4</td>
<td>The Scottish Government requires health boards across Scotland to report on outbreaks of Hepatitis, this is then collated by laboratories and Health Protection Scotland.</td>
</tr>
<tr>
<td>3.5</td>
<td>In developing the Scottish Government’s Action Plan national research has been carried out and continues to be done by Health Protection Scotland.</td>
</tr>
<tr>
<td>4.2</td>
<td>Hepatitis B is also covered by the Scottish Government’s Sexual Health and Blood Borne Virus Framework 2011–15.</td>
</tr>
<tr>
<td>4.4</td>
<td>All transmission routes for all blood-borne viruses are covered in the Scottish Government’s national framework cited above, including Hepatitis B and mother-to-child transmission.</td>
</tr>
<tr>
<td>5.1</td>
<td>We have national guidance for the management of all blood-borne viruses.</td>
</tr>
</tbody>
</table>
United Kingdom of Great Britain and Northern Ireland

Waverley Care continued

Information reported by government (2012–2013)

4.3 Information was not provided on the percentage of newborn infants nationally in a given recent year who received the first dose of hepatitis B vaccine within 24 hours of birth or the percentage of one-year-olds nationally (ages 12–23 months) in a given recent year who received three doses of hepatitis B vaccine.

Civil society respondent comments (2014)

I do not know the answer to this question.

4.7 Official government estimates of the number and percentage of unnecessary injections administered annually in health-care settings were not known.

I do not know the answer to this question.

Statement from Waverley Care regarding key hepatitis policy issues in the United Kingdom of Great Britain and Northern Ireland:

National coordination. The Scottish Government has an excellent approach to national coordination. The Scottish Governments Sexual Health and Blood Borne Virus Framework 2011–15 was developed by all key stakeholders including health boards, clinical and social care staff, NGO’s and patients. All National Health Service Boards have an established Managed Care Network for BBVs and these are multidisciplinary teams involving all stakeholders at a local level. All NHS Boards in Scotland are expected to submit annual activity reports in line with the national framework to the Scottish Governments Sexual Health and Blood Borne Virus Team.

Awareness-raising, partnerships and resource mobilisation. Noting the Scottish Government has done an excellent job and our national strategy and its implementation are regarded as an excellent approach and model, worldwide.

Evidence-based policy and data for action. It is clearly the role of all governments to take equal responsibility of the care of all citizens living with a blood-borne virus.

Prevention of transmission. All stakeholders should have an equal involvement in the development of national blood-borne virus strategies and policies to enable these policies to be effective and responsive to the needs of individuals living with a BBV. This is clearly the case in Scotland.

Screening, care and treatment. The Scottish Government’s national Sexual Health and Blood Borne Virus Framework 2011–15. How this has been implemented is well documented and is recognised as a model that has worked.
South-East Asia Region
This chapter presents South-East Asia region findings from the World Hepatitis Alliance’s 2014 civil society survey in two sections.

The first section provides an overview of respondents. The second section describes the extent to which respondents agreed or disagreed with what their governments reported about hepatitis policies and programmes for the 2013 World Health Organization (WHO) Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States. It also notes the issues associated with the greatest amount of agreement and disagreement.

8.1. Respondents

Nine organisations from six countries in the South-East Asia region responded to the World Hepatitis Alliance’s 2014 civil society survey. The governments of all of those countries provided information for the 2013 WHO global policy report, and thus all respondents were able to comment on the accuracy of their governments’ responses. Additional information about respondents is presented in Table 8.1.

### Table 8.1. South-East Asia region respondents to the World Hepatitis Alliance’s 2014 civil society survey (N=9)

<table>
<thead>
<tr>
<th>Country</th>
<th>Civil society survey respondents (#)</th>
<th>NGO – hepatitis patient group</th>
<th>NGO – direct service provider</th>
<th>NGO – other</th>
<th>Medical society</th>
<th>Private Foundation</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indonesia</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myanmar</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nepal</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thailand</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
One respondent (11%) identified itself as a nongovernmental direct service provider (Figure 8.1). Two (22%) identified themselves as medical societies, and two (22%) identified themselves as private foundations.

Fifty-five percent of respondents were either voting or non-voting members of the World Hepatitis Alliance at the time they submitted their surveys (data not shown).

Two respondents (22%) were based in upper-middle-income countries, three (33%) in lower-middle-income countries, and four (44%) in low-income countries (Figure 8.2).

8.2. Highlights relating to civil society agreement or disagreement with what governments reported

The civil society survey contained 25 items based on the information that governments provided for the 2013 WHO global policy report. For each item, civil society stakeholders were asked to consider the government response to one or more questions about national hepatitis policies and programmes, and to select one of the following three statements: To our knowledge, this information is accurate; To our knowledge, this information is not accurate; or We take no position regarding this statement.

Detailed findings for all civil society survey items are presented in Annex C. In sum, two-thirds of all civil society respondents thought that the information from their governments was accurate for 20 or more of the 25 items. Regarding the proportions of respondents who marked items as “not accurate,” one-third thought that the information from their governments was not accurate for at least six items.

The following survey items were most commonly identified as points on which civil society respondents in the South-East Asia region agreed with their governments’ responses: item 2.1, regarding World Hepatitis Day activities and viral hepatitis awareness campaigns; item 3.5, regarding a national viral hepatitis research agenda and viral hepatitis serosurveys; item 4.1, regarding the existence of a national hepatitis A vaccination policy; item 4.2, regarding the goal of eliminating hepatitis B; item 4.6, regarding injection safety in health care settings; and item 4.8, regarding infection control for blood products. Further details are presented in Table 8.2.

The following survey items were most commonly identified as points on which civil society respondents in the South-East Asia region disagreed with their governments’ responses: item 1.3, regarding whether the government has a viral hepatitis prevention and control programme that includes activities targeting specific populations, and item 5.5, regarding the inclusion of hepatitis B drugs and hepatitis C drugs on national essential medicines lists and in government-subsidised programmes. Further details are presented in Table 8.3.
Table 8.2. Survey items eliciting the highest levels of agreement from civil society respondents, South-East Asia region (N=9)

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Question(s) addressed by governments for 2013 WHO global policy report</th>
<th># (%) of respondents who indicated agreement with their governments’ response(s) by selecting “to our knowledge, this information is accurate”</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Did your government hold events for World Hepatitis Day 2012?</td>
<td>9 (100%)</td>
</tr>
<tr>
<td></td>
<td>Has your government funded any public viral hepatitis awareness campaigns since January 2011, other than World Hepatitis Day?</td>
<td></td>
</tr>
<tr>
<td>3.5</td>
<td>Is there a national public health research agenda for viral hepatitis?</td>
<td>8 (88.9%)</td>
</tr>
<tr>
<td></td>
<td>Are viral hepatitis serosurveys conducted regularly?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If yes, how often? When was the last one carried out?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Please specify the target populations.</td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td>Is there a national hepatitis A vaccination policy?</td>
<td>8 (88.9%)</td>
</tr>
<tr>
<td></td>
<td>If yes, what groups does the policy address?</td>
<td></td>
</tr>
<tr>
<td>4.2</td>
<td>Has your government established the goal of eliminating hepatitis B?</td>
<td>8 (88.9%)</td>
</tr>
<tr>
<td></td>
<td>If yes, in what timeframe?</td>
<td></td>
</tr>
<tr>
<td>4.6</td>
<td>Is there a national policy on injection safety in health care settings?</td>
<td>8 (88.9%)</td>
</tr>
<tr>
<td></td>
<td>If yes, what type of syringes does the policy recommend for therapeutic injections?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are single-use or auto-disable syringes, needles and cannulas always available in all health care facilities?</td>
<td></td>
</tr>
<tr>
<td>4.8</td>
<td>Is there a national infection control policy for blood banks?</td>
<td>8 (88.9%)</td>
</tr>
<tr>
<td></td>
<td>Are all donated blood units (including family donations) and blood products nationwide screened for hepatitis B?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are all donated blood units (including family donations) and blood products nationwide screened for hepatitis C?</td>
<td></td>
</tr>
</tbody>
</table>

Table 8.3. Survey items eliciting the highest levels of disagreement from civil society respondents, South-East Asia region (N=9)

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Question(s) addressed by governments for 2013 WHO global policy report</th>
<th># (%) of respondents who indicated disagreement with their governments’ response(s) by selecting “to our knowledge, this information is not accurate”</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3</td>
<td>Does your government have a viral hepatitis prevention and control programme that includes activities targeting specific populations? If yes, please indicate which populations.</td>
<td>5 (55.6%)</td>
</tr>
<tr>
<td>5.5</td>
<td>Which hepatitis B drugs and hepatitis C drugs are included on the national essential medicines list or are subsidised by the government?</td>
<td>3 (33.3%)</td>
</tr>
</tbody>
</table>
There is no routine surveillance for viral hepatitis. On the national level there is no routine surveillance system for viral hepatitis. Recently the government started surveillance of foodborne infectious diseases in one of its surveillance programmes where hepatitis A and hepatitis E are included and being conducted regularly. Similarly, hepatitis B and hepatitis C are monitored regularly in another programme (safe blood programme).

There is no national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are not conducted regularly. Recently the government has planned to start a serosurvey programme nationwide for several diseases including viral hepatitis.

Information was not provided on the percentage of newborn infants nationally in a given recent year who received the first dose of hepatitis B vaccine within 24 hours of birth or the percentage of one-year-olds nationally (ages 12–23 months) in a given recent year who received three doses of hepatitis B vaccine. First dose of Hepatitis B vaccine is given at 6th week of age along with DPT Vaccine in EPI programme.

There is no national policy on injection safety in health-care settings. Single-use or auto-disable syringes, needles and cannulas are always available in all health-care facilities. Draft injection safety policy is waiting for approval of government.

Survey comments from the Liver Foundation of Bangladesh:

- The government information was thought to be accurate for 80.0% of items.
- The government information was thought to not be accurate for 16.0% of items.
- The respondent took no position on the government information for 4.0% of items.

To our knowledge, this information is accurate.

- 1.1, 1.2, 2.1, 2.2, 3.1, 3.2, 3.3, 3.4, 3.5, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.9, 5.2, 5.3 and 5.5.

- 1.3, 4.8, 4.10 and 5.1.

- 5.4.

In different issues regarding prevention and control of viral hepatitis, some government officials regularly communicate with the Liver Foundation of Bangladesh.

On the national level there is no routine surveillance system for viral hepatitis. Recently the government started surveillance of foodborne infectious diseases in one of its surveillance programmes where hepatitis A and hepatitis E are included and being conducted regularly. Similarly, hepatitis B and hepatitis C are monitored regularly in another programme (safe blood programme).

Recently the government has planned to start a serosurvey programme nationwide for several diseases including viral hepatitis.

First dose of Hepatitis B vaccine is given at 6th week of age along with DPT Vaccine in EPI programme.

Draft injection safety policy is waiting for approval of government.
5.4 Publicly funded treatment is not available for hepatitis B or hepatitis C.

To our knowledge, this information is not accurate.

5.5 The following drugs for treating hepatitis B drugs are on the national essential medicines list: interferon alpha, pegylated interferon, lamivudine, adefovir dipivoxil, entecavir, telbivudine and tenofovir. The following drugs for treating hepatitis C are on the national essential medicines list: interferon alpha, pegylated interferon, ribavirin, boceprevir and telaprevir.

To our knowledge, this information is accurate.

4.8 There is a national infection control policy for blood banks. Not all donated blood units and blood products nationwide are screened for hepatitis B. It is not known whether all donated blood units (including family donations) and blood products nationwide are screened for hepatitis C.

We take no position regarding this statement.

4.10 The government does not have guidelines that address how hepatitis A and hepatitis E can be prevented through food and water safety.

To our knowledge, this information is not accurate.

5.3 The health system as a whole may be developed with introducing health insurance scheme for health services in the country.

To establish a viral hepatitis disease unit, similar to other major departments in health services like mycobacterial disease control, malaria and parasitic disease control, and National AIDS and Sexually Transmitted Disease Control Programme under director general of health services.

A separate institute may be established and designated as national viral hepatitis institute which may function as a centre of excellence in this field and all types of investigation, surveillance of outbreaks, case management, monitoring and follow-up of chronic patients and conduct of all hepatitis-related research activities and to establish network with other international organisations.

A person may be designated as a viral hepatitis focal point holding responsibility to oversee viral hepatitis activities in the country.

The designated institute/person should establish liaison/links with national and international stakeholders, development partners like the United Nations Development Programme, UNICEF, the World Health Organization and the World Bank for implementing programmes at micro levels for awareness-raising, human resource development and capacity-building for diagnosis and management. Local pharmaceutical companies may contribute through production of vaccines, reagents and essential drugs for diagnosis, prevention and management of hepatitis at a subsidised rate.

Statement from the Liver Foundation of Bangladesh regarding key hepatitis policy issues in Bangladesh:

As viral hepatitis and its consequences are multi-faceted, prevention and control measures and management procedures differ from one another. The diseases also traverse both communicable and noncommunicable phases. So the disease burden in acute and chronic stage including cirrhosis and liver cancer and great complications in pregnancy contribute at a great extent to disease burden of the country.

In view of the facts above, we must have changes in the country’s health system. Considering viral hepatitis a major public health issue, the systemic changes proposed in health services are as follows:

- There are prevention and control activities in the national EPI programme targeting children under the age of one.

- Though there is a law of “Safe Blood Transfusion Act 2002” which was approved by parliament, a national blood policy is still required to guide and bring blood use in a uniform way to be followed by all blood transfusion centres across the country.

- There is a foodborne infection surveillance programme started by the Institute of Epidemiology, Disease Control and Research, Bangladesh from 2013.

- Only lamivudine and tenofovir are present to the essential drug list.
SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Bangladesh reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

✓ The government information was thought to be accurate for 52.0% of items.
  Survey points marked “accurate”: 1.1, 1.2, 2.1, 3.1, 3.2, 3.3, 3.4, 3.5, 4.1, 4.6, 4.8, 4.10 and 5.3.

✗ The government information was thought to not be accurate for 24.0% of items.
  Survey points marked “not accurate”: 1.3, 4.3, 4.4, 5.1, 5.4 and 5.5.

✗ The respondent took no position on the government information for 24.0% of items.
  Survey points marked “take no position”: 2.2, 4.2, 4.5, 4.7, 4.9 and 5.2.

The Viral Hepatitis Foundation Bangladesh did not provide any comments about survey items. The respondent also did not provide a statement regarding key hepatitis policy issues in Bangladesh.
There is no routine surveillance for viral hepatitis. Even the existing antiretroviral centres do not maintain the data for coinfection.

There are standard case definitions for hepatitis. Hepatitis deaths are not reported to a central registry. The percentage of hepatitis cases reported as “undifferentiated” or “unclassified” hepatitis is not known.

Even patients on antiretroviral therapy with hepatitis B coinfection are not encouraged with tenofovir.

The government has not established the goal of eliminating hepatitis B.

It is not known whether there is a national policy relating to the prevention of viral hepatitis among people who inject drugs.

The government does not have national policies relating to screening and referral to care for hepatitis B or hepatitis C.

The referral services provided by targeted intervention projects for HIV testing to Integrated counselling and testing centres do not include hepatitis.

The concerned officials bluntly ignore us when we approach them to initiate a consultation on improving access to hepatitis C treatment.

Even the existing antiretroviral centres do not maintain the data for coinfection.

Government is still yet to realise that mortality among people on antiretroviral therapy is due to hepatitis B and hepatitis C.

Whenever we approach the State AIDS Control Society for hepatitis-related issues among people who inject drugs (PWID), they are not concerned. Prevention of hepatitis C among PWID is not on the agenda in national harm reduction strategy.

The referral services provided by targeted intervention projects for HIV testing to Integrated counselling and testing centres do not include hepatitis.
### Information reported by government (2012–2013)

1.1 There is a written national strategy or plan that focuses exclusively on the prevention and control of viral hepatitis. It includes components for raising awareness, surveillance, vaccination, prevention in general, prevention of transmission via injecting drug use, prevention of transmission in health-care settings, and treatment and care.

1.2 There is a designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities. It has four staff members. It is not known how many people work full-time on hepatitis-related activities in all government agencies/bodies.

1.3 The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific population: health-care workers, including health-care waste handlers.

3.3 Liver cancer cases and cases with HIV/hepatitis co-infection are registered nationally. The government does not publish hepatitis disease reports.

3.4 Hepatitis outbreaks are reported to the government and are further investigated. There is inadequate laboratory capacity nationally to support investigation of viral hepatitis outbreaks and other surveillance activities.

5.3 People testing for both hepatitis B and hepatitis C register by name; the names are kept confidential within the system. Hepatitis B and hepatitis C tests are free of charge for all individuals and are compulsory for blood donors.

### Civil society respondent comments (2014)

- **1.1** At least the government has started taking the initiative for hepatitis B vaccination for newborn babies.

- **1.2** We have been doing advocacy on improving access to hepatitis C treatment since 2012 with the Government Health Department. However, we do not know of the existence of such teams or units at the state level solely for hepatitis C.

- **1.3** Based on our experience, most health care providers are still lacking adequate information on viral hepatitis.

- **3.3** Cases are not registered nationally and as such the disease report is not applicable.

- **3.4** Hepatitis outbreaks are neither reported to the government nor does the government have any adequate laboratory to support investigations.

- **5.3** We have no such system as of now. Hepatitis B and hepatitis C are among the mandatory tests for antiretroviral initiation. Peoples are paying Rs 300 to the government hospital whereas the fee is Rs 750 at private diagnostic centres.

- **4.1** Our network mainly focuses on hepatitis B and hepatitis C. We have no information on hepatitis A.
Statement from the Community Network for Empowerment regarding key hepatitis policy issues in India:

India does not have a surveillance system for hepatitis C and the burden of the disease is unknown. However, the graveness of the situation is documented through data and information from independent studies. Recent studies conducted by the World Health Organization have reported that among people who inject drugs the national prevalence rate of HIV/hepatitis C coinfection is 92% while individual sites have also reported a prevalence range of 26% to 93%. In the context of Manipur, the prevalence of the coinfection has been reported as 92% and 90.2% in Churachandpur district.

In spite of having such rich data for more than a decade now, and in spite of India being a signatory to the World Health Assembly’s 2010 viral hepatitis resolution, nothing substantial has been done to improve services, prevention measures or provide treatment as a government response.

Considering the seriousness of the hepatitis issue in India, particularly hepatitis C, the government should develop a national strategy to respond to this public health issue including resource allocation at the earliest. An exclusive programme for prevention of hepatitis should be implemented in collaboration with different key stakeholders.

Civil society should be provided a greater role in curbing viral hepatitis in terms of planning, implementation and monitoring. Community-based groups and networks of hepatitis C-infected and -affected people should be involved in all decision-making, planning and implementation of hepatitis programming.

2. Ibid p/16.
India

Liver Foundation, West Bengal*

NGO – direct service provider
Kolkata, India
www.liverfoundation.in

SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of India reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

- The government information was thought to be accurate for **80.0%** of items.
  - Survey points marked “accurate”: 1.3, 2.1, 2.2, 3.1, 3.2, 3.3, 3.4, 3.5, 4.1, 4.2, 4.3, 4.5, 4.6, 4.7, 4.8, 4.9, 5.1, 5.2, 5.4 and 5.5.

- The government information was thought to not be accurate for **4.0%** of items.
  - Survey points marked “not accurate”: 1.1.

- The respondent took no position on the government information for **16.0%** of items.
  - Survey points marked “take no position”: 1.2, 4.4, 4.10 and 5.3.

*The Liver Foundation, West Bengal did not provide any comments about survey items.*

Statement from the Liver Foundation, West Bengal regarding key hepatitis policy issues in India:

Chronic hepatitis, as a term, is exclusionary for insurance coverage by most insurance providers.

No national hepatitis control programme exists that can provide support to infected and diseased people for their health care expenditures through government funding.

No guidelines or standard protocol for the management of hepatitis exist. This lays bare the situation even further and creates a freestyle situation in patient care strategies. In the absence of any system for monitoring of clinical and hospital practice, this often turns out to be an absolutely “zero protection” scenario for patient interest. Indiscriminate and unnecessary hospitalisations, unnecessary drug use and unnecessary therapeutic procedures are some of the examples of imperfect practice of relevance in hepatitis care that are in vogue.

There is a perception even in government circles that hepatitis B and hepatitis C are not priorities in India which is besieged with so many other conditions. Lack of data on the disease burden and economic impact of hepatitis are the primary reasons for this.

National coordination for necessary regulations for supporting patient’s interest including health care-related travel subsidies, treatment subsidies, other social security benefits that are available to people with chronic diseases such as HIV and cancer should be initiated. There are multiple stakeholders with different roles that can be knitted together to create a proactive hepatitis supportive ambience.

Liver Foundation, West Bengal, is a voluntary organisation focused on different health issues. Initiated by a handful of professionals and socially committed scientists having an interest and focus on liver disease awareness as well as public health issues facing the country. So this view is based on our own experience as well as different reports and statistics.
The Association of Viral Hepatitis Controllers in Indonesia

Medical society
Central Jakarta, Indonesia

SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Indonesia reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ The government information was thought to be accurate for 96.0% of items.</td>
<td>As far as we have observed, the Indonesian government, especially the Ministry of Health has been striving to increase the awareness of hepatitis virus (in particular Hepatitis B) starting from boosting the theme of hepatitis in the World Health Assembly, then supporting the World Hepatitis Day campaign every July 28 since the year 2010. The prevention programme towards hepatitis B has been implemented since the year of 1986, which was the pilot project in Lombok; and then integrated to the programme of basic immunization in 1997 and in 2003, a vaccination to the newborn babies, afterwards in 2004 HB was integrated with the combination of DPT/HB and in 2014, it was integrated with vaccine HIB (Haemophylus influenzae B). Hepatitis surveillance has been executed but it was still clinically based (not in a laboratory way) so it has not been broken up into its kind (A, B, or C). Prevention for drug abuse has been done together with the prevention programme for HIV. The pilot project for screening the pregnant women are being done currently, and it has been planned that HBIG will be given to babies. Regarding the treatment, it has been sought to give the lamivudine with low cost, and it has been proposed to be put into BPJS (social security programme).</td>
</tr>
<tr>
<td>✓ The government information was thought to not be accurate for 4.0% of items.</td>
<td></td>
</tr>
</tbody>
</table>

Survey comments from the Association of Viral Hepatitis Controllers in Indonesia:

1.1 There is a written national strategy or plan that focuses exclusively on the prevention and control of viral hepatitis. It includes components for raising awareness, surveillance, vaccination, prevention in general, prevention of transmission via injecting drug use, prevention of transmission in health-care settings, and treatment and care.

Information reported by government (2012–2013):

To our knowledge, this information is accurate.
1.3 The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific population: health-care workers, including health-care waste handlers.

1.2 There is no designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities. There are 12 full-time equivalent staff members who work on hepatitis-related activities in all government agencies/bodies.

2.1 The government held events for World Hepatitis Day 2012. It has funded other viral hepatitis public awareness campaigns since January 2011 (Annex A).

Based on our observations, it is true that at this time in the Department of Health there is no specific department for hepatitis but it is combined with diarrhea, gastrointestinal infection and hepatitis. Also in October 2010 recently, actually at least 20 personnel are needed to prevention and treatment programmes. Details on this case are being prepared. We cooperate with professional organisations (The Indonesian Association for the study of the Liver) and Working Group of Viral Hepatitis in the Department of Health to help preparing the guideline of hepatitis B treatment and guideline for screening the pregnant mother.

For prevention and control, the prevention activity is performed by immunisation at the earliest age possible by giving HB-O immediately after the baby born and after given vitamin K. Immunisation can only be given to the babies born at the hospital/maternity clinic or other health facilities. As it is known there is still quite a big number of babies who were born outside the health facilities so that it was still tolerable if immunisation was given to the babies whose age were less than seven days for the areas which are difficult to reach.

For health-workers, the immunisation are carried out independently by some hospitals, whilst in general for health-care and waste handlers it was done by the Environmental Health Directorate in PHBS programme (Clean and healthy behaviour programme). For the event of World Hepatitis Day 2012, the government prepared fund to increase public awareness, and this campaign has started since January 2011. Because this is the new activity then it requires a bureaucratic time.

To our knowledge, this information is accurate.
There are standard case definitions for hepatitis. Deaths, including from hepatitis, are reported to a central registry. Information was not provided on the percentage of hepatitis cases reported as “undifferentiated” or “unknown” hepatitis.

Indonesia has had a guideline prepared by the government and experts using the reference of World Health Organization guidelines. The report in the main office is received by the sub-directorate of surveillance disease control and environmental health, but it has not been socialised properly and not yet fully understood the definition of establishing the diagnosis and the treatment procedure. Need to be improved.

Liver cancer cases are registered nationally, but it is not known whether cases with HIV/hepatitis coinfection are. The government publishes hepatitis disease reports monthly and annually.

3.4 Hepatitis outbreaks are reported to the government and are further investigated. There is adequate laboratory capacity nationally to support investigation of outbreaks and other surveillance activities.

There is always an investigation for the outbreak condition. Blood sample is taken and then sent to Badan Lit Bang Kes (Agency for Healthcare Research and Development) to identify the hepatitis type. The readiness of this Agency is sufficient in the term of reagent supply and the examination elisa/PCR.
4.2 The government has not established the goal of eliminating hepatitis B. Government has not established the goal of eliminating hepatitis B because they still have to arrange several matters for example, to reach the high level and evenly coverage of hepatitis B immunisation; to enhance the surveillance system that can cover the entire health care facility; to be able to have a network for the examination of the type of hepatitis; to increase the awareness towards the hepatitis disease; to improve the knowledge of the health-workers to understand/recognise the hepatitis disease; to refer the patient that should be referred; and free treatment for hepatitis disease.

The constraint that we have is we need to establish the correct magnitude of the problem. The accurate data is not yet known.

4.3 Information was not provided on the percentage of newborn infants nationally in a given recent year who received the first dose of hepatitis B vaccine within 24 hours of birth. Nationally, 94% of one-year-olds (ages 12–23 months) in a given recent year received three doses of hepatitis B vaccine.

Regarding the result of the coverage yearly, it could be seen from JRF/Joint Report Form which was assessed by WHO and UNICEF, it was separated between the coverage of babies born in the health-facility and in the field who were assisted by midwives. For Booster purposes, Pentavalent was given in the age of 18 months (this is the new policy). There are still differences in the data between Western and Eastern Indonesia.
4.4 There is a national policy specifically targeting mother-to-child transmission of hepatitis B (Annex B).

To our knowledge, this information is accurate.

4.5 There is no specific national strategy and/or policy for preventing hepatitis B and hepatitis C infection in health-care settings. Health-care workers are not vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood.

Information reported by government (2012–2013)

4.6 There is a national policy on injection safety in health-care settings, which recommends single-use and auto-disable syringes for therapeutic injections. Single use or auto-disable syringes, needles and cannulas are always available in all healthcare facilities.

Civil society respondent comments (2014)

Blood screening is currently being done in Jakarta towards the pregnant mothers. It is as an early initiation and approximately targeted about 5,000 pregnant women; and the next step is for those who are indicated “positive” to be followed by the examination of HBV-DNA, and their baby will be given HIG (at this time it is still in trial process).

In 2013 a screening had been carried out throughout Jakarta. In 2014 in Jakarta plus 12 new provinces, there will be an examination for 126,000 pregnant mothers and health workers. The collection of blood will be done approximately in August this year.

Up to now, there is not any government policy yet to undertake the screening and immunisation to the health-care workers, but there are several private hospitals that delivered immunisation to their employees. In the National General Hospital Cipto Mangunkusumo, it had ever been given the immunisation of hepatitis B assisted by Askes (national insurance for civil servants/government employee).

For the prevention of hepatitis C, the education to the Health-care workers who will do the medical treatment or who are in contact with blood, such as transfusion, then the injection is given in order to follow the existing Standard Operating Procedure (SOP).

National policy for safety injection especially for conducting the immunisation, it has been used auto-disable syringe in order to prevent to be used again. The need for a syringe is sufficiently available.
### Indonesia

#### The Association of Viral Hepatitis Controllers in Indonesia

<table>
<thead>
<tr>
<th><strong>Information reported by government (2012–2013)</strong></th>
<th><strong>Civil society respondent comments (2014)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5.1 Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools of health professionals (pre-service education) and on-the-job training. There are no national clinical guidelines for the management of viral hepatitis.</strong></td>
<td>Recently, the Sub-directorate of diarrhoea, hepatitis Disease Control along with the professional organisations have prepared guidelines for treatment of Hepatitis B and Hepatitis C. As stated earlier since October 2010 the programme of Hepatitis viruses have been included in the Sub-Directorate Disease Control in the Directorate General of Disease Control and Environmental Health, and started to perform several programmes related to hepatitis viruses, especially hepatitis B and hepatitis C. It is initiated with the examination of lab workers within the MOH and studies of pregnant woman. If they are positive then a further treatment is carried out in Jakarta. They will perform the same action next year in the other 12 provinces throughout Indonesia.</td>
</tr>
<tr>
<td><strong>5.2 The government does not have national policies relating to screening and referral to care for hepatitis B or hepatitis C.</strong></td>
<td>There is not a national policy yet for screening against hepatitis B or C, it is still in the level of Pilot Project to the pregnant mothers in Jakarta.</td>
</tr>
<tr>
<td><strong>5.3 People testing for both hepatitis B and hepatitis C register by name, the names are kept confidential within the system. Hepatitis B and hepatitis C tests are not free of charge. Information was not provided on whether hepatitis B or hepatitis C tests are compulsory for members of any specific group.</strong></td>
<td>Policy from Government to screen the blood donor for hepatitis B, hepatitis C, HIV and syphilis exists. Their names are kept confidential and screening in Red Cross Lab is free of charge. The cost will be borne by the blood users including the blood bags. The patient with the lab result “positive” will be given a letter and afterwards, they get treatment. It is not compulsory to do a screening for those who are not a blood donor.</td>
</tr>
<tr>
<td><strong>4.8 There is a national infection control policy for blood banks. All donated blood units (including family donations) and blood products nationwide are screened for hepatitis B and hepatitis C.</strong></td>
<td>There is national infection control policy for blood banks. All donors are screened for hepatitis B, C, HIV and syphilis. It was initiated in 1992 and has since then been implemented.</td>
</tr>
<tr>
<td><strong>4.10 The government has guidelines addressing how hepatitis A and hepatitis E can be prevented through food and water safety.</strong></td>
<td>There has been a guideline in the sub-directorate of water supply and sanitation. It explains the transmission of hepatitis A and E through food and drinks. The rapid test is needed.</td>
</tr>
<tr>
<td><strong>5.4 Government employees are eligible for publicly funded treatment for hepatitis B and hepatitis C. Information was not provided on the amount spent by the government on such treatment.</strong></td>
<td>The government employee who suffers from hepatitis B and C after diagnosis by the expert will get treatment. There is not any report yet as to how many people have been treated by the government subsidy (in Askes -the government employee insurance/ names of medicines used has been listed).</td>
</tr>
</tbody>
</table>
To our knowledge, this information is not accurate.

5.5 The following drugs for treating hepatitis B are on the national essential medicines list: pegylated interferon, lamivudine, adefovir dipivoxil and telbivudine. The following drugs for treating hepatitis C are on the national essential medicines list: pegylated interferon and ribavirin.

4.9 It is not known whether there is a national policy relating to the prevention of viral hepatitis among people who inject drugs.

Information reported by government (2012–2013)

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>Hepatitis B: (Pegylated Interferon, Lamivudine, Telbivudin); (Pegylated Interferon and Ribavirin for Hepatitis C).</td>
</tr>
<tr>
<td>2013</td>
<td>The essential medicines which are available for Hepatitis B.</td>
</tr>
<tr>
<td>2014</td>
<td>There have been guidelines already for educating people who inject drugs in the form of pamphlet, brochures and flyer for user in the health centre.</td>
</tr>
</tbody>
</table>

Civil society respondent comments (2014)

The group above should continuously provide more intensive information to the policy makers, health professionals and to the wider community. Undoubtedly the people in the Ministry of Health will be supported by various stakeholders who are very concerned with the problem of hepatitis because during this time the problem of hepatitis has become the huge public health problem which has been neglected. It is expected that the prevention and control of viral hepatitis will be running much better.

In 1997, government had launched a mass vaccination for hepatitis B in all provinces in Indonesia, but the results are not yet as expected by all parties which is the decrease in the prevalence. One of the factors which may cause is the first HB vaccination coverage that might not hit the target. And also the catch-up vaccination has not yet been programmed as well as the vaccination for high-risk groups. Another issue is the difficulty to access to the diagnostics for people living with hepatitis as well as the access to the further treatment. As we have known these costs are very high.

The majority of people in Indonesia do not have the access to treatment for Hepatitis B, let alone for Hepatitis C. Is local production for these hepatitis medicines possible?
2.1 The government did not hold events for World Hepatitis Day 2012, but has funded other viral hepatitis public awareness campaigns since January 2011 (Annex A).

Liver Unit (Yangon General Hospital) has held “World Hepatitis Day” events since 2009 while Liver Foundation (Myanmar) and GI and Liver Society (Myanmar Medical Association) carried out the events in 2013.

4.8 There is a national infection control policy for blood banks. All donated blood units (including family donations) and blood products nationwide are screened for hepatitis B and hepatitis C.

There are some drawbacks as screening tests are not molecular assays.

3.1 There is routine surveillance for viral hepatitis. There is a national surveillance system for the following types of acute hepatitis: A, B and C. There is a national surveillance system for the following types of chronic hepatitis: B and C.

It is included in notifiable diseases on paper but public is not aware and it is not carried out systematically.

3.3 Liver cancer cases and cases with HIV/hepatitis coinfection are registered nationally. The government publishes hepatitis disease reports monthly and annually.

This is just on paper and not accurate.

---

Survey comments from the Liver Foundation:

To our knowledge, this information is accurate:

1.2 There is a designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities. It has 20 staff members. There are 49 full-time equivalent staff members who work on hepatitis-related activities in all government agencies/bodies.

To our knowledge, this information is not accurate:

2.1 The government did not hold events for World Hepatitis Day 2012, but has funded other viral hepatitis public awareness campaigns since January 2011 (Annex A).

Survey comments from the Liver Foundation:

There are Liver units in the Department of Medical Research and General Hospitals in Yangon, Mandalay, Naypyidaw, North Okalapa and Defence Services (Government).

Liver Unit (Yangon General Hospital) has held “World Hepatitis Day” events since 2009 while Liver Foundation (Myanmar) and GI and Liver Society (Myanmar Medical Association) carried out the events in 2013.

There are some drawbacks as screening tests are not molecular assays.

---

Survey comments from the Liver Foundation:

To our knowledge, this information is not accurate:

3.1 There is routine surveillance for viral hepatitis. There is a national surveillance system for the following types of acute hepatitis: A, B and C. There is a national surveillance system for the following types of chronic hepatitis: B and C.

It is included in notifiable diseases on paper but public is not aware and it is not carried out systematically.

This is just on paper and not accurate.

---

Survey comments from the Liver Foundation:

3.3 Liver cancer cases and cases with HIV/hepatitis coinfection are registered nationally. The government publishes hepatitis disease reports monthly and annually.

This is just on paper and not accurate.
### Information reported by government (2012–2013)

<table>
<thead>
<tr>
<th>3.5</th>
<th>There is a national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are conducted regularly; the most recent one was in 2010.</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.5</td>
<td>There is a specific national strategy and/or policy/guidelines for preventing hepatitis B and hepatitis C infection in health-care settings. Health-care workers are vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood.</td>
</tr>
<tr>
<td>5.3</td>
<td>People testing for both hepatitis B and hepatitis C register by name; the names are kept confidential within the system. Hepatitis B and hepatitis C tests are not free of charge for everyone, but they are free for pregnant women and blood donors. Hepatitis B and hepatitis C tests are compulsory for pregnant women, blood donors and people applying for employment.</td>
</tr>
</tbody>
</table>

---

### Civil society respondent comments (2014)

| 3.5 | Funds are required for national serosurveys and has not been available for many years. |
| 4.5 | Few departments have this kind of facility. |
| 5.3 | True for blood donors and for some antenatal care centres. |

---

### We take no position regarding this statement.

| 1.1 | There is a written national strategy or plan that focuses primarily on the prevention and control of viral hepatitis, and also integrates other diseases. It includes components for raising awareness, surveillance, vaccination, prevention in general, prevention of transmission via injecting drug use, prevention of transmission in health-care settings, and treatment and care. |
| 4.3 | Nationally, 10% of newborn infants in a given recent year received the first dose of hepatitis B vaccine within 24 hours of birth and 38% of one-year-olds (ages 12–23 months) in a given recent year received three doses of hepatitis B vaccine. |
| 4.9 | There is a national policy relating to the prevention of viral hepatitis among people who inject drugs. |

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### Other relevant points

- Bylaws may be required for legal use of syringes for people who inject drugs.
- These drugs are too expensive for routine use.
- Birth dose may be true in cities but difficult in rural areas.
Statement from the Liver Foundation regarding key hepatitis policy issues in Myanmar:

Of the five types of viral hepatitis, Hepatitis A, B, C, and E are endemic in Myanmar. Hepatitis B and C are blood borne infections and can cause chronic infections leading to complications. Hepatitis A and E are water-borne infections. All four infections can be prevented and it is very important for the general population to be aware of these facts and the duty of the government to carry out awareness-raising activities to educate the public.

Currently there is weakness in the awareness-raising activities both for blood-borne infections (hepatitis B and C) and waterborne infections (hepatitis A and E) by the government. There should be increase in the distribution of educational posters, pamphlets, advertisements on TV and radio broadcasting to reach the community. Simple advice such as not sharing razors, toothbrushes, nail cutters, using only disposable syringes, compulsory screening of blood donors, personal hygiene, sanitation and vaccination are all of great importance to prevent transmission.

In Myanmar, according to research findings, the main mode of transmission for hepatitis B is from mother to child during birth. Thus birth dose of hepatitis B vaccine is of great importance to prevent chronic infection in the child. However, although hepatitis B vaccine has been introduced into the EPI over 10 years ago, the schedule is 2.5, 3.5 and 4.5 months with the pentavalent vaccine currently. The Government is trying to obtain monovalent HB vaccine for birth dose but not carried out as yet.

In Myanmar, prior permission from the government or local authority is required for local NGOs or international NGOs to carry out activities in the community such as health education talks, blood screening, and vaccination programmes. Thus these groups should all work together in harmony to obtain successful results. The government should take the initiative, make health plans and projects and also work in collaboration and coordination with local NGOs and international NGOs to use their participation, to give them official recognition and also use their resources and funding as available.
SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Nepal reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

- ✔ The government information was thought to be accurate for 80.0% of items.
- ❌ The government information was thought to not be accurate for 16.0% of items.
- ❌ The respondent took no position on the government information for 4.0% of items.

Survey points marked “accurate”: 1.1, 1.2, 2.1, 2.2, 3.1, 3.3, 3.5, 4.1, 4.2, 4.3, 4.4, 4.5, 4.7, 4.8, 4.9, 4.10, 5.1, 5.2, 5.3 and 5.4.

Survey points marked “not accurate”: 1.3, 3.4, 4.6 and 5.5.

Survey points marked “take no position”: 3.2.

Union C did not provide any comments about survey items.

Statement from Union C regarding key hepatitis policy issues in Nepal:

National coordination. The government of Nepal should acknowledge the need and express a greater level of commitment to hepatitis screening, diagnosis, treatment, care and support. For that, it should immediately identify the national coordination body which can work in close coordination with national centre for AIDS and STD control.

Viral hepatitis among people who use drugs must be appropriately included in national HIV programmes and drug strategies and programmes, as well as in the Universal Access framework, Global Fund, Pooled Fund programmes and other national platforms.

Increase access to affordable, high quality, effective and safe diagnostic and testing services. Except for a few tests such as antibody and LFT, other diagnostics are carried out by sending blood samples to the Indian laboratories. HIV testing should always be offered to clients with hepatitis, and hepatitis B and hepatitis C testing should likewise be offered to people living with HIV.

Awareness-raising, partnerships and resource mobilisation. Work with community to increase the awareness on viral hepatitis including media.

Evidence-based policy and data for action. People who use drugs and people living with hepatitis B or hepatitis C or HIV coinfection must be involved in the formulation, implementation, monitoring, and evaluation of all strategies and policies that affect their lives.

The United Nations, donors and foreign development agencies supporting HIV prevention and other services targeting people who use drugs must include a hepatitis component in their programme.

Harm reduction programmes must not only be sustained, but urgently scaled up and expanded to provide adequate coverage and a wide range of services including (but not limited to) needle and syringe programmes.

Prevention of transmission. A rapid regimen of hepatitis B vaccination should be made widely available for people who inject drugs as recommended by WHO.

Screening, care and treatment. Currently, no pharmaceutical companies exist in the country. Patients need to go to the Indian cities to bring in even pegylated interferon.

Facilitate to make available the medication for hepatitis B and hepatitis C including pegylated interferon and new generation direct-acting antiviral agents. Government should start a dialogue with pharmaceutical companies to reduce the price of medication.

Union C – hepatitis patient group
Kathmandu, Nepal

Chapter 8: South-East Asia Region

Global Community Hepatitis Policy Report

Nepal

211
Thailand

Liver Care Foundation*
Private foundation
Khon Kaen, Thailand

SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Thailand reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

- The government information was thought to be accurate for 96.0% of items.
- Survey points marked “accurate”: 1.1, 1.2, 1.3, 2.1, 2.2, 3.1, 3.2, 3.3, 3.5, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, 4.10, 5.1, 5.2, 5.3, 5.4 and 5.5.
- The respondent took no position on the government information for 4.0% of items.
- Survey points marked “take no position”: 3.4.

Survey comments from the Liver Care Foundation:

<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To our knowledge, this information is accurate.</td>
<td></td>
</tr>
<tr>
<td>1.1 There is no written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis.</td>
<td>We have had universal vaccine since 1994 in newborn but we lack evaluation.</td>
</tr>
<tr>
<td>1.2 There is no designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities. There are no people working full-time on hepatitis-related activities in any government agency/body.</td>
<td>Last year the infectious control department had a committee about this but up to now there is no progression. There is no action.</td>
</tr>
<tr>
<td>1.3 The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific population: healthcare workers, including health-care waste handlers.</td>
<td>This policy was individual for each hospital with regards to health care workers. Further, the vaccine costs could not be reimbursed.</td>
</tr>
<tr>
<td>2.1 The government did not hold events for World Hepatitis Day 2012 and has not funded other viral hepatitis public awareness campaigns since January 2011.</td>
<td>They have not any campaign and no budget for this event.</td>
</tr>
<tr>
<td>2.2 The government does not collaborate with in-country civil society groups to develop and implement its viral hepatitis prevention and control programme.</td>
<td>They are only planning.</td>
</tr>
</tbody>
</table>

* World Hepatitis Alliance member.
3.2 There are standard case definitions for hepatitis. Deaths, including from hepatitis, are reported to a central registry. Of hepatitis cases, 25% are reported as “undifferentiated” or “unclassified” hepatitis.

We do not have a standard form for reported deaths from hepatitis. In Thailand not only hepatitis A, B and C infection we have toxic hepatitis from herbal medicine so when the patient died from hepatitis we couldn’t differentiate the definite course of hepatitis.

3.5 There is no national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are not conducted regularly. The most recent serosurvey, which targeted the general population, was carried out in 2004.

Up to now they did not.

4.1 There is no national policy on hepatitis A vaccination.

They have no policy and vaccine is not reimbursed.

4.2 The government has not established the goal of eliminating hepatitis B.

They have universal vaccination for newborns since 1994 but we lack the education for preventing transmission to a hepatitis B-infected person’s contacts.

4.3 Nationally, 99% of newborn infants in a given recent year received the first dose of hepatitis B vaccine within 24 hours of birth and 98% of one-year-olds (ages 12–23 months) in a given recent year received three doses of hepatitis B vaccine.

In theory it should be 99% but in real life it is not, it depends on each area such as university hospital and local hospital. Universal coverage plan for all newborns but we lack the knowledge of natural history of HBV for medical personnel and the people so the percentage was low in some areas. In the Northeast of Thailand, the prevalence of the people around 20 years old is more than 3% (Liver Care Foundation 2010).

4.4 There is a national policy that specifically targets mother-to-child transmission of hepatitis B (Annex B).

We have no national policy, only vaccination after birth, HBIG is not universally used, depends on the knowledge of medical personnel and budget of the mother.

4.5 There is a specific national strategy and/or policy for preventing hepatitis B and hepatitis C infection in health-care settings, but it addresses only vaccination for healthcare workers. Health-care workers are not vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood.

The prevention was done by each hospital and commonly was done after starting work so put them to contaminate before vaccination.
4.6 There is a national policy on injection safety in health-care settings, which recommends single-use syringes for therapeutic injections. Single-use or auto-disable syringes, needles and cannulas are always available in all health-care facilities.

4.8 There is a national infection control policy for blood banks. All donated blood units (including family donations) and blood products nationwide are screened for hepatitis B and hepatitis C.

5.1 Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools for health professionals (pre-service education), on-the-job training and technical seminars. There are national clinical guidelines for the management of viral hepatitis, which include recommendations for cases with HIV coinfection.

5.2 The government has national policies relating to screening and referral to care for hepatitis B, but not for hepatitis C.

5.3 People testing for both hepatitis B and hepatitis C register by name; the names are kept confidential within the system. Hepatitis B and hepatitis C tests are not free of charge for all individuals, but they are for pregnant women, blood donors and civil servants. Hepatitis C tests are free of charge for blood donors. Hepatitis B and hepatitis C tests are compulsory for blood donors.

5.4 Publicly funded treatment is available for hepatitis B and hepatitis C. Patients under the universal coverage scheme are eligible. However, only lamivudine and tenofovir are included in the universal coverage package for hepatitis B, and major drugs for treating hepatitis C are not included. The amount spent by the government on publicly funded treatment for hepatitis B and hepatitis C is not known.

To our knowledge, this information is accurate.

Up to now we used disposable syringe and needle. The cannula is reused.

We have had a national policy for screening for more than 20 years.

They did not obtain the skills or knowledge. We have only guidelines from liver society of Thailand.

They do not have this policy.

The government does not have the data for these patients and the screening was free of charge for few persons and hepatitis B and hepatitis C are screened free for blood donors.

Up to now lamivudine and tenofovir are the only essential drugs for chronic hepatitis B treatment and chronic hepatitis C treatment was immediately available in all genotypes and HIV coinfection HCV. The criteria are active HCV infection with significant fibrosis.
Statement from the Liver Care Foundation regarding key hepatitis policy issues in Thailand:

According to our work about five years ago we gave the education for awareness of chronic hepatitis infection in each province of Northeast Thailand we found that they have high prevalence rate of hepatitis B and hepatitis C infection. The average HBV was 8% and HCV was 4% so we are faced with high rates of complications such as cirrhosis and liver cancer average 1-2:500 in each event of tour. Our plan in next year will be screen, give the education, find the new case, prevention in the family and assess the treatment in this area that cover the people more than 22.5 million. Our problem was we lack the funds and implement from the government. So our plan will do as much as our fund we can.

5.5 The following drugs for treating hepatitis B are on the national essential medicines list: lamivudine and tenofovir. No drug for treating hepatitis C is on the national essential medicines list.

Drugs for HCV treatment in all genotypes and coinfection HIV&HCV is immediately available in soon.

3.4 Hepatitis outbreaks are reported to the government and are further investigated. There is adequate laboratory capacity nationally to support investigation of viral hepatitis outbreaks and other surveillance activities.

We have not both of medical personnel and laboratory test for evaluation especially if we have severe outbreak.
Statement from the Thai Association for the Study of the Liver regarding key hepatitis policy issues in Thailand:

In Thailand, we are currently funding treatment of chronic hepatitis C genotypes 2 and 3. However, only 900 patients are treated in the first year as compared to our estimation of 2,000. This emphasises the need for an awareness campaign. In 2015 the treatment will extend to all genotypes and HIV/hepatitis C co-infection as well. We really do need a good awareness programme throughout the next few years to reach patients who need the treatment. For chronic hepatitis B, there is no good policy yet, and it may come out rather late. So we need both awareness and the establishment of a national policy.
Western Pacific Region
This chapter presents Western Pacific region findings from the World Hepatitis Alliance’s 2014 civil society survey in three sections.

The first section provides an overview of respondents. The second section describes the extent to which respondents agreed or disagreed with what their governments reported about hepatitis policies and programmes for the 2013 World Health Organization (WHO) Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States. It also notes the issues associated with the greatest amount of agreement and disagreement. The third section highlights some of the qualitative findings from respondents based in countries where governments did not submit information for the 2013 WHO global policy report.

### 9.1. Respondents

Twelve organisations from seven countries and one special administrative region in the Western Pacific region responded to the World Hepatitis Alliance’s 2014 civil society survey. The governments of five countries provided information for the 2013 WHO global policy report, and thus the nine respondents based in those countries were able to comment on the accuracy of their governments’ responses. The governments of two countries did not provide information for the 2013 report. The two respondents based in those countries instead commented on their governments’ responses to viral hepatitis by writing short statements about key issues. One additional respondent provided a short statement about how viral hepatitis is being addressed by the Special Administrative Region of Hong Kong, which was not invited to submit information for the WHO global policy report because it is part of China. Additional information about respondents is presented in Table 9.1 overleaf.

---

1. **Australia**
   - Hepatitis Australia

2. **China**
   - Asiahep Hong Kong Limited
   - Inno Community Development Organisation
   - ITPC China
   - Liver Department of Wu Jieping Medical Foundation

3. **Japan**
   - Institute of Biomedical and Health Sciences, Hiroshima University
   - Japan Association for Promotion of Hepatitis Measures
   - Social Welfare Corporation, Habataki, Welfare Project

4. **Mongolia**
   - Onom Foundation

5. **New Zealand**
   - Hepatitis Foundation of New Zealand

6. **Philippines**
   - Yellow Warriors Society Philippines

7. **Taiwan (Chinese Taipei)**
   - Taiwan Liver Research Foundation

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*For the purposes of this report, Taiwan (Chinese Taipei) is referred to as a “country.” The World Hepatitis Alliance takes no position regarding the legal status of Taiwan (Chinese Taipei) as a sovereign state.*

*One of the two countries did not submit information for the 2013 WHO global policy report. One other country, Taiwan (Chinese Taipei), was not invited to submit information because it is part of China. Additional information about respondents is presented in Table 9.1 overleaf.*
Western Pacific Region continued

Table 9.1. Western Pacific region respondents to the World Hepatitis Alliance’s 2014 civil society survey (N=12)

<table>
<thead>
<tr>
<th>Country</th>
<th>Civil society survey respondents (#)</th>
<th>NGO – hepatitis patient group</th>
<th>NGO – direct service provider</th>
<th>NGO – other</th>
<th>Medical society</th>
<th>Private foundation</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>China</td>
<td>4</td>
<td>3</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Japan</td>
<td>3</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Mongolia</td>
<td>1</td>
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<td></td>
</tr>
<tr>
<td>New Zealand</td>
<td>1</td>
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</tr>
<tr>
<td>Philippines</td>
<td>1</td>
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</tr>
<tr>
<td>Taiwan</td>
<td>1</td>
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</tr>
</tbody>
</table>

* One of the four civil society respondents from China was Asiahep Hong Kong Limited, which assessed the hepatitis response of the Special Administrative Region of Hong Kong rather than the hepatitis response of the Chinese government.

Table 9.2. Survey items eliciting the highest levels of agreement from civil society respondents, Western Pacific region (N=9)

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Question(s) addressed by governments for 2013 WHO global policy report</th>
<th># (%) of respondents who indicated agreement with their governments’ response(s) by selecting “to our knowledge, this information is accurate”</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2</td>
<td>Does your government collaborate with any civil society group within your country (such as patient groups or national or local nongovernmental organisations) to develop and implement its viral hepatitis prevention and control programme? If yes, please name major partners.</td>
<td>9 (100%)</td>
</tr>
<tr>
<td>4.5</td>
<td>Is there a specific national strategy and/or policy/guidelines for preventing hepatitis B and hepatitis C infection in health care settings? If yes, are health workers vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood?</td>
<td>9 (100%)</td>
</tr>
</tbody>
</table>
Three-fourths of respondents identified themselves as some type of nongovernmental organisation (including hepatitis patient groups), and one respondent (8%) identified itself as a private foundation (Figure 9.1).

More than 80% of respondents were either voting or non-voting members of the World Hepatitis Alliance at the time they submitted their surveys (data not shown).

Almost half of respondents were based in high-income countries, and one-third were based in upper-middle-income countries. (Figure 9.2).

9.2. Highlights relating to civil society agreement or disagreement with what governments reported

The civil society survey contained 25 items based on the information that governments provided for the 2013 WHO global policy report. For each item, civil society stakeholders were asked to consider the government response to one or more questions about national hepatitis policies and programmes, and to select one of the following three statements: To our knowledge, this information is accurate; To our knowledge, this information is not accurate; or We take no position regarding this statement.

Detailed findings for all civil society survey items are presented in Annex C. In sum, one-third of all civil society respondents thought that the information from their governments was accurate for 20 or more of the 25 items. Regarding the proportions of respondents who marked items as “not accurate,” one-third thought that the information from their governments was not accurate for at least six items.

The following survey items were most commonly identified as points on which civil society respondents in the Western Pacific region agreed with their governments’ responses: item 2.2, regarding government collaboration with civil society groups, and item 4.5, regarding prevention of hepatitis B and hepatitis C in health care settings. Further details are presented in Table 9.2.

The following survey items were most commonly identified as points on which civil society respondents in the Western Pacific region disagreed with their governments’ responses: item 3.4, regarding the reporting and investigation of hepatitis outbreaks; item 5.1, regarding health professional training and viral hepatitis clinical guidelines; item 5.3, regarding hepatitis B and hepatitis C testing; and item 5.4, regarding publicly funded treatment for hepatitis B and hepatitis C. Further details are presented in Table 9.3 overleaf.
9.3. Qualitative findings from countries where government information is lacking

Civil society survey respondents based in countries where governments did not submit information for the 2013 WHO global policy report did not have any information to review and hence did not complete the component of the survey discussed in the preceding section. They only completed a survey component in which respondents were invited to write brief statements discussing the policy response to viral hepatitis in their countries. Respondents were encouraged to focus on one or more of five topics: national coordination; awareness-raising, partnerships and resource mobilisation; evidence-based policy and data for action; prevention of transmission; and screening, care and treatment.

The purpose of this section is to present some excerpts that are generally reflective of the concerns of respondents in the Western Pacific region. The following data represent only the views of the three civil society survey respondents that did not have government information to review (one each from the Special Administrative Region of Hong Kong, the Philippines and Taiwan [Chinese Taipei]). The full text of all respondents’ statements can be found later in this chapter.

One key issue that respondents discussed in their statements was awareness-raising. Yellow Warriors Society Philippines (YWSP) wrote:

> We believe that awareness is still low. Due to stigma, [viral hepatitis] carriers do not talk about this topic. ... More needs to be done if we want a higher level of awareness. A solution is networking with organisations just like what YWSP is doing now. Also, more informational materials are needed.

The Taiwan Liver Research Foundation wrote that viral hepatitis awareness “remains ... a critical public health issue in our country.” The respondent added:

> We are making every effort to raise disease awareness in our community by means of public education, free screening and symposia held for medical professionals. Of note was that we created a strategy aiming to have young children teach their parents and families about hepatitis prevention.

Another area of concern was viral hepatitis screening. Asiahep Hong Kong Limited noted that in the Hong Kong Special Administrative Region, government hospitals and clinics do not have viral hepatitis screening programmes. This respondent also stated:

> Government’s role should be the coordinator for hepatologists and infectious disease doctors in the private and public sectors – draw up a plan to screen the population and provide advice and treatment.

The Taiwan Liver Research Foundation made the following observations about hepatitis screening:

> We have recently seen a friendly change at the Ministry of Health and Welfare regarding hepatitis screening, with screening efforts incorporated into a nationwide health check-up programme.
### Table 9.3: Survey items eliciting the highest levels of disagreement from civil society respondents, Western Pacific region (N=9)

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Question(s) addressed by governments for 2013 WHO global policy report</th>
<th># (%) of respondents who indicated disagreement with their governments’ response(s) by selecting “to our knowledge, this information is not accurate”</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4</td>
<td>Are hepatitis outbreaks required to be reported to the government? If yes, are they further investigated? Is there adequate laboratory capacity nationally to support viral hepatitis outbreak investigations and other surveillance activities?</td>
<td>3 (33.3%)</td>
</tr>
<tr>
<td>5.1</td>
<td>How do health professionals in your country obtain the skills and competencies required to effectively care for people with viral hepatitis? Are there national clinical guidelines for the management of viral hepatitis? If yes, do they include recommendations for cases of HIV co-infection? If no, are there national clinical guidelines for the management of HIV that include recommendations for co-infection with viral hepatitis?</td>
<td>3 (33.3%)</td>
</tr>
<tr>
<td>5.3</td>
<td>Please answer the following questions about hepatitis B and hepatitis C testing in your country. - When testing, do people register by name? - If people register by name, are their names kept confidential within the system, or is there open access to the names? - Is the test free of charge for all individuals? - Is the test free of charge for members of any specific group? - Is the test compulsory for members of any specific group?</td>
<td>4 (44.4%)</td>
</tr>
<tr>
<td>5.4</td>
<td>Is publicly funded treatment available for hepatitis B? If yes, who is eligible? Is publicly funded treatment available for hepatitis C? If yes, who is eligible? How much does the government spend on publicly funded treatment for hepatitis B and hepatitis C?</td>
<td>3 (33.3%)</td>
</tr>
</tbody>
</table>
Australia

Hepatitis Australia*

NGO – peak national hepatitis community organisation
Woden, ACT, Australia
www.hepatitisaustralia.com

SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Australia reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

The government information was thought to be accurate for 68.0% of items.
Survey points marked “accurate”: 1.1, 1.3, 2.2, 3.1, 3.3, 3.4, 4.1, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 5.2, 5.3, 5.4 and 5.5.

The government information was thought to not be accurate for 12.0% of items.
Survey points marked “not accurate”: 1.2, 3.2 and 3.5.

The respondent took no position on the government information for 20.0% of items.
Survey points marked “take no position”: 2.1, 4.2, 4.9, 4.10 and 5.1.

Survey comments from Hepatitis Australia:

1.1 There is a written national strategy or plan that focuses exclusively on the prevention and control of hepatitis B and hepatitis C. It includes components for raising awareness, surveillance, vaccination, prevention in general, prevention of transmission via injecting drug use, prevention of transmission in health-care settings, treatment and care, and coinfection with HIV.

1.3 The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific populations: health-care workers (including health-care waste handlers), people who inject drugs, migrants, prisoners, the homeless, people living with HIV, indigenous people, pregnant women, men who have sex with men, sex workers, partners and other household and intimate contacts of people who have chronic hepatitis B infection, people travelling to and from high-prevalence countries, people with mental health issues, and children born to mothers who have tested positive for hepatitis B infection.

2.2 The government collaborates with the following in-country civil society groups to develop and implement its viral hepatitis prevention and control programme: Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections, Blood Borne Viruses and Sexually Transmissible Infections Standing Committee, Australian National Council on Drugs, Hepatitis Australia, Australian Society for HIV Medicine, and Australian Injecting and Illicit Drug Users League Incorporated.

The Third National Hepatitis C Strategy 2010 to 2013 and the First National Hepatitis B Strategy 2010–2013 have both expired. The revisions have been delayed and consequently we currently have no operational national strategies at present (March 2014).

The information provided is incomplete and oddly worded. The listed specific populations may reflect the populations for which hepatitis B vaccination is recommended. However, these vaccinations are not all funded and it is a stretch to say that there programmatic activities for all these groups.

On the other hand they haven’t even mentioned that the Australian and State and Territory governments fund needle and syringe programmes and prevention education and awareness programmes through NGOs.

The wording in the government response does not really reflect the very comprehensive partnership approach across community organisations, clinicians and researchers and governments – this is a key feature of the Australian response.
<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 There is routine surveillance for viral hepatitis. There is a national surveillance system for the following types of acute hepatitis: A, B, C, D and E, and for the following types of chronic hepatitis: B, C and D.</td>
<td>Hepatitis E infection is not included in the Annual Surveillance Report.</td>
</tr>
<tr>
<td>4.4 There is a national policy specifically targeting mother-to-child transmission of hepatitis B (Annex B).</td>
<td>All pregnant women are screened for hepatitis B infection, however, follow up of the infected mother remains sub-optimal.</td>
</tr>
<tr>
<td>4.6 There is no national policy on injection safety in health-care settings. Single-use or auto-disable syringes, needles and cannulas are always available in all health-care facilities.</td>
<td>Re-use of syringes is not permitted under the standard best practice framework in health care settings — it does occur but is not common and due to malpractice.</td>
</tr>
<tr>
<td>4.7 Official government estimates of the number and percentage of unnecessary injections administered annually in health-care settings were not known.</td>
<td>Unnecessary injections is a cultural issue for some countries but is not a primary concern in Australia.</td>
</tr>
<tr>
<td>5.2 The government has national policies relating to screening and referral to care for hepatitis B and hepatitis C.</td>
<td>This forms part of the National Testing policies.</td>
</tr>
<tr>
<td>5.3 People testing for both hepatitis B and hepatitis C register by name; the names are kept confidential within the system. Hepatitis B tests are not free of charge for all individuals, but they are free for high-risk groups. Hepatitis C tests are not free of charge. Hepatitis B and hepatitis C tests are not compulsory for members of any specific group.</td>
<td>This is mostly accurate but I’m not sure that tests are free for all high-risks groups.</td>
</tr>
<tr>
<td>5.4 Publicly funded treatment is available for hepatitis B and hepatitis C. The following people are eligible: medicare holders. Information was not provided on the amount spent by the government on such treatment for hepatitis B and hepatitis C.</td>
<td>Other clinical restrictions on treatment access are listed too.</td>
</tr>
</tbody>
</table>

To our knowledge, this information is accurate.
The following drugs for treating hepatitis B are on the national essential medicines list or subsidised by the government: interferon alpha, pegylated interferon, lamivudine, adefovir dipivoxil, entecavir, telbivudine and tenofovir. The following drugs for treating hepatitis C are on the national essential medicines list or subsidised by the government: interferon alpha, pegylated interferon and ribavirin.

In April 2013, Boceprevir and Telaprevir were also subsidised by the government for hepatitis C genotype 1.

To our knowledge, this information is accurate.

There is no designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities. It is not known how many people work full-time on hepatitis-related activities in all government agencies/bodies.

For well over a decade there has been a section within the federal department of health which is responsible for the management of the national strategies and distribution of government funding. Each of the State and Territory governments also have units of varying size.

To our knowledge, this information is not accurate.

There are standard case definitions for hepatitis. Deaths, including from hepatitis, are reported to a central registry. No hepatitis case is reported as “undifferentiated” or “unclassified” hepatitis.

The Kirby Institute (which is the organisation charged with reporting on hepatitis C deaths) states it is unable to do so because current surveillance systems are inadequate. All hepatitis cases are reported as A, B, C, etc.

There is a viral hepatitis research agenda. However, viral hepatitis serosurveys are not conducted “regularly.” There has been no general population serosurvey since 2007-08 to my knowledge. The prevalence figure derived from the 2007-08 survey was far higher than previous estimates (however, different research methodology may be the reason for this discrepancy).
Information reported by government (2012–2013)

2.1 The government held events for World Hepatitis Day 2012 and has funded other viral hepatitis public awareness campaigns since January 2011 (Annex A).

4.2 The government has established the goal of eliminating hepatitis B but the timeframe is not specified.

4.9 There is no national policy relating to the prevention of viral hepatitis among people who inject drugs.

5.1 Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools for health professionals (pre-service education), on-the-job training and postgraduate training. There are no national clinical guidelines for the management of viral hepatitis or for the management of HIV, which include recommendations for coinfection with viral hepatitis.

Civil society respondent comments (2014)

Hepatitis Australia takes responsibility for coordinating World Hepatitis Day (WHD) each year and receives a very small amount of grant funding from the government to do so. (The majority of our funds for WHD are sourced from elsewhere).

There were no significant public WHD events run by the government in 2012 to our knowledge. However there were numerous events run by other organisations. I am not aware of what other “viral hepatitis public awareness campaigns” since January 2011 that the government has held. There has never been a federal government-led public awareness “campaign” on viral hepatitis although they do support our general media and consumer information activities.

I was not aware that the government had established the goal of eliminating hepatitis B and it is not to my knowledge articulated in any policy document. However, I am very pleased to see it written here in a public document.

There is national framework for the prevention of viral hepatitis among people who inject drugs – this includes recommendations for hepatitis B vaccination, provision of needle and syringe programmes and funding of drug user organisations for the peer education and other awareness programmes. Australia has also had a long standing National Drug Policy which incorporates harm reduction (e.g. needle and syringe programmes), demand reduction (e.g. opioid substitution therapy), and supply reduction.

There are national testing policies and professional organisations have published guidelines for clinical management – both medical and nursing – although these may not be formally endorsed national documents.
Statement from Hepatitis Australia regarding key hepatitis policy issues in Australia:

National coordination. The structures for the national co-ordination of hepatitis B and hepatitis C are in place: an inter-government committee and a Ministerial Advisory Committee for all blood-borne viruses and sexually transmitted infections. NGOs participate in these committees.

National strategies for hepatitis B and hepatitis C have been developed but expired at the end of 2013 and have not yet been replaced (although the process is in train). Implementation plans are developed but not all areas are progressed.

We do not have nationally approved targets for hepatitis B and hepatitis C yet (although these are in place for HIV) and need these to drive action.

Awareness-raising, partnerships and resource mobilisation. The First Hepatitis B Strategy was eventually approved in 2010 (ten years after the First Hepatitis C Strategy) but no new funding has been distributed at a national level to support implementation yet — this acts as a major brake on the implementation process.

The Hepatitis C Partnership is much more developed than the Hepatitis B Partnership.

The Federal Government has never run a comprehensive public awareness campaign for hepatitis C despite it being listed as a priority action in the National Strategy since 1999 and similarly has not run a comprehensive public awareness campaign for hepatitis B. They do provide a very small amount of funding to support World Hepatitis Day activities.

There is no balance in funding allocations across blood-borne viruses and sexually transmitted infections. HIV is an example of a well-funded response with good outcomes compared to hepatitis B and hepatitis C.

Evidence-based policy and data for action. There are three designated national research centres covering virological, clinical, epidemiological, prevention and social research — they are provided with government funds to assist with viral hepatitis research and surveillance. Other research institutes also contribute to building the evidence and data for action.

Although effort is put into the development of the evidence-base, gaps remain.

Prevention of transmission. Needle and syringe programmes are in place in the community. Opioid substitution therapy is available. Universal infant hepatitis B vaccination is in place including the birth dose. Education and information to support prevention is provided through various agencies. No regulated government-supported prison needle exchange is operating yet.

Screening, care and treatment. Australia has an estimated diagnosis rate of over 80% for hepatitis C but it is much lower for hepatitis B. Treatment rates are very low — in 2012 less than 1% for hepatitis C (2,360 people) and it was thought to be less than 3% for hepatitis B but there is insufficient rigorous data to estimate.
Asiahep Hong Kong Limited did not comment on the information that the Chinese government submitted to the World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

Instead, the organisation provided the following general statement regarding key hepatitis policy issues in the Hong Kong Special Administrative Region:

In Hong Kong, the Centre for Health Protection of the Department of Health monitors the trend of viral hepatitis A to E through voluntary notification system. HBsAg and anti-HCV prevalence are deduced from blood donors, compulsory prenatal check, premarital and pre-pregnancy data from the Hong Kong Family Planning Association, and governmental healthcare workers’ pre-employment check. However, governmental hospitals and clinics do not screen the population or have any active programmes. There is reliance on private insurance health checks and NGO activities to promote awareness.

Many people are told that they are hepatitis B carriers with no explanation, no counselling and no follow-up. This means missing opportunities to assess disease activity, treat appropriate patients and reduce morbidity and mortality through appropriate medical management.

Government’s role should be the coordinator for hepatologists and infectious disease doctors in the private and public sectors – draw up plans to screen the population and provide advice and treatment.

NGOs should coordinate advocacy activities to achieve more sustainable and impactful results. This requires resources which can be provided by government, pharmaceutical companies, philanthropists, and fundraising activities. Please refer to data from the Centre for Health Protection (Hong Kong Department of Health) website (December 2013 update).

Asiahep Hong Kong Limited has an annual World Hepatitis Day press conference to offer free or sponsored free blood tests. It also has a longstanding collaboration with Hong Kong Family Planning Association. For World Hepatitis Day 2013, a joint press conference raised awareness for HBV DNA testing and sponsored initial assessment for HBsAg-positive individuals, including HBeAg HBV DNA and ALT. Over 600 people participated. 

http://www.asiahep.org.hk
Statement from Inno Community Development Organisation regarding key hepatitis policy issues in China:

Viral hepatitis is one of the issues that Inno Community Development Organisation (Inno) focuses on. Based on data from the Inno workplace hepatitis hotline, more than 80% of calls are from people seeking knowledge of hepatitis B, and 17% of calls are for psychological support. Less than 2% of people are calling because they have experienced hepatitis-related discrimination.

From the data analysis of Inno Database, we could say:

- The majority of people lack a correct knowledge of hepatitis and an awareness of how to protect themselves from the hepatitis virus.
- On one hand, mandatory hepatitis B testing is not allowed by Chinese laws and regulations. If a company requires employees to undergo testing, the company is violating the law. However, the Chinese government maintains a policy of forbidding hepatitis carriers from being state employees. What the Chinese government has done is inconsistent with what the law says. As a result, most people are confused and fear hearing anything about hepatitis. They think viral hepatitis is equal to cancer.
- Though the Chinese government tries hard to eliminate discrimination against hepatitis-infected people, such as amending laws for eliminating discrimination, inequality in social status exists between hepatitis-infected and -uninfected people. Few social resources can be used by hepatitis-infected people. If a student is found to be a hepatitis carrier, the school will stop him/her from attending.

A system of supervision and assessment, made by government, has a great impact on the execution and quality of the hepatitis programmes. Some partners or programme executives focus on data, neglecting the quality when they run a hepatitis project. The data could show to the public easily and make the executives more easy to sell themselves to other funders, however, the quality of a hepatitis programme is hard to assess.
Statement from ITPC China regarding key hepatitis policy issues in China:

**National coordination.** There has not yet been a national strategy or plan that focuses on the prevention and control of hepatitis C (HCV). Only in 2013, the national Centre for Disease Control (CDC) started to set up an HCV office, which is under the national HIV/AIDS programme. As HCV is being increasingly addressed by both the national and international level, we think that a strategy to prevent and control HCV in China should come out as soon as possible under the leadership of the national CDC and with support from other stakeholders.

**Awareness-raising, partnerships and resource mobilisation.** Collaboration with civil society organisations is far from enough in the issue of viral hepatitis. The awareness-raising done by the government is not effective or efficient. Civil society and the business sector should be mobilised to develop more creative and effective ways to raise public awareness on viral hepatitis, particularly dealing with the stigma caused by some of the previous “awareness-raising” ads. Hepatitis C should be emphasised more in all activities, as the Chinese public is not aware of it.

**Information reported by government (2012–2013)**

- The following drugs for treating hepatitis B are on the national essential medicines list or subsidised by the government: interferon alpha, pegylated interferon, lamivudine, adefovir dipivoxil, entecavir, tenofovir and tenofovir.
- The following drug for treating hepatitis C is on the national essential medicines list or subsidised by the government: ribavirin.

**Civil society respondent comments (2014)**

- However, ribavirin is not approved to treat hepatitis C, which is weird but doesn't affect its actual use.
- There is compulsory testing for people detained for compulsory detox, as far as we know.
- A few provinces/cities have included pegylated interferon in their health insurance for treating hepatitis C, while most others only include interferon.

**Survey comments from ITPC China:**

- The government information was thought to be accurate for 76.0% of items.
- The government information was thought to not be accurate for 8.0% of items.
- The respondent took no position on the government information for 16.0% of items.
- Survey points marked “accurate”: 1.1, 1.3, 2.1, 2.2, 3.1, 3.2, 3.3, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.8, 4.9, 4.10, 5.1, 5.2 and 5.5.
- Survey points marked “not accurate”: 5.3 and 5.4.
- Survey points marked “take no position”: 1.2, 3.4, 3.5 and 4.7.
Prevention of transmission. Harm reduction strategies are not widely available among the PWID population in many parts of China. The national policy prefers compulsory detoxification more than methadone maintenance treatment and clean syringe programmes. More humane and practical intervention approaches need to be widely adopted to reduce the risk of viral hepatitis transmission in the PWID population.

Screening, care and treatment.
The biggest challenge is the accessibility and availability of treatment.

For hepatitis B, the reimbursement rate covered by different types of health insurances varies. There are three major health insurance systems co-funded by both the government and the beneficiaries: rural health insurance, urban resident health insurance, and urban employee health insurance. In general, the less income you have, the more you will need to pay out of your own pocket. In most cases, patients need to be hospitalised to get reimbursed by health insurance, while being treated as outpatients is more cost-effective for both the patient and the government. Besides, as noted by a hepatitis B expert, “if all of the nonsense liver protection meds and herbs are removed from the health insurance reimbursement list, China can double its coverage of hepatitis B treatment with no more extra investment.”

For hepatitis C, pegylated interferon (peg-IFN) is not covered by health insurance in most parts of China, and even in some areas where it is covered, patients still need to be hospitalised to get reimbursement. The out-of-pocket cost for a 48-week course with peg-IFN and ribavirin therefore ranges from US$ 2,500 to 10,000. This is very unacceptable considering that most people living with hepatitis C are rural residents or have a history of intravenous drug use, and their annual income is typically less than US$ 800.

To deal with treatment access issue, the following major changes are required:

- Health insurance policies need to change, by removing nonsense medications, and including medications that are commonly regarded as “gold standard” by the international community. The threshold at which patients get reimbursement from health insurance needs to change to prioritise outpatient treatment rather than inpatient treatment. Putting more recommended medications onto the essential medicines list will allow more patients to access them at basic healthcare facilities.
- The government should take the lead in negotiating the price of viral hepatitis drugs with Big Pharma. While China produces most of the ingredients of many chemical drugs, the price of the drugs is much more expensive compared to other middle-income countries. This is essential for the government to develop and implement a national programme on viral hepatitis.
- Civil society organisations should act to mobilise affected communities to know their own viral hepatitis status, and to create more demand for accessible treatment.
### China

**Liver Department of Wu Jieping Medical Foundation**

*Medical society*  
Beijing, China  
[www.cnsid.org](http://www.cnsid.org)

#### SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of China reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

- **The government information was thought to be accurate for 68.0% of items.**
- **Survey points marked “accurate”:**  
  1.1, 2.1, 2.2, 3.1, 3.3, 3.5, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, 5.1 and 5.3.

- **The government information was thought to not be accurate for 32.0% of items.**
- **Survey points marked “not accurate”:**  
  1.2, 1.3, 3.2, 3.4, 4.10, 5.2, 5.4 and 5.5.

**Survey comments from the Liver Department of Wu Jieping Medical Foundation:**

<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2 There is a designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities. The name of this office was not provided. It has seven staff members. There are seven full-time equivalent staff members who work on hepatitis-related activities in all government agencies/bodies.</td>
<td>There is a designated government department responsible for hepatitis but not solely.</td>
</tr>
<tr>
<td>1.3 The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific populations: health-care workers (including health-care waste handlers) and people who inject drugs.</td>
<td>Not national programme.</td>
</tr>
<tr>
<td>3.4 Hepatitis outbreaks are required to be reported to the government and are further investigated. There is adequate laboratory capacity nationally to support outbreak investigations and other surveillance activities for hepatitis A, hepatitis B and hepatitis C, but not for hepatitis E.</td>
<td>Surveillance activities also includes hepatitis E.</td>
</tr>
<tr>
<td>5.2 The government has national policies relating to screening and referral to care for hepatitis B, but not for hepatitis C.</td>
<td>Has policies for hepatitis C too.</td>
</tr>
<tr>
<td>5.4 Publicly funded treatment is available for hepatitis B, but not for hepatitis C. Information was not provided on who is eligible or the amount spent by the government on such treatment.</td>
<td>Treatment is also for Hepatitis C.</td>
</tr>
</tbody>
</table>

* World Hepatitis Alliance member.

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Chapter 9: Western Pacific Region

Global Community Hepatitis Policy Report

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Statement from the Liver Department of Wu Jieping Medical Foundation regarding key hepatitis policy issues in China:

We believe that the greatest problem is that screening, care and treatment are not accessible to hepatitis patients from rural areas and the countryside, since reimbursement for the disease is limited and treatment in these areas is in urgent need of standardisation. Reimbursement of the cost of treatment in rural areas should be increased, while the doctor’s diagnosis and treatment skills should be improved in order to achieve greater health equity. Currently, the New Rural Cooperative Medical System (medical insurance for rural residents) reimbursement is only 50%; the rest is paid by the individual patient. The survey of hepatitis C disease burden by Wu Jieping Medical Foundation shows that patients with liver disease also suffer a substantial economic burden, and many patients are unable to take on long-term drug treatment.

We also investigated the doctor’s treatment skills; there is no uniform norm to promote the implementation of treatment, resulting in uneven levels of treatment. So many patients in rural or remote areas do not have access to regular and effective treatment.

Government in addressing these issues should play a leading role, and only on the support of national policies the reform can be promoted; other related organisations should also actively cooperate in this process with the government, and contribute their efforts. For example, related NGOs can do advocacy with the government and can conduct patient education about their disease. Academic organisations can provide standard guidelines and conduct training for doctors. Pharmaceutical companies should try to provide cheap and good-quality drugs. International societies and organisations can actively promote international cooperation and exchange, and also can promote the development of national government programmes.

To our knowledge, this information is not accurate.

5.5 The following drugs for treating hepatitis B are on the national essential medicines list or subsidised by the government: interferon alpha, pegylated interferon, lamivudine, adefovir dipivoxil, entecavir, telbivudine and tenofovir. The following drug for treating hepatitis C is on the national essential medicines list or subsidised by the government: ribavirin.

The listed medicines are only subsidised by government in some specific cities and provinces.
3.5 There is a national public health research agenda for viral hepatitis. It is not known whether viral hepatitis serosurveys are conducted regularly.

4.2 The government has not established the goal of eliminating hepatitis B.

4.3 Nationally, no newborn infant in a given recent year received the first dose of hepatitis B vaccine within 24 hours of birth and no one-year-old (age 12–23 months) in a given recent year received three doses of hepatitis B vaccine.

4.5 There is a specific national strategy and/or policy/guidelines for preventing hepatitis B and hepatitis C infection in health-care settings. Health-care workers are vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood.

4.8 There is a national infection control policy for blood banks. All donated blood units (including family donations) and blood products nationwide are screened for hepatitis B and hepatitis C.

4.9 There is no national policy relating to the prevention of viral hepatitis among people who inject drugs.

3.3 There is no national policy relating to the prevention of viral hepatitis among people who inject drugs.

4.1 The government information was thought to be accurate for 64.0% of items.

Survey points marked “accurate”: 1.1, 1.2, 1.3, 2.1, 2.2, 3.1, 3.4, 3.5, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 5.1, 5.3 and 5.4.

The government information was thought to not be accurate for 28.0% of items.

Survey points marked “not accurate”: 3.3, 4.1, 4.6, 4.7, 5.1, 5.3 and 5.4.

The respondent took no position on the government information for 8.0% of items.

Survey points marked “take no position”: 3.2 and 5.5.

Survey comments from the Institute of Biomedical and Health Sciences, Hiroshima University:

To our knowledge, this information is accurate.

Now we have the national programme for viral hepatitis screening for persons aged 40 years or older in residence.

Japan has met the WHO hepatitis B control goal of reducing the hepatitis surface antigen seroprevalence in children at least five years of age to less than 2% by 2012.

However, Japan has had a selective vaccination programme for babies born to mothers who are hepatitis B carriers. So the HBsAg seroprevalence in children under age five is less than 1% now.

In addition, students in medical universities are also vaccinated against hepatitis B.

In Japan, all donated blood units and blood products have been screened for hepatitis B since 1972, and for hepatitis C since 1990.

People who inject drugs now are rare in Japan.
### Japan

#### Institute of Biomedical and Health Sciences, Hiroshima University continued

<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.10 The government does not have guidelines that address how hepatitis A and hepatitis E can be prevented through food and water safety.</td>
<td>Hepatitis A and hepatitis E are not health problems in Japan. However, we have effective disease prevention through food and water safety.</td>
</tr>
<tr>
<td>3.3 Liver cancer cases are registered nationally, but cases with HIV/hepatitis coinfection are not. The government publishes hepatitis disease reports weekly.</td>
<td>Cancer registration system now is working. HIV cases are nationally reported, so we can identify HIV/hepatitis coinfection.</td>
</tr>
<tr>
<td>4.1 There is no national policy on hepatitis A vaccination.</td>
<td>The government recommends hepatitis A vaccination for residents who intend to travel to hepatitis A endemic countries.</td>
</tr>
<tr>
<td>4.6 It is not known whether there is a national policy on injection safety in health-care settings, or whether single-use or autodisable syringes, needles and cannulas are always available in all health-care facilities.</td>
<td>Japan has had a policy on injection safety for many decades. Now autodisable syringes, needles and cannulas are always fully available in all healthcare facilities.</td>
</tr>
<tr>
<td>4.7 Official government estimates of the number and percentage of unnecessary injections administered annually in health-care settings were not known.</td>
<td>Unnecessary injections in healthcare settings is not currently a problem in Japan.</td>
</tr>
<tr>
<td>5.1 It is not known how health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis. There are national clinical guidelines for the management of viral hepatitis, but they do not include recommendations for cases with HIV coinfection. There are national clinical guidelines for the management of HIV, which include recommendations for coinfection with viral hepatitis.</td>
<td>Since 2010, the Japanese government has established a system of counsellors specialising in viral hepatitis.</td>
</tr>
<tr>
<td>5.3 People testing for hepatitis B and hepatitis C do not register by name. Hepatitis B and hepatitis C tests are free of charge for all individuals and are not compulsory for members of any specific group.</td>
<td>Hepatitis B and hepatitis C tests are free of charge for persons aged 40 years or over. Local health centres where people take the tests know and keep their name confidential.</td>
</tr>
</tbody>
</table>
Publicly funded treatment is available for hepatitis B and hepatitis C. The following group is eligible for such treatment for hepatitis B: patients receiving interferon therapy or nucleoside analogue therapy. The following group is eligible for publicly funded treatment for hepatitis C: patients receiving interferon therapy. Information was not provided on the amount spent by the government on such treatment for hepatitis B and hepatitis C.

Statement from the Institute of Biomedical and Health Sciences, Hiroshima University regarding key hepatitis policy issues in Japan:

**Prevention of transmission.** Although we have a national surveillance system for viral hepatitis, the rate of reporting from medical doctors for acute hepatitis cases is insufficient. Government should have a policy for raising awareness of the importance of the surveillance system among all medical doctors.

**Screening, care and treatment.** Because of the achievement of the hepatitis B and hepatitis C screening program, the number of unaware infected persons has decreased. However, many diagnosed infected persons who have no symptoms and seem to be healthy do not visit hospitals for treatment. Government should continue to increase awareness of the risk of hepatocellular carcinoma as well as the publicly funded treatment for hepatitis B and hepatitis C.
Statement from the Japan Association for Promotion of Hepatitis Measures regarding key hepatitis policy issues in Japan:

Awareness-raising, partnerships and resource mobilisation

What are the greatest problems with this component of the national response to viral hepatitis?

- Low awareness for prevention medicine of Japanese national.
- Educational activities in the workplace are obstructed by lack of knowledge about hepatitis and discrimination against infected people.
- Low budget for educational activity from Japanese government.

What needs to change?

- Increase awareness for prevention medicine of Japanese national.
- Enhanced educational activities in the workplace.
- Government should seek cooperation from private companies as a national movement, not as mere public relations.

What should be the government’s role in bringing about these changes? What responsibilities should the government have?

- It is important for the government to enhance partnerships with civilian organisations like us which focus on educational activities and patient advocacy groups that deal with irradiation, and also have a responsibility to support their activities.

What should be the roles and responsibilities of other stakeholders at the community, national and international levels?

- They should support more pro-actively civilian organisations like us which focus on educational activities and patient advocacy groups that deal with irradiation.
- They should provide us with more academic information.
- They should back up the investigation by hepatology specialists directly.

What evidence exists to support your organisation’s viewpoint?

- Estimates of hearing survey by our own visits to local authority.
- Independent investigation for having a relationship with hepatology specialists directly.
- Result of national study by our association and partnership private company.

To our knowledge, this information is accurate.

2.2 The government collaborates with the following in-country civil society groups to develop and implement its viral hepatitis prevention and control programme: the Japan Hepatitis Council and the Viral Hepatitis Research Foundation of Japan.

Survey comments from the Japan Association for Promotion of Hepatitis Measures:

- It is not compulsory for members of any specific group, however, only some people who meet some determinate requirements can test for free.

To our knowledge, this information is not accurate.

5.3 People testing for hepatitis B and hepatitis C do not register by name. Hepatitis B and hepatitis C tests are free of charge for all individuals and are not compulsory for members of any specific group.

However, they should support private organisations like us actively, who are also a member of the World Hepatitis Alliance the same as the two associations, for expanding an understanding of hepatitis. We make sure appeal to Japanese government continually.

SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Japan reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

- The government information was thought to be accurate for 80.0% of items.
- Survey points marked “accurate”: 1.1, 1.2, 1.3, 2.1, 2.2, 3.1, 3.2, 3.3, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.9, 4.10, 5.1, 5.2, 5.4 and 5.5.

- The government information was thought to not be accurate for 8.0% of items.
- Survey points marked “not accurate”: 3.4 and 5.3

- The respondent took no position on the government information for 12.0% of items.
- Survey points marked “take no position”: 3.3, 4.6 and 4.7.

JAPAN association for Promotion of Hepatitis Measures* (Tokyo, Japan, http://www.jspah.org/)

* World Hepatitis Alliance member.
SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Japan reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

- The government information was thought to be accurate for 64.0% of items.
- The government information was thought to not be accurate for 16.0% of items.
- The respondent took no position on the government information for 20.0% of items.

Survey comments from the Social Welfare Corporation, Habataki, Welfare Project:

<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2 There is a designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities: the Office for Promotion of Hepatitis Measures within the Health Service Bureau of the Ministry of Health, Labour and Welfare. It has 12 staff members. There are two full-time equivalent staff members who work on hepatitis-related activities in all government agencies/bodies.</td>
<td>Some staff members within the Health Service Bureau of the Ministry of Health, Labour and Welfare work to settle a massive hepatitis lawsuit in Japan. So all of them are not engaged in promotion of hepatitis measures.</td>
</tr>
<tr>
<td>2.1 The government held events for World Hepatitis Day 2012 and has funded other viral hepatitis public awareness campaigns since January 2011 (Annex A).</td>
<td>Habataki organisation collaboratively worked the events for World Hepatitis Day 2012 with government and contributed to the public awareness campaign. However, we were not given any government funding.</td>
</tr>
<tr>
<td>2.2 The government collaborates with the following in-country civil society groups to develop and implement its viral hepatitis prevention and control programme: the Japan Hepatitis Council and the Viral Hepatitis Research Foundation of Japan.</td>
<td>It is regrettable that the name of our Social Welfare Corporation, Habataki Welfare Project, is missing from this section. We are also dedicated to making many efforts for patients with hepatitis. Surveillance for blood products is insufficient.</td>
</tr>
<tr>
<td>3.5 There is a national public health research agenda for viral hepatitis. It is not known whether viral hepatitis serosurveys are conducted regularly.</td>
<td>Their designed scheme concerning public health should be possible on the background of robust research and survey.</td>
</tr>
</tbody>
</table>

* World Hepatitis Alliance member.
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>4.2</strong> The government has not established the goal of eliminating hepatitis B.</td>
<td><strong>Hepatitis vaccination is not a priority in Japan. This truth of hepatitis in Japan is extremely shameful in comparison with other Asian countries. They should set numerical targets for vaccination.</strong></td>
</tr>
<tr>
<td><strong>4.3</strong> Nationally, no newborn infant in a given recent year received the first dose of hepatitis B vaccine within 24 hours of birth and no one-year-old (age 12–23 months) in a given recent year received three doses of hepatitis B vaccine.</td>
<td><strong>Hepatitis vaccinations are optional for individuals in Japan. Vaccination should be an obligatory task among the Japanese as soon as possible.</strong></td>
</tr>
<tr>
<td><strong>4.5</strong> There is a specific national strategy and/or policy/guidelines for preventing hepatitis B and hepatitis C infection in health-care settings. Health-care workers are vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood.</td>
<td><strong>Manuals for avoiding medical accidents are prepared for health care providers. Some health care providers do not get vaccinated. There are reports that they are accidentally involved in medical mishaps.</strong></td>
</tr>
<tr>
<td><strong>4.8</strong> There is a national infection control policy for blood banks. All donated blood units (including family donations) and blood products nationwide are screened for hepatitis B and hepatitis C.</td>
<td><strong>All donated blood units and blood products nationwide are screened for hepatitis B, hepatitis C and HIV.</strong></td>
</tr>
<tr>
<td><strong>4.9</strong> There is no national policy relating to the prevention of viral hepatitis among people who inject drugs.</td>
<td><strong>Government has not arranged for policy and business operations for people who use drugs. Thus, it is regretful that the occurrence of co-infection with HIV and hepatitis C is gradually increasing because of sharing injection equipment with other drug users.</strong></td>
</tr>
<tr>
<td><strong>4.10</strong> The government does not have guidelines that address how hepatitis A and hepatitis E can be prevented through food and water safety.</td>
<td><strong>All donated blood units and blood products are screened for hepatitis A and hepatitis E. Public announcements let us know how raw meat such as deer meat presents a hepatitis A transmission risk.</strong></td>
</tr>
</tbody>
</table>

To our knowledge, this information is accurate.
5.1 It is not known how health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis. There are national clinical guidelines for the management of viral hepatitis, but they do not include recommendations for cases with HIV coinfection. There are national clinical guidelines for the management of HIV, which include recommendations for coinfection with viral hepatitis.

5.5 The following drugs for treating hepatitis B are on the national essential medicines list or subsidised by the government: pegylated interferon, lamivudine, adefovir dipivoxil and entecavir. The following drugs for treating hepatitis C are on the national essential medicines list or subsidised by the government: interferon alpha, pegylated interferon, ribavirin and telaprevir.

1.1 There is a written national strategy or plan that focuses exclusively on the prevention and control of hepatitis B and hepatitis C. It includes components for raising awareness, vaccination, prevention in general, prevention of transmission in health-care settings, and treatment and care.

3.4 Hepatitis outbreaks are required to be reported to the government. There is adequate laboratory capacity nationally to support investigation of viral hepatitis outbreaks and other surveillance activities.

4.4 There is a national policy specifically targeting mother-to-child transmission of hepatitis B (Annex B).

5.3 People testing for hepatitis B and hepatitis C do not register by name. Hepatitis B and hepatitis C tests are free of charge for all individuals and are not compulsory for members of any specific group.

Regarding HIV, lecture and guidance is already arranged for medical care providers in order to obtain skills and capability required to provide effective treatment for patients.

Only a few patients have no medical fees. Fees need to be proportionally paid depending on patients’ income.

We know that government has a written national strategy and plan for prevention and control of hepatitis B and hepatitis C. However, these are not directly linked to raising awareness, vaccination and prevention in general.

Generally speaking, the reporting of hepatitis outbreaks is not compulsory.

We carefully focus on targeting mother-to-child transmission of hepatitis B.

Since it is not essential to get vaccinated in Japan, mother-to-child transmission has not been eliminated.

It is free of charge to receive a viral load test in a local public health center. Yet there is a fee for undergoing the same test in a hospital.
We take no position regarding this statement.

3.1 There is routine surveillance for viral hepatitis. There is a national surveillance system for the following types of acute hepatitis: A, B, C, D and E, but not for any type of chronic hepatitis.

3.2 There are standard case definitions for hepatitis. Deaths, including from hepatitis, are reported to a central registry. Of hepatitis cases, 5.6% are reported as “undifferentiated” or “unclassified” hepatitis.

3.3 Liver cancer cases are registered nationally, but cases with HIV/hepatitis coinfection are not. The government publishes hepatitis disease reports weekly.

5.4 Publicly funded treatment is available for hepatitis B and hepatitis C. The following group is eligible for such treatment for hepatitis B: patients receiving interferon therapy or nucleoside analogue therapy. The following group is eligible for publicly funded treatment for hepatitis C: patients receiving interferon therapy. Information was not provided on the amount spent by the government on such treatment for hepatitis B and hepatitis C.

Information collection and grasp is insufficient.

In this section, it is mentioned that hepatitis deaths are required to be reported to government registry. However, we do not think it is obligatory to report and register newly diagnosed hepatitis patients. A comprehensive structure based on law is really necessary to carry this out.

It is very regrettable that we are incapable of seeing the overall picture of coinfection patients. We think that it is an immediate issue to grasp the current situation of these people.

Only hepatitis-infected patients with agreement of hepatitis lawsuit can receive an admission free of medical fees. The majority of patients with hepatitis must pay for all medical costs.

Statement from the Social Welfare Corporation, Habataki, Welfare Project regarding key hepatitis policy issues in Japan:

Since viral hepatitis is a chronic disease, Government should implement a policy focusing on the fact that it is very important to consider long-term treatment of patients. To achieve this, Government should create a basis of life for patients, coordinating with welfare policy as well as their work. Both of them are essential and neither should be omitted. Medical care providers need to take a patient-oriented approach in order to make their life healthy, including their policy-making system. When looking back on medical measure for hepatitis, treatment for people with immediate hepatitis is well established. However measures for people with chronic hepatitis are unsatisfactory.

Comprehensive medical care is quickly required to sustain the long-term treatment of patients. Of course government is responsible for conducting this, and we think that the financial base as well as awareness-raising for eliminating prejudice of hepatitis among people in general is necessary. From the international standpoint, introduction and/or uptake by new system around the world will make up for shortcomings of the Japanese system. Also we have a responsibility to share our unique and proficient system to the rest of the world.

Habataki organisation is actively targeting for work of patients with hepatitis as well as make efforts to grasp their life and conduct both of research and survey, quantifying the degree of difficulty by using International Classification of Functioning, Disability and Health. We are taking care of numerous patients coinfected with hepatitis and HIV. In order to resolve their difficulty of life, we energetically propose an advocacy that makes them happier and healthier to government as well as people in general.
SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of Mongolia reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

- The government information was thought to be accurate for 88.0% of items.
- The respondent took no position on the government information for 12.0% of items.

Survey points marked “accurate”: 1.1, 1.2, 1.3, 2.1, 2.2, 3.1, 3.3, 3.4, 3.5, 4.1, 4.2, 4.3, 4.4, 4.5, 4.7, 4.9, 4.10, 5.1, 5.2, 5.3, 5.4 and 5.5.

Survey points marked “take no position”: 3.2, 4.6 and 4.8.

Survey comments from the Onom Foundation:

Information reported by government (2012–2013)

1.1 There is a written national strategy or plan that focuses exclusively on the prevention and control of viral hepatitis. It includes components for raising awareness, surveillance, vaccination, prevention in general, health-care transmission prevention and coinfection with HIV.

- To our knowledge, this information is accurate.
  - It all exists on paper but not a lot of actions are happening. Hepatitis B vaccination is the one part being done quite well. Other points do not have enough funding or not real orchestrated efforts that we can see.

1.2 There is a designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities: Hepatitis Surveillance Unit, National Center for Communicable Diseases. It has five staff members. There are 84 full-time equivalent staff members who work on hepatitis-related activities in all government agencies/bodies.

- I am not sure about the 84 full-time equivalent staff members; we do not see a whole lot of work being done.

2.1 The government held events for World Hepatitis Day 2012. It has funded other viral hepatitis public awareness campaigns since January 2011.

- On World Hepatitis Day there usually is a paragraph of news in a few news outlets. Other than that, I have not seen an active public awareness campaign. We are working to this end using SMS, traditional media such as radio, TV and newspaper, social media and website.

2.2 The government does not collaborate with in-country civil society groups to develop and implement its viral hepatitis prevention and control programme.

- I hope that we can change this and work with the Government. Currently, there are talks going on.

3.1 There is routine surveillance for viral hepatitis. There is a national surveillance system for the following types of acute hepatitis: A, B and C. There is a national surveillance system for the following types of chronic hepatitis: B, C and D.

- This is true. But the surveillance system is rudimentary; it is more of a registry system. It registers newly detected cases only within the government hospital system as a number. There is no follow-up or actual registry of patients.

Civil society respondent comments (2014)

* World Hepatitis Alliance member.
Mongolia

Information reported by government (2012–2013)  

3.5 Information was not provided regarding whether or not there is a national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are not conducted regularly.

4.3 Nationally, 96.2% of newborn infants in a given recent year received the first dose of hepatitis B vaccine within 24 hours of birth and 98.8% of one-year-olds (ages 12–23 months) in a given recent year received three doses of hepatitis B vaccine.

5.1 Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools of health professionals (pre-service education).

5.5 The following drug for treating hepatitis B is included on the national essential medicines list or is subsidised by the government: lamivudine. The following drug for treating hepatitis C is included on the national essential medicines list or is subsidised by the government: ribavirin.

Civil society respondent comments (2014)  

We recently carried out a serosurvey from four aimags and capital city Ulaanbaatar (n=1162). This study was carried out 10 years after the last serosurvey.

There is no evaluation of the efficacy and whether there is a need for booster vaccination.

We believe that this national guideline needs to be revised, as there is no inclusion of hepatitis C treatment advances.

Formerly, 80% of the cost was subsidised. Since last year 66% is being subsidised.

To our knowledge, this information is accurate.

Statement from the Onom Foundation regarding key hepatitis policy issues in Mongolia:

There is an existing treatment guideline for both hepatitis C virus (HCV) and hepatitis B virus (HBV) that was approved by the Ministry of Health. The guideline recommends 48 weeks monotherapy peginterferon or peginterferon with ribavirin combination therapy for HCV patients after liver biopsy. HBV treatment recommendation is that if HBeAg positive, interferon for 16 weeks, peginterferon for two to 48 weeks, and lamivudine/ adefovir/entecavir/tenofovir for a year, and following seroconversion of HbeAg, at least another 6 months.

However, the guideline is not widely distributed and doctors are generally not aware of its existence. In addition, patients also complain often to our experts that they get different treatment recommendations from every doctor they visit, illustrating the fact that this treatment guideline is not well followed by the doctors. The situation is worsened by the self-medication of patients and treatment by traditional medicine as well as alternative doctors.

When we convened over 80 leading hepatologists during the National Conference on Viral Hepatitis that we organised on March 26, 2014, there was a discussion on updating the treatment guideline, training of doctors, and its enforcement within the health care system. Because of rapid advances in treatment options for viral hepatitis, we recognise the need for updated treatment guidelines incorporating elements from the latest versions such as the Hepatitis C Guideline issued by the World Health Organization on April 9, 2014. More importantly, we would like to highlight the urgent need for a proper training scheme for doctors and hepatologists.

To make the situation even worse, the cost of the interferon and ribavirin treatment regimen is very expensive in Mongolia. From the current market prices for these drugs, it is calculated that a 12-month treatment regimen of interferon and ribavirin will cost US$10,000 to US$18,300 in direct drug expenses, not including costs for medical tests and doctors. In fact, it is common for people who receive such treatment regimen for HCV to incur out-of-pocket costs of more than US$20,000.

For hepatitis B, it does not help to have oral antivirals that are several times more expensive in Mongolia, as people with HBV will require long-term suppressive therapy. Although 66.7% subsidies exist for lamivudine and hepaviral paid by the Health Insurance Fund, out-of-pocket expenses for hepatitis B control run into the thousands of dollars.

These figures contrast starkly with the reality that Mongolia is a low-income country. According to the National Statistical Office, average annual income for an average Mongolian was around US$4,300 in 2013. In turn, it means that receiving a viral hepatitis treatment will require approximately five years of income for an average Mongolian. In addition, it is reported that nearly 30% of the Mongolian population is living below the poverty line of US$ 2 per day. Because of these brutal realities, odds are really stacked
against Mongolians and it is no surprise that Mongolia has the highest mortality rate of liver cancer in the world.

The Problem:

- No formal screening
- No strong specific training scheme for healthcare workers
- No financial solution yet

The Solution:

- Currently, we are proposing to carry out national screening of viral hepatitis and create a national viral hepatitis database. We are looking to implement this in cooperation with other stakeholders and with support from the Ministry of Health.
- Comprehensive training is crucially important for the long-term success of eradication of viral hepatitis in Mongolia that we at Onom Foundation propose to implement within the Viral Hepatitis Eradication Program in Mongolia.
- We believe that the financial difficulties of getting the treatment can only be overcome with cooperation between pharmaceutical companies, the government, the national Health Insurance Fund and civil society.
New Zealand

Hepatitis Foundation of New Zealand*

NGO – direct service provider
Whakatane, New Zealand
hepatitisfoundation.org.nz

SURVEY HIGHLIGHTS

The respondent reviewed 25 items of information that the government of New Zealand reported for the 2013 World Health Organization Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States.

- The government information was thought to be accurate for 80.0% of items. Survey points marked “accurate”: 1.1, 1.2, 1.3, 2.2, 3.3, 3.4, 3.5, 4.1, 4.2, 4.4, 4.5, 4.6, 4.8, 4.9, 4.10, 5.2, 5.3, 5.4, and 5.5.

- The government information was thought to not be accurate for 8.0% of items. Survey points marked “not accurate”: 2.1 and 5.1.

- The respondent took no position on the government information for 12.0% of items. Survey points marked “take no position”: 3.2, 4.3 and 4.7.

Survey comments from the Hepatitis Foundation of New Zealand:

- To our knowledge, this information is accurate.

  1.1 There is no written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis.

  A first draft of a national hepatitis C strategy will be developed mid-2014.

  There is also a staff member working on hepatitis C in Long Term Conditions, Sector Capability and Implementation.

  Needle exchange.

  Hepatitis Foundation of New Zealand is government-funded to follow up chronic hepatitis B in a national hepatitis B programme: to date we have 16,000 hepatitis B patients in long term follow-up.

  The latest serosurvey was conducted November 2013 by Needle Exchange.

* World Hepatitis Alliance member.
People testing for both hepatitis B and hepatitis C register by name; the names are kept confidential within the system. Hepatitis B and hepatitis C tests are free of charge for all individuals. Hepatitis B tests are compulsory for blood donors and immigrants, and hepatitis C tests for blood donors.

Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools for health professionals (pre-service education), on-the-job training and postgraduate training. There are no national clinical guidelines for the management of viral hepatitis, but there are for the management of HIV, which include recommendations for coinfection with viral hepatitis.

Publicly funded treatment for hepatitis B and hepatitis C is available to some segments of the population, but information was not provided on who is eligible. In fiscal year 2011/2012, the government spent NZ$ 16,080,000 (US$ 13,026,971) on such treatment for hepatitis B and hepatitis C. However this information is impossible to retrieve given the huge number of different codes for hepatitis.

New Zealand citizens and residents only.

To our knowledge, this information is accurate.

Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools for health professionals (pre-service education), on-the-job training and postgraduate training. There are no national clinical guidelines for the management of viral hepatitis, but there are for the management of HIV, which include recommendations for coinfection with viral hepatitis.

I would suggest more needs to be done with health workers to require the correct skills to deal with people with viral hepatitis.

To our knowledge, this information is not accurate.

Information reported by government (2012–2013)

Civil society respondent comments (2014)

Statement from the Hepatitis Foundation of New Zealand regarding key hepatitis policy issues in New Zealand:

New Zealand is unique in that it has addressed hepatitis B for the past 30 years working in partnership with the Hepatitis Foundation (New Zealand) and the New Zealand government. To date New Zealand has a robust system in place to identify hepatitis-infected individuals. However there is still a lack of empathy in general practice and other healthcare providers that viral hepatitis is not a serious disease regardless of continuing education. The New Zealand government could do more by listing viral hepatitis as a health target for general practice. By doing so patients would be screened and appropriate action taken, i.e. follow-up, treatment or vaccination. In saying this though New Zealand is resourced better than most countries but still has many hills to climb.
SURVEY HIGHLIGHTS

The Government of the Philippines did not respond to the World Health Organization survey for the 2013 Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States, and therefore the Yellow Warriors Society Philippines could not comment on government information for this report.

The organisation provided the following general statement regarding key hepatitis policy issues in the Philippines:

Current situation. The Department of Health has a free hepatitis B vaccine programme for infants [birth to age one]. But since the Philippines is an archipelago, bringing vaccine to far-flung provinces poses a challenge. We can see this because of the increase in the prevalence of hepatitis B. We believe strict implementation and monitoring would solve this problem — making sure that vaccine will be available to newborns and making sure that the vaccination regimen will be completed. Yellow Warriors Society Philippines has been attending meetings for us to share our experience and help in the formulation of policies and guidelines.

Awareness-raising. We believe that awareness is still low. Due to stigma, [viral hepatitis] carriers do not talk about this topic. More needs to be done if we want a higher level of awareness. A solution is networking with organisations just like what Yellow Warriors Society Philippines is doing now. Also, more informational materials are needed. Yellow Warriors Society Philippines as an organisation will always be ready to accept hepatitis carriers and enlighten their families and close friends.

Evidence-based policy. The government should use its resources to create a policy. Proper monitoring is required in order to pinpoint high-risk areas and assess how effectively programmes are implemented.

Prevention of transmission. We believe vaccination is the key. Unfortunately, vaccine is only free to infants from birth to age one. The government should expand this policy and also give free vaccine to adults. Again, an information drive would help in preventing transmission.

Screening, care and treatment. We still need to work more on this. Unlike in other countries where health care is provided for viral hepatitis carriers, here it is not included in health care. We hope we can convince the government to help hepatitis B and hepatitis C carriers by at least subsidising the medicines.
The organisation provided the following general statement regarding key hepatitis policy issues in Taiwan (Chinese Taipei):

**Awareness-raising, partnerships and resource mobilisation.** Disease awareness remains a critical issue in our country. We’re pleased to address this issue by working closely with many non-profit organisations in Taiwan. The achievement has been much beyond what our government has done. We have learned and shared constructive strategies with many domestic and foreign allies.

We have recently seen a friendly change at the Ministry of Health and Welfare regarding hepatitis screening, with screening efforts incorporated into a nationwide health check-up programme. We are making every effort to raise disease awareness in our community by means of public education, free screening and symposia held for medical professionals. Of note was that we created a strategy aiming to have young children teach their parents and families about hepatitis prevention and the importance of disease awareness.

**Screening, care and treatment.** As hepatitis C virus (HCV) infection is often asymptomatic and could easily remain undiagnosed, screening in a community-based setting becomes an important task. With the progressive emergence of HCV/HIV coinfection in intravenous drug users, the prognosis and outcome of HCV infection will be exacerbated. Therefore, searching for HCV reservoirs becomes an essential step, both in the general population as well as in high-risk groups.

We have conducted more than 20 voluntary mass screening sessions in residents. The items include HBsAg, anti-HCV, transaminases, alpha-fetoprotein, and abdominal ultrasonography. All anti-HCV-positive subjects will be tested further for HCV RNA. Meanwhile, a self-administered questionnaire is designed to identify possible routes of infection. We also have provided examinations for people at high risk of HCV infection, such as haemodialysis patients, intravenous drug users, HIV-infected patients and those patients requiring periodic transfusion.

HCV is a curable disease at present. The key points of preventing and reducing the burden of HCV are early diagnosis, effective preventing programmes, and appropriate treatment. As the screening, diagnosis, and treatment of HCV infection continues to evolve with the availability of more effective yet more costly treatments, the cost of care will continue to rise.

However, this increasing cost of care may still be acceptable and justifiable if it results in an accompanying improvement in quality-adjusted life years and amelioration of related morbidity and mortality. Therefore, medical accessibility and disease awareness remain critical steps for a better chance of curing people with hepatitis C. We provide free transportation for indigenous people living in mountainous areas and for poor people to access medical care for their hepatitis C infection.
Annexes
The 2014 Global Community Hepatitis Policy Report is based on findings from the World Hepatitis Alliance’s 2014 civil society survey. The survey was written in English. Survey responses were sought from World Hepatitis Alliance members (patient groups) and other civil society actors, including nongovernmental organisations, academic institutions and medical associations. The survey was distributed via e-mail to focal points identified by the World Hepatitis Alliance, with e-mails sent to approximately 800 organisations worldwide. It was also distributed via social media, and was available for download on the World Hepatitis Alliance website (http://www.worldhepatitisalliance.org/en/civil-society-report-2014.html). Data collection took place from 1 February 2014 to 15 June 2014.

There are two versions of the World Hepatitis Alliance’s 2014 civil society survey. Both versions can be found in Annex B.

The three-part version of the survey was sent to organisations based in countries where governments had contributed information to the Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States, published by the World Health Organization (WHO) in 2013. Part A of the civil society survey collected information about the responding organisation. Part B consisted of 25 items based on information provided by governments for the 2013 WHO report. Each civil society survey respondent reviewed the information from the government of its own country and indicated whether the government reporting appeared to be accurate or inaccurate. In Part C, respondents were invited to write statements about key national hepatitis policy issues of their choosing.

The two-part version of the civil society survey was sent to organisations based in countries where governments had not submitted information for the 2013 WHO report. Part A collected information about the responding organisation. Part B asked respondents to write statements about key national hepatitis policy issues of their choosing.

Global, regional and country summaries in this report were developed using the completed survey responses. Quantitative data presented in tables and figures may not total 100% due to the rounding of decimals. Information about income group classification was obtained from World Bank 2013 data (http://data.worldbank.org/about/country-classifications/country-and-lending-groups). Survey comments were left in the respondents’ own words aside from minor edits made for clarity.

This study is subject to a number of limitations. Firstly, generalisability is restricted by the number of countries represented. Ninety-five organisations from 58 countries and one special administrative region submitted surveys. Seventy-six organisations from 46 countries were able to comment on their governments’ responses from the 2013 WHO report. These data provide the basis for the quantitative analyses in the 2014 Global Community Hepatitis Policy Report, and therefore the quantitative findings represent only 46 countries. The other 19 organisations responded from 12 countries and one special administrative region where no government information had been provided for the 2013 WHO report, and hence they could only provide qualitative data.

Furthermore, regarding the findings for the six geographical regions designated in this report, some regions were represented by only a small number of survey responses. This both restricts generalisability about trends within regions and also limits the value of comparisons across regions.

Civil society survey responses were received from multiple organisations in some countries, while other countries are represented by a single organisation. Consequently, the accuracy or inaccuracy of government information may be over-reported in countries from which multiple survey submissions were received.

The 2014 civil society survey was only available in English. This may have prevented some organisations from fully understanding questions and also may have affected their ability to provide accurate responses.

The time lag between when governments submitted information to WHO and when civil society organisations submitted information to the World Hepatitis Alliance also needs to be recognised. Data collection for the 2013 WHO report took place from July 2012 to February 2013. The fact that data collection for the 2014 Global Community Hepatitis Policy Report took place more than one year later may have implications for how some civil society organisations viewed the information from their governments.

Finally, the findings presented in the report are drawn entirely from the survey responses of the civil society organisations identified in Chapters 3–9. It was not possible to independently verify the information submitted by survey respondents.
This annex presents the two surveys that form the basis of this report: the first was for organisations in countries where governments contributed information to the 2013 WHO hepatitis policy survey and the second was for organisations in countries where governments did not contribute information.

World Hepatitis Alliance 2014 Survey of Civil Society Stakeholders


Your organisation’s cooperation is requested in gathering data for the World Hepatitis Alliance’s 2014 global hepatitis policy report. This report is seen as a civil society response to information provided by governments for the 2013 global hepatitis policy report published by the World Health Organization (WHO) [http://www.who.int/csr/disease/hepatitis/global_report/en/].

The following survey has three parts:

- **Part A** your organisation is asked to provide basic information about itself.
- **Part B** your organisation is asked to review the actual published text that describes what your government stated for the 2013 report, and to comment on whether the information is correct.
- **Part C** your organisation is asked to discuss the policy response to hepatitis in your country in greater depth, focusing on issues that your organisation wishes to prioritise. Your organisation also is invited to put forth an “agenda for change” outlining proposed roles and responsibilities for key stakeholders.

### Part A. Organisational information

<table>
<thead>
<tr>
<th>Organisation name</th>
<th>First name of person completing survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street address</td>
<td>Last name of person completing survey</td>
</tr>
<tr>
<td>City</td>
<td>Position</td>
</tr>
<tr>
<td>Postal code/zip code</td>
<td>E-mail address</td>
</tr>
<tr>
<td>Country</td>
<td>Phone number (+)</td>
</tr>
<tr>
<td>Website</td>
<td></td>
</tr>
</tbody>
</table>

Please select the one item that best describes your organisation:

- [ ] NGO: hepatitis patient group
- [ ] NGO: direct service provider
- [ ] NGO: other (please describe: ____________________________ )
- [ ] Medical society
- [ ] Private foundation
- [ ] Other: ____________________________
### Part B. Response to Information Reported by Governments

#### Information reported by [country] government
(All text in this column is copied from the Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States, 2013)

#### Civil society perspective
(please complete by selecting one check-box in each cell)

<table>
<thead>
<tr>
<th>1. National coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.1. Government response to:</strong></td>
</tr>
<tr>
<td>In your country, is there a written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis?</td>
</tr>
<tr>
<td>If yes, is it exclusive for viral hepatitis or does it also address other diseases? Please indicate components of the strategy or plan.</td>
</tr>
<tr>
<td>☐ To our knowledge, this information is accurate.</td>
</tr>
<tr>
<td>☐ To our knowledge, this information is not accurate.</td>
</tr>
<tr>
<td>☐ We take no position regarding this statement.</td>
</tr>
<tr>
<td>Comments: (200 words maximum)</td>
</tr>
</tbody>
</table>

| 1.2. Government response to: |
| Is there a designated governmental unit/department responsible only for coordinating and/or carrying out viral hepatitis-related activities? |
| If yes, what is its name? |
| How many people work full-time (or how many full-time equivalent staff) on hepatitis-related activities in all government agencies/bodies? |
| ☐ To our knowledge, this information is accurate. |
| ☐ To our knowledge, this information is not accurate. |
| ☐ We take no position regarding this statement. |
| Comments: (200 words maximum) |

| 1.3. Government response to: |
| Does your government have a viral hepatitis prevention and control programme that includes activities targeting specific populations? |
| If yes, please indicate which populations. |
| ☐ To our knowledge, this information is accurate. |
| ☐ To our knowledge, this information is not accurate. |
| ☐ We take no position regarding this statement. |
| Comments: (200 words maximum) |

#### 2. Awareness-raising and partnerships

| 2.1. Government response to: |
| Did your government hold events for World Hepatitis Day 2012? |
| Has your government funded any public viral hepatitis awareness campaigns since January 2011, other than World Hepatitis Day? |
| ☐ To our knowledge, this information is accurate. |
| ☐ To our knowledge, this information is not accurate. |
| ☐ We take no position regarding this statement. |
| Comments: (200 words maximum) |

| 2.2. Government response to: |
| Does your government collaborate with any civil society group within your country (such as patient groups or national or local nongovernmental organisations) to develop and implement its viral hepatitis prevention and control programme? |
| If yes, please name major partners. |
| ☐ To our knowledge, this information is accurate. |
| ☐ To our knowledge, this information is not accurate. |
| ☐ We take no position regarding this statement. |
| Comments: (200 words maximum) |
### 3. Evidence-based policy and data for action

#### 3.1. Government response to:
- Is there routine surveillance for viral hepatitis?
- If yes, is there a national surveillance system for the following types of acute hepatitis? A, B, C.
- Is there a national surveillance system for the following types of chronic hepatitis? B, C.

**Civil society perspective**
- To our knowledge, this information is accurate.
- To our knowledge, this information is not accurate.
- We take no position regarding this statement.

**Comments:** (200 words maximum)

#### 3.2. Government response to:
- Are there standard case definitions for hepatitis infections?
- Are deaths, including from hepatitis, reported to a central registry?
- What percentage of hepatitis cases are reported as “undifferentiated” or “unclassified” hepatitis?

**Civil society perspective**
- To our knowledge, this information is accurate.
- To our knowledge, this information is not accurate.
- We take no position regarding this statement.

**Comments:** (200 words maximum)

#### 3.3. Government response to:
- Are liver cancer cases registered nationally?
- Are cases of HIV/hepatitis co-infection registered nationally?
- How often are hepatitis disease reports published?

**Civil society perspective**
- To our knowledge, this information is accurate.
- To our knowledge, this information is not accurate.
- We take no position regarding this statement.

**Comments:** (200 words maximum)

#### 3.4. Government response to:
- Are hepatitis outbreaks required to be reported to the government?
- If yes, are they further investigated?
- Is there adequate laboratory capacity nationally to support viral hepatitis outbreak investigations and other surveillance activities?

**Civil society perspective**
- To our knowledge, this information is accurate.
- To our knowledge, this information is not accurate.
- We take no position regarding this statement.

**Comments:** (200 words maximum)

#### 3.5. Government response to:
- Is there a national public health research agenda for viral hepatitis?
- Are viral hepatitis serosurveys conducted regularly?
- If yes, how often?
- When was the last one carried out? Please specify the target populations.

**Civil society perspective**
- To our knowledge, this information is accurate.
- To our knowledge, this information is not accurate.
- We take no position regarding this statement.

**Comments:** (200 words maximum)
### Information reported by [country] government

<table>
<thead>
<tr>
<th>Civil society perspective</th>
<th>4. Prevention of transmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>(All text in this column is copied from the Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States, 2013)</td>
<td><strong>4.1. Government response to:</strong></td>
</tr>
<tr>
<td></td>
<td>Is there a national hepatitis A vaccination policy?</td>
</tr>
<tr>
<td></td>
<td>If yes, what groups does the policy address?</td>
</tr>
<tr>
<td></td>
<td>To our knowledge, this information is accurate.</td>
</tr>
<tr>
<td></td>
<td>To our knowledge, this information is not accurate.</td>
</tr>
<tr>
<td></td>
<td>We take no position regarding this statement.</td>
</tr>
<tr>
<td></td>
<td>Comments: (200 words maximum)</td>
</tr>
</tbody>
</table>

|  | **4.2. Government response to:** |
|  | Has your government established the goal of eliminating hepatitis B? If yes, in what timeframe? |
| | To our knowledge, this information is accurate. |
| | To our knowledge, this information is not accurate. |
| | We take no position regarding this statement. |
|  | Comments: (200 words maximum) |

|  | **4.3. Government response to:** |
|  | Nationally, what percentage of newborn infants in a given recent year received the first dose of hepatitis B vaccine within 24 hours of birth? |
|  | Nationally, what percentage of one-year-olds (ages 12–23 months) in a given recent year received three doses of hepatitis B vaccine? |
| | To our knowledge, this information is accurate. |
| | To our knowledge, this information is not accurate. |
| | We take no position regarding this statement. |
|  | Comments: (200 words maximum) |

|  | **4.4. Government response to:** |
|  | Is there a national policy specifically targeting mother-to-child transmission of hepatitis B? |
| | To our knowledge, this information is accurate. |
| | To our knowledge, this information is not accurate. |
| | We take no position regarding this statement. |
|  | Comments: (200 words maximum) |

|  | **4.5. Government response to:** |
|  | Is there a specific national strategy and/or policy/guidelines for preventing hepatitis B and hepatitis C infection in health care settings? |
|  | If yes, are health workers vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood? |
| | To our knowledge, this information is accurate. |
| | To our knowledge, this information is not accurate. |
| | We take no position regarding this statement. |
|  | Comments: (200 words maximum) |

<p>|  | <strong>4.6. Government response to:</strong> |
|  | Is there a national policy on injection safety in health-care settings? |
|  | If yes, what type of syringes does the policy recommend for therapeutic injections? |
|  | Are single-use or auto-disable syringes, needles and cannulas always available in all health care facilities? |
| | To our knowledge, this information is accurate. |
| | To our knowledge, this information is not accurate. |
| | We take no position regarding this statement. |
|  | Comments: (200 words maximum) |</p>
<table>
<thead>
<tr>
<th>Information reported by [country] government</th>
<th>Civil society perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>(All text in this column is copied from the Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States, 2013)</td>
<td>(please complete by selecting one check-box in each cell)</td>
</tr>
</tbody>
</table>

### 4.7. Government response to:
- What are your government’s official estimates of the number and percentage of unnecessary injections administered annually in healthcare settings? (e.g., injections that are given when an equivalent oral medication is available)

| □ To our knowledge, this information is accurate. |
| □ To our knowledge, this information is not accurate. |
| □ We take no position regarding this statement. |
| **Comments:** (200 words maximum) |

### 4.8. Government response to:
- Is there a national infection control policy for blood banks?
- Are all donated blood units (including family donations) and blood products nationwide screened for hepatitis B?
- Are all donated blood units (including family donations) and blood products nationwide screened for hepatitis C?

| □ To our knowledge, this information is accurate. |
| □ To our knowledge, this information is not accurate. |
| □ We take no position regarding this statement. |
| **Comments:** (200 words maximum) |

### 4.9. Government response to:
- Is there a national policy relating to the prevention of viral hepatitis among people who inject drugs?

| □ To our knowledge, this information is accurate. |
| □ To our knowledge, this information is not accurate. |
| □ We take no position regarding this statement. |
| **Comments:** (200 words maximum) |

### 4.10. Government response to:
- Does your government have guidelines addressing how hepatitis A and hepatitis E can be prevented through food and water safety?

| □ To our knowledge, this information is accurate. |
| □ To our knowledge, this information is not accurate. |
| □ We take no position regarding this statement. |
| **Comments:** (200 words maximum) |

### 5. Screening, care and treatment

#### 5.1. Government response to:
- How do health professionals in your country obtain the skills and competencies required to effectively care for people with viral hepatitis?
- Are there national clinical guidelines for the management of viral hepatitis?
- If yes, do they include recommendations for cases of HIV co-infection?
- If no, are there national clinical guidelines for the management of HIV that include recommendations for co-infection with viral hepatitis?

<p>| □ To our knowledge, this information is accurate. |
| □ To our knowledge, this information is not accurate. |
| □ We take no position regarding this statement. |
| <strong>Comments:</strong> (200 words maximum) |</p>
<table>
<thead>
<tr>
<th><strong>Information reported by [country] government</strong> (All text in this column is copied from the Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States, 2013)</th>
<th><strong>Civil society perspective</strong> (please complete by selecting one check-box in each cell)</th>
</tr>
</thead>
</table>
| **5.2. Government response to:** Does your government have a national policy relating to screening and referral to care for hepatitis B? For hepatitis C? | ☐ To our knowledge, this information is accurate.  
☐ To our knowledge, this information is not accurate.  
☐ We take no position regarding this statement.  
**Comments:** (200 words maximum) |
| **5.3. Government response to:** Please answer the following questions about hepatitis B and hepatitis C testing in your country.  
- When testing, do people register by name?  
- If people register by name, are their names kept confidential within the system, or is there open access to the names?  
- Is the test free of charge for all individuals?  
- Is the test free of charge for members of any specific group?  
- Is the test compulsory for members of any specific group? | ☐ To our knowledge, this information is accurate.  
☐ To our knowledge, this information is not accurate.  
☐ We take no position regarding this statement.  
**Comments:** (200 words maximum) |
| **5.4. Government response to:** Is publicly funded treatment available for hepatitis B? If yes, who is eligible?  
Is publicly funded treatment available for hepatitis C? If yes, who is eligible?  
How much does the government spend on publicly funded treatment for hepatitis B and hepatitis C? | ☐ To our knowledge, this information is accurate.  
☐ To our knowledge, this information is not accurate.  
☐ We take no position regarding this statement.  
**Comments:** (200 words maximum) |
| **5.5. Government response to:** Which hepatitis B drugs and hepatitis C drugs are included on the national essential medicines list or are subsidised by the government? | ☐ To our knowledge, this information is accurate.  
☐ To our knowledge, this information is not accurate.  
☐ We take no position regarding this statement.  
**Comments:** (200 words maximum) |
Part C. Key Hepatitis Policy Issues and Proposed Agenda for Change

For Part C, your organisation is asked to discuss the policy response to viral hepatitis in your country in greater depth, focusing on one or more of five topics listed below. Please follow these steps:

Choose one of the five topics:

1. National coordination
2. Awareness-raising, partnerships and resource mobilisation (WHO Axis 1)
3. Evidence-based policy and data for action (WHO Axis 2)
4. Prevention of transmission (WHO Axis 3)
5. Screening, care and treatment (WHO Axis 4)

Write your organisation’s assessment of the national response to viral hepatitis as it relates to the topic you chose (maximum 400 words and please use the box below). Some points to consider are:

- What are the greatest problems with this component of the national response to viral hepatitis?
- What needs to change?
- What should be the government’s role in bringing about these changes? What responsibilities should the government have?
- What should be the roles and responsibilities of other stakeholders at the community, national and international levels? (You may wish to list these in bullet points.)
- What evidence exists to support your organisation’s viewpoint? (Consider, for example, citing surveys, research reports, statistics and newspaper articles.)

Please repeat these steps for as many of the five topics as you wish to address.

---

World Hepatitis Alliance 2014 Survey of Civil Society Stakeholders


Your organisation’s cooperation is requested in gathering data for the World Hepatitis Alliance’s 2014 global hepatitis policy report. This report is seen as a civil society response to information provided by governments for the 2013 global hepatitis policy report published by the World Health Organization (http://www.who.int/csr/disease/hepatitis/global_report/en/).

All World Health Organization member states were surveyed for the 2013 report. Civil society organisations in countries where governments responded to the survey are being invited to comment on the information that their governments provided.

Your government did not respond to the 2013 survey. The World Hepatitis Alliance therefore would like to ask you to complete a modified version of its 2014 survey of civil society stakeholders. The following survey has two parts:

- In **Part A** your organisation is asked to provide basic information about itself.
- In **Part B** your organisation is asked to discuss the policy response to hepatitis in your country, focusing on issues that your organisation wishes to prioritise. Your organisation also is invited to put forth an “agenda for change” outlining proposed roles and responsibilities for key stakeholders.

### Part A. Organisational information

<table>
<thead>
<tr>
<th>Organisation name</th>
<th>First name of person completing survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street address</td>
<td>Last name of person completing survey</td>
</tr>
<tr>
<td>City</td>
<td>Position</td>
</tr>
<tr>
<td>Postal code/zip code</td>
<td>E-mail address</td>
</tr>
<tr>
<td>Country</td>
<td>Phone number (+)</td>
</tr>
<tr>
<td>Website</td>
<td></td>
</tr>
</tbody>
</table>

*Please select the one item that best describes your organisation:*

- [ ] NGO: hepatitis patient group
- [ ] NGO: direct service provider
- [ ] NGO: other (please describe: __________________________)  
- [ ] Medical society
- [ ] Private foundation
- [ ] Other: __________________________
Part B. Key hepatitis policy issues and proposed agenda for change

For Part B, your organisation is asked to discuss the policy response to viral hepatitis in your country in greater depth, focusing on one or more of five topics listed below. Please follow these steps:

Choose one of the five topics:

1. National coordination
2. Awareness-raising, partnerships and resource mobilisation (WHO Axis 1)
3. Evidence-based policy and data for action (WHO Axis 2)
4. Prevention of transmission (WHO Axis 3)
5. Screening, care and treatment (WHO Axis 4)

Write your organisation’s assessment of the national response to viral hepatitis as it relates to the topic you chose (maximum 400 words and please use the box below). Some points to consider are:

- What are the greatest problems with this component of the national response to viral hepatitis?
- What needs to change?
- What should be the government’s role in bringing about these changes? What responsibilities should the government have?
- What should be the roles and responsibilities of other stakeholders at the community, national and international levels? (You may wish to list these in bullet points.)
- What evidence exists to support your organisation’s viewpoint? (Consider, for example, citing surveys, research reports, statistics and newspaper articles.)

Please repeat these steps for as many of the five topics as you wish to address.

---

The following tables (Tables 1–5) present civil society respondent answers for each item in the 25-item survey, with the tables reflecting the organisation of the survey into five sections: national coordination; awareness-raising and partnerships; evidence-based policy and data for action; prevention of transmission; and screening, care and treatment. The questions addressed by governments are summarised in the tables rather than being copied verbatim from the text of the survey that was sent to governments for the 2013 World Health Organization (WHO) Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States. For the original survey, please see Annex E of that report.

### Table 1. National coordination: how civil society organisations responded to hepatitis policy information provided by their governments

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Question(s) addressed by governments for 2013 WHO global policy report</th>
<th>Response chosen by civil society survey respondent (N=76)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Is there a written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis?</td>
<td>To our knowledge, this information is accurate (%) 78.9%  To our knowledge, this information is not accurate (%) 18.4%  We take no position regarding this statement (%) 2.7%  No response (%) 0%</td>
</tr>
<tr>
<td>1.2</td>
<td>Is there a designated governmental unit/department responsible only for coordinating and/or carrying out viral hepatitis-related activities? If yes, what is the name of the unit/department, and how many staff members does it have? How many people work full-time (or how many full-time equivalent staff) on hepatitis-related activities in all government agencies/bodies?</td>
<td>To our knowledge, this information is accurate (%) 73.7%  To our knowledge, this information is not accurate (%) 17.1%  We take no position regarding this statement (%) 9.2%  No response (%) 0%</td>
</tr>
<tr>
<td>1.3</td>
<td>Does your government have a viral hepatitis prevention and control programme that includes activities targeting specific populations? If yes, please indicate which populations.</td>
<td>To our knowledge, this information is accurate (%) 61.8%  To our knowledge, this information is not accurate (%) 32.9%  We take no position regarding this statement (%) 5.3%  No response (%) 0%</td>
</tr>
</tbody>
</table>

### Table 2. Awareness-raising and partnerships: how civil society organisations responded to hepatitis policy information provided by their governments

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Question(s) addressed by governments for 2013 WHO global policy report</th>
<th>Response chosen by civil society survey respondent (N=76)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Did your government hold events for World Hepatitis Day 2012? Has your government funded any public viral hepatitis awareness campaigns since January 2011, other than World Hepatitis Day?</td>
<td>To our knowledge, this information is accurate (%) 67.1%  To our knowledge, this information is not accurate (%) 23.7%  We take no position regarding this statement (%) 9.2%  No response (%) 0%</td>
</tr>
<tr>
<td>2.2</td>
<td>Does your government collaborate with any civil society group within your country (such as patient groups or national or local nongovernmental organisations) to develop and implement its viral hepatitis prevention and control programme? If yes, please name major partners.</td>
<td>To our knowledge, this information is accurate (%) 68.4%  To our knowledge, this information is not accurate (%) 23.7%  We take no position regarding this statement (%) 7.9%  No response (%) 0%</td>
</tr>
</tbody>
</table>
### Table 3. Evidence-based policy and data for action: how civil society organisations responded to hepatitis policy information provided by their governments

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Question(s) addressed by governments for 2013 WHO global policy report</th>
<th>Response chosen by civil society survey respondent (N=76)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Is there routine surveillance for viral hepatitis? If yes, for which types of acute and chronic hepatitis?</td>
<td>To our knowledge, this information is accurate (%)</td>
</tr>
<tr>
<td></td>
<td>64.5% 28.9% 6.6% 0%</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>3.2</td>
<td>Do standard case definitions for hepatitis infections exist? Are deaths, including from hepatitis, reported to a central registry? What percentage of hepatitis cases are reported as “undifferentiated” or “unclassified” hepatitis?</td>
<td>52.6% 18.4% 28.9% 0%</td>
</tr>
<tr>
<td>3.3</td>
<td>Are liver cancer cases registered nationally? Are cases of HIV/hepatitis co-infection registered nationally? How often are hepatitis disease reports published?</td>
<td>59.2% 32.9% 79% 0%</td>
</tr>
<tr>
<td>3.4</td>
<td>Are hepatitis outbreaks required to be reported to the government? If yes, are they further investigated? Is there adequate laboratory capacity nationally to support viral hepatitis outbreak investigations and other surveillance activities?</td>
<td>65.8% 26.3% 79% 0%</td>
</tr>
<tr>
<td>3.5</td>
<td>Is there a national public health research agenda for viral hepatitis? Are viral hepatitis serosurveys conducted regularly? If yes, how often? When was the last one carried out? Please specify the target populations.</td>
<td>68.4% 19.7% 11.8% 0%</td>
</tr>
</tbody>
</table>
Table 4. Prevention of transmission: how civil society organisations responded to hepatitis policy information provided by their governments

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Question(s) addressed by governments for 2013 WHO global policy report</th>
<th>To our knowledge, this information is accurate (%)</th>
<th>To our knowledge, this information is not accurate (%)</th>
<th>We take no position regarding this statement (%)</th>
<th>No response (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Is there a national hepatitis A vaccination policy? If yes, what groups does the policy address?</td>
<td>77.6%</td>
<td>17.1%</td>
<td>5.3%</td>
<td>0%</td>
</tr>
<tr>
<td>4.2</td>
<td>Has your government established the goal of eliminating hepatitis B? If yes, in what timeframe?</td>
<td>72.4%</td>
<td>15.8%</td>
<td>11.8%</td>
<td>0%</td>
</tr>
<tr>
<td>4.3</td>
<td>Nationally, what percentage of newborn infants in a given recent year received the first dose of hepatitis B vaccine within 24 hours of birth? Nationally, what percentage of one-year-olds (ages 12–23 months) in a given recent year received three doses of hepatitis B vaccine?</td>
<td>67.1%</td>
<td>10.5%</td>
<td>22.4%</td>
<td>0%</td>
</tr>
<tr>
<td>4.4</td>
<td>Is there a national policy specifically targeting mother-to-child transmission of hepatitis B?</td>
<td>68.4%</td>
<td>19.7%</td>
<td>11.8%</td>
<td>0%</td>
</tr>
<tr>
<td>4.5</td>
<td>Is there a specific national strategy and/or policy/guidelines for preventing hepatitis B and hepatitis C infection in health care settings? If yes, are health workers vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood?</td>
<td>75.0%</td>
<td>13.2%</td>
<td>10.5%</td>
<td>1.3%</td>
</tr>
<tr>
<td>4.6</td>
<td>Is there a national policy on injection safety in health care settings? If yes, what type of syringes does the policy recommend for therapeutic injections? Are single-use or auto-disable syringes, needles and cannulas always available in all health care facilities?</td>
<td>77.6%</td>
<td>79%</td>
<td>14.5%</td>
<td>0%</td>
</tr>
<tr>
<td>4.7</td>
<td>What are your government’s official estimates of the number and percentage of unnecessary injections administered annually in health care settings? (e.g., injections given when an equivalent oral medication is available)</td>
<td>60.8%</td>
<td>6.6%</td>
<td>27.6%</td>
<td>0%</td>
</tr>
<tr>
<td>4.8</td>
<td>Is there a national infection control policy for blood banks? Are all donated blood units (including family donations) and blood products nationwide screened for hepatitis B and hepatitis C?</td>
<td>84.2%</td>
<td>6.6%</td>
<td>79%</td>
<td>1.3%</td>
</tr>
<tr>
<td>4.9</td>
<td>Is there a national policy relating to the prevention of viral hepatitis among people who inject drugs?</td>
<td>65.8%</td>
<td>18.4%</td>
<td>14.5%</td>
<td>1.3%</td>
</tr>
<tr>
<td>4.10</td>
<td>Does your government have guidelines addressing how hepatitis A and hepatitis E can be prevented through food and water safety?</td>
<td>68.4%</td>
<td>15.8%</td>
<td>14.5%</td>
<td>1.3%</td>
</tr>
</tbody>
</table>
Table 5. Screening, care and treatment: how civil society organisations responded to hepatitis policy information provided by their governments

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Question(s) addressed by governments for 2013 WHO global policy report</th>
<th>Response chosen by civil society survey respondent (N=76)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To our knowledge, this information is accurate (%)</td>
<td>To our knowledge, this information is not accurate (%)</td>
</tr>
<tr>
<td>5.1</td>
<td>How do health professionals in your country obtain the skills and competencies required to effectively care for people with viral hepatitis? Are there national clinical guidelines for the management of viral hepatitis? If yes, do they include recommendations for cases of HIV co-infection? If no, are there national clinical guidelines for the management of HIV that include recommendations for coinfection with viral hepatitis?</td>
<td>67.1%</td>
</tr>
<tr>
<td>5.2</td>
<td>Does your government have a national policy relating to screening and referral to care for hepatitis B? For hepatitis C?</td>
<td>71.1%</td>
</tr>
<tr>
<td>5.3</td>
<td>When testing for hepatitis B and hepatitis C in your country, do people register by name? If people register by name, are their names kept confidential within the system, or is there open access? Is the test free of charge for all individuals? Is the test free of charge for members of any specific groups? Is the test compulsory for members of any specific groups?</td>
<td>65.8%</td>
</tr>
<tr>
<td>5.4</td>
<td>Is publicly funded treatment available for hepatitis B? If yes, who is eligible? Is publicly funded treatment available for hepatitis C? If yes, who is eligible? How much is spent by the government on publicly funded treatment for hepatitis B and hepatitis C?</td>
<td>68.4%</td>
</tr>
<tr>
<td>5.5</td>
<td>Which hepatitis B and hepatitis C drugs are included on the national essential medicines list or are subsidised by the government?</td>
<td>75.0%</td>
</tr>
</tbody>
</table>
Hepatitis

The Sixty-seventh World Health Assembly,

Having considered the report on hepatitis; 1

Reaffirming resolution WHA 63.18, adopted in 2010 by the World Health Assembly, which recognized viral hepatitis as a global public health problem and the need for governments and populations to take action to prevent, diagnose and treat viral hepatitis, and that called upon WHO to develop and implement a comprehensive global strategy to support these efforts, and expressing concern at the slow pace of implementation;

Recalling also resolution WHA 45.17 on immunisation and vaccine quality, which urged Member States to include hepatitis B vaccines in national immunisation programmes, and expressing concern that currently the global hepatitis B vaccine coverage for infants is estimated at 79% and is therefore below the 90% global target;

Recalling further resolution WHA 61.21, which adopted the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property;

Noting with deep concern that viral hepatitis is now responsible for 1.4 million deaths every year (compared to 1.6 million deaths from HIV/AIDS, 1.3 million deaths from tuberculosis and 600,000 deaths from malaria), that around 500 million people are currently living with viral hepatitis and some 2000 million have been infected with hepatitis B virus, and considering that most people with chronic hepatitis B or C are unaware of their infection and are at serious risk of developing cirrhosis or liver cancer, contributing to global increases in both of those chronic diseases;

Also noting that millions of acute infections with hepatitis A virus and hepatitis E virus occur annually and result in tens of thousands of deaths almost exclusively in lower- and middle-income countries;

Considering that while hepatitis C is not preventable by vaccination, current treatment regimens offer high cure rates that are expected to further improve with upcoming new treatments; and that although hepatitis B is preventable with a safe and effective vaccine, there are 240 million people living with hepatitis B virus infection and available effective therapies could prevent cirrhosis and liver cancer among many of those infected;

Expressing concern that preventive measures are not universally implemented and that equitable access to and availability of quality, effective, affordable and safe diagnostics and treatment regimens for both hepatitis B and C are lacking in many parts of the world, particularly in developing countries;

Recognizing the role of health promotion and prevention in the fight against viral hepatitis, and emphasizing the importance of strengthening vaccination strategies as high impact and cost-effective actions for public health;

Noting with concern that globally the birth dose coverage rate with hepatitis B vaccine remains unacceptably low;

Acknowledging also that, in Asia and Africa, hepatitis A and E continue to cause major outbreaks while a safe effective hepatitis A vaccine has been available for nearly two decades, that hepatitis E vaccine candidates have been developed but not yet certified by WHO, that lack of basic hygiene and sanitation promotes the risks of hepatitis A virus and hepatitis E virus transmission and that most vulnerable populations do not have that access to those vaccines;

Taking into account the fact that injection overuse and unsafe practices account for a substantial burden of death and disability worldwide, with an estimated 1.7 million hepatitis B virus infections and 320,000 hepatitis C virus infections in 2010;

Recognizing the need for safe blood to be available to blood recipients, as established by resolution WHA 28.72 on utilization and supply of human blood and blood products, in which the Health Assembly recommended the development of national public services for blood donation, and in resolution WHA 58.13, in which the Health Assembly agreed to the establishment of an annual World Blood Donor Day, considering that one of the main routes of transmission of hepatitis B virus and hepatitis C virus is parenteral;

Further recognizing the need to strengthen health systems and integrate collaborative approaches and synergies between prevention and control measures for viral hepatitis and those for infectious diseases such as HIV and other related sexually transmitted and bloodborne infections and other mother-to-child transmitted diseases, as well as for cancer and noncommunicable disease programmes;

Noting that hepatitis B virus, and particularly hepatitis C virus, disproportionally impact people who inject drugs around the world, an estimated 16 million people who inject drugs around the world, an estimated 10 million are living with hepatitis C virus infection and 1.2 million are living with hepatitis B virus infection;

Recalling United Nations General Assembly resolution 65/277 paragraph 59(h) which recommends “giving consideration, as appropriate, to implementing and expanding risk- and harm-
reduction programmes, taking into account the WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug User in accordance with national legislation, as important components of both hepatitis B and hepatitis C prevention, diagnosis and treatment programmes and that access to these remain limited or absent in many countries that have a high burden of infection with hepatitis B virus and hepatitis C virus;

Cognizant of the fact that 4–5 million people living with HIV are coinfected with hepatitis C virus and more than 3 million are coinfected with hepatitis B virus, which has become a major cause of disability and mortality among those receiving antiretroviral therapy;

Taking into account the fact that viral hepatitis is a major problem within indigenous communities in some countries;

Welcoming the development by WHO of a global strategy, within a health systems approach, on the prevention and control of viral hepatitis infection;

Considering that most Member States lack adequate surveillance systems for viral hepatitis to enable them to take evidence-based policy decisions;

Taking into account that a periodic evaluation of implementation of the WHO strategy is crucial to monitoring the global response to viral hepatitis and the fact that the process was initiated with the publication in 2013 of the Global policy report on the prevention and control of viral hepatitis in WHO Member States;

Acknowledgeing the need to reduce liver cancer mortality rates and that viral hepatitis is responsible for 78% of cases of primary liver cancer, and welcoming the inclusion of an indicator on hepatitis B virus and hepatitis C virus in the comprehensive global monitoring framework adopted in resolution WHA 66.10 on the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases;

Acknowledging the need to fight and to eliminate stigmatization of, and discrimination against, people living with or affected by viral hepatitis and determined to protect and safeguard their human rights,

1. **URGES Member States:**

   1. to develop and implement coordinated multisectoral national strategies for preventing, diagnosing, and treating viral hepatitis based on the local epidemiological context;
   2. to enhance actions related to health promotion and prevention of viral hepatitis, while stimulating and strengthening immunisation strategies, including for hepatitis A, based on the local epidemiological context;
   3. to promote the involvement of civil society in all aspects of preventing, diagnosing and treating viral hepatitis;
   4. to put in place an adequate surveillance system for viral hepatitis in order to support decision-making on evidence-based policy;
   5. to strengthen the system for collection of blood from low-risk, voluntary, non-remunerated donors, for quality-assured screening of all donated blood to avoid transmission of HIV, hepatitis B, hepatitis C and syphilis, and for good transfusion practices to ensure patient safety;
   6. to strengthen the system for quality-assured screening of all donors of tissues and organs to avoid transmission of HIV, hepatitis B, hepatitis C and syphilis;
   7. to reduce the prevalence of chronic hepatitis B infection as proposed by WHO regional committees, in particular by enhancing efforts to prevent perinatal transmission through the delivery of the birth dose of hepatitis B vaccine;
   8. to strengthen measures for the prevention of hepatitis A and E, in particular the promotion of food and drinking water safety and hygiene;
   9. to strengthen infection control in health care settings through all necessary measures to prevent the reuse of equipment designed only for single use, and cleaning and either high-level disinfection or sterilization, as appropriate, of multi-use equipment;
   10. to include hepatitis B vaccine for infants, where appropriate, in national immunisation programmes, working towards full coverage;
   11. to make special provision in policies for equitable access to prevention, diagnosis and treatment for populations affected by viral hepatitis, particularly indigenous people, migrants and vulnerable groups, where applicable;
   12. to consider, as necessary, national legislative mechanisms for the use of the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights in order to promote access to specific pharmaceutical products;
   13. to consider, whenever necessary, the use of administrative and legal means in order to promote access to preventive, diagnostic and treatment technologies against viral hepatitis;
   14. to implement comprehensive hepatitis prevention, diagnosis and treatment programmes for people who inject drugs, including the nine core interventions, as appropriate, in line with the WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, and in line with the global health sector strategy on HIV/AIDS, 2011–2015, and the United Nations General Assembly resolution 65/277, taking into account the domestic context, legislation and jurisdictional responsibilities;
   15. to aim to transition by 2017 to the exclusive use, where appropriate, of WHO prequalified or equivalent safety-engineered injection devices including reuse-prevention syringes and sharp injury prevention devices for therapeutic injections and develop related national policies;
16. to review, as appropriate, policies, procedures and practices associated with stigmatization and discrimination, including the denial of employment, training and education, as well as travel restrictions, against people living with and affected by viral hepatitis, or impairing their full enjoyment of the highest attainable standard of health;

2. CALLS upon all relevant United Nations funds, programmes, specialized agencies and other stakeholders:

1. to include prevention, diagnosis and treatment of viral hepatitis in their respective work programmes and work in close collaboration;
2. to identify and disseminate mechanisms to support countries in the provision of sustainable funding for the prevention, diagnosis and treatment of viral hepatitis;

3. REQUESTS the Director-General:

1. to provide the necessary technical support to enable Member States to develop robust national viral hepatitis prevention, diagnosis and treatment strategies with time-bound goals;
2. to develop specific guidelines on adequate, effective and affordable algorithms for diagnosis in developing countries;
3. in consultation with Member States, to develop a system for regular monitoring and reporting on the progress in viral hepatitis prevention, diagnosis and treatment;
4. to provide technical guidance on cost-effective ways to integrate the prevention, testing, care and treatment of viral hepatitis into existing health care systems and make best use of existing infrastructure and strategies;
5. to work with national authorities, upon their request, to promote comprehensive and equitable access to prevention, diagnosis and treatment of viral hepatitis, with particular attention to needle and syringe programmes and opioid substitution therapy or other evidence-based treatments for people who inject drugs, in national plans, taking into consideration national policy context and procedures and to support countries, upon request, to implement these measures;

6. to provide technical guidance on prevention of transfusion-transmitted hepatitis B and C through safe donation from low-risk, voluntary, non-remunerated donors, counselling, referral and treatment of infected donors, and effective blood screening;
7. to examine the feasibility of and strategies needed for the elimination of hepatitis B and hepatitis C, with a view to potentially setting global targets;
8. to estimate global, regional and domestic economic impact and burden of viral hepatitis in collaboration with Member States and relevant organizations, taking into due account potential and perceived conflicts of interest;
9. to support Member States with technical assistance in the use of the flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights when needed, in accordance with the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property;
10. to lead a discussion and work with key stakeholders to facilitate equitable access to quality, effective, affordable and safe hepatitis B and C treatments and diagnostics;
11. to assist Member States to ensure equitable access to quality, effective, affordable and safe hepatitis B and C treatments and diagnostics, in particular in developing countries;
12. to maximize synergies between viral hepatitis prevention, diagnosis and treatment programmes and ongoing work to implement the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020;
13. to report to the Sixty-ninth World Health Assembly, or earlier if needed, through the Executive Board, on the implementation of this resolution.

Ninth plenary meeting, 24 May 2014

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1. Document A67/13
6. And, where applicable, regional economic integration organizations.
7. The WTO General Council in its Decision of 30 August 2003 (i.e. on Implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health) decided that “pharmaceutical product means any patented product, or product manufactured through a patented process, of the pharmaceutical sector needed to address the public health problems as recognized in paragraph 1 of the Declaration. It is understood that active ingredients necessary for its manufacture and diagnostic kits needed for its use would be included.”
8. Needle and syringe programmes; opioid substitution therapy and other drug dependence treatment; HIV testing and counselling; antiretroviral therapy; prevention and treatment of sexually transmitted infections; condom programmes for people who inject drugs and their sexual partners; targeted information, education and communication for people who inject drugs and their sexual partners; vaccination, diagnosis and treatment of viral hepatitis; prevention, diagnosis and treatment of tuberculosis.
The World Hepatitis Alliance seeks to highlight civil society perspectives on hepatitis in this 2014 report – the first of its kind. Civil society stakeholders are relative newcomers to the global public health arena, and their roles are still being defined in many intergovernmental and national forums, including those involving the World Health Organization (WHO). To ensure that their voices are heard, the 2014 Global Community Hepatitis Policy Report has been planned as a civil society response to information provided by governments for the 2013 hepatitis policy report published by WHO. That document, the Global Policy Report on the Prevention and Control of Viral Hepatitis in WHO Member States, is a welcome resource, but it only utilises information provided by governments. A full and accurate picture of the policy response to hepatitis at the country level requires additional input from stakeholders with diverse perspectives.

In recent decades, civil society actors have made invaluable contributions to global public health issues. In some ways, they have even helped to shape fundamental public health paradigms. Involvement of such a nature is our only hope for overcoming the immense barriers to viral hepatitis prevention and control.

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