World Hepatitis Alliance

Viral Hepatitis: Global Policy

Foreword

The World Hepatitis Alliance is a non-governmental organisation that represents approximately 280 hepatitis B and hepatitis C patient groups around the world. It is a global voice for the 500 million people worldwide living with chronic viral hepatitis B or C, all of whom are affected by the policies and practices of national governments and international agencies.

This report summarises the results of a study undertaken by the Alliance for the World Health Organization (WHO) across all 193 Member States. It examines their policies and programmes aimed at preventing and controlling viral hepatitis and the areas in which the WHO might assist with this. 135 countries responded to the survey, many of them taking significant amounts of time and trouble to do so, for which the Alliance is very grateful. What was especially impressive was the number of countries that managed to respond even in the middle of wars or other major political upheavals.

The responses reveal widely varying situations from countries that have not yet begun to tackle viral hepatitis to those with comprehensive policies for both hepatitis B and C that are integrated into their health systems. What clearly emerges is the lack of a co-ordinated global strategy.

In a world in which there is so much migration it is hard to see how these two highly prevalent, infectious diseases can be effectively prevented and controlled without a more unified approach. This is a view now widely shared and it is no coincidence that this report is being published exactly one month prior to the start of the 63rd World Health Assembly at which the first comprehensive resolution on viral hepatitis will be discussed.

The resolution, agreed by the WHO Executive Board in January, begins by explicitly acknowledging the 'seriousness of viral hepatitis as a global public health problem'. It calls for a broad range of action across surveillance, awareness, prevention, diagnosis, care and access to treatment. If adopted at the Assembly, it would represent a major step forward in addressing the needs of the one-twelfth of the global population currently infected and preventing the ongoing transmission to millions more every year.

This report provides compelling evidence to support the need for this timely initiative by the Member States of the WHO. It also shows the crucial role that Member States want the WHO to play in order to be able to deliver effectively the actions called for in the resolution.

Charles Gore
President
On behalf of the World Hepatitis Alliance

Executive Summary

Chronic viral hepatitis is highly prevalent globally, with some five hundred million people estimated to be currently infected with hepatitis B or C. These two diseases are the cause of significant global mortality and morbidity with approximately 1 million deaths each year attributable to them and their sequelae, liver disease and primary liver cancer.

This report provides an unprecedented analysis and overview of countries' policies and programmes that determine prevention and control of viral hepatitis. Collected through a survey of Ministries of Health across all WHO Member States, these describe the work already underway, the areas in which further action is needed and where assistance is wanted.

The unambiguous message that emerges from the study is the importance now being given to viral hepatitis on national health agendas. Of the 135 countries that responded to the survey, 80% said that they regard hepatitis B and/or C as an urgent public health issue. In the Western Pacific and Eastern Mediterranean regions the figure was 90% and in Africa closer to 100%. And, overall, the results underscore that, while very effective policy and programming exists in some areas, there is huge variation and in much of the world it is either not yet in place or requires significant strengthening.

Hepatitis prevention and control programmes are multi-faceted and may involve immunisation, blood screening, injection safety, public health awareness and education, sexual health programmes, surveillance, drug and alcohol services, and blood testing and treatment access. Strategic planning and coordination are therefore essential. 70% of countries report having a national strategy for the prevention and control of viral hepatitis and 71% national goals. However, from further detail supplied it is clear that some strategies are more a series of uncoordinated programmes than a cohesive strategic approach. That the majority of countries which do, as well as of those which do not, already have goals in place want help from the WHO developing these suggest that many existing goals do not comprehensively address this issue.

Much progress is being made in protecting the next generation from hepatitis B; vaccination policies are in place in almost every country and almost all of these policies include infants. However, other risk groups are often not covered, particularly in lower income countries. 40% of countries would like assistance with the delivery of vaccination, highlighting the need to widen and strengthen vaccination policies and programmes.

The lack of accurate prevalence data on hepatitis is widely recognised as inhibiting more effective prevention and control at both international and national levels. 82% of countries report having hepatitis B and/or C surveillance measures in place, although the components of these differ considerably; one-third of countries report having no prevalence data available and more than two-thirds request assistance with surveillance.

Access to testing and treatment is very variable and across some regions both are extremely limited. Just two in five people live in countries where testing is accessible to more than half of the population and only 4% of low income countries report that testing is accessible. More than half of the population lives in countries with no provision for free testing and 41% in countries where no government funding exists for treatment of hepatitis B or C. Four out of five low income countries and almost one in three high income countries would welcome assistance to increase access to treatment.

In addition to access to testing, improving diagnosis requires awareness of risks and routes of transmission among those who may have been exposed to hepatitis B or hepatitis C. This is also crucial for prevention. However, government-funded public awareness work is rare. Many innovative examples were provided that show how effective this can be in improving prevention and control of viral hepatitis and some two-thirds of governments would like assistance in initiating or improving awareness raising activities in future, including the majority of those that report having already undertaken some.

The diverse components required for effective prevention and control mean that effective programming can be very complex. Although challenging, this complexity also offers opportunities both to integrate viral hepatitis into existing programmes and to introduce new policies that may positively impact other high priority public health issues such as HIV/AIDS and intravenous drug use, therefore serving to strengthen the health system as a whole.

In light of the many dimensions to prevention and control, it is perhaps not surprising that the majority of governments do not choose to tackle hepatitis alone: almost three quarters report collaborating with non-state organisations. Of the 60 countries that gave details on this, 44 report working with the WHO and more than 9 out of 10 would like further assistance. This underlines the importance of the WHO's technical expertise to an effective global response to viral hepatitis.

This report clearly shows the disparities that currently exist across the world and therefore how much work needs to be done to begin addressing viral hepatitis in a coordinated global manner. It also shows, however, that there is widespread agreement on the need to start this process and that the political will exists for this to be done.

Glossary

AFRO	Africa Regional Office of the WHO
AIDS	Acquired Immune Deficiency Syndrome
CBO	Community-Based Organization
CDC	Centre for Disease Control
DALY	Disability-Adjusted Life Year
DTP-HepB	Diphtheria, Tetanus, Pertussis, Hepatitis B vaccine
DTP-HepB-Hib	Diphtheria, Tetanus, Pertussis, Hepatitis B, Haemophilus influenzae type B vaccine
EMRO	Eastern Mediterranean Regional Office of the WHO
EPI	Expanded Programme on Immunisation
EURO	Europe Regional Office of the WHO
GAVI	The Global Alliance for Vaccines and Immunisation
GDP	Gross Domestic Product
GNI	Gross National Income
GUM	Genito-Urinary Medicine
HBIG	Hepatitis B Immune Globulin
HBeAg	Hepatitis B 'e' Antigen
HBsAg	Hepatitis B surface Antigen
HBV	Hepatitis B Virus
HCC	Hepatocellular Carcinoma
HCV	Hepatitis C Virus
HCW	Healthcare Worker
HepB	Hepatitis B vaccine
HIV	Human Immunodeficiency Virus
HLE	Healthy Life Expectancy
IDU	Injecting Drug User
JICA	Japan International Cooperation Agency
MoH	Ministry of Health
MSM	Men who have Sex with Men
NIP	National Immunisation Programme
NGO	Non-Governmental Organisation
PAHO	Pan-American Health Organization (Americas Regional Office of the WHO)
PEP	Post-Exposure Prophylaxis
PH	Public Health
SEARO	South-East Asia Regional Office of the WHO
STI	Sexually Transmitted Infection
UN	United Nations
UNAIDS	United Nations program on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
WHO	World Health Organization
WPRO	Western Pacific Regional Office of the WHO

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Introduction

Chronic viral hepatitis is highly prevalent globally, with some five hundred million people estimated to be currently infected with hepatitis B or C. These two diseases are the cause of significant global mortality and morbidity and approximately 1 million deaths each year are attributable to them and their sequelae, liver disease and primary liver cancer. Although not spread homogenously throughout the world, hepatitis B and C are an important challenge in all regions. Furthermore, since these diseases are infectious and since in some areas there is considerable migration between high and low endemic countries, control and prevention of viral hepatitis is important nationally, regionally and globally.

Surveillance of viral hepatitis varies widely from country to country and is generally inadequate. However, it is accepted that the highest rates of hepatitis B are found in South-East Asia, Sub-Saharan Africa and parts of the Pacific Basin and Amazon Basin.[1] Here 70-90% of the population will be infected by the time they are 40 and many are infected under the age of five, which brings a much higher likelihood of developing chronic infection, liver cancer and cirrhosis. In Western and Northern Europe, North America, some parts of South America and in Australia prevalence rates overall are believed low. Prevalence of hepatitis C also varies across the world and is estimated to be highest in Africa and the Middle East and, again, lowest in much of Western Europe and the Americas.[2] The proportion of people with hepatitis B and hepatitis C can vary considerably between, and within, countries and therefore, even in areas of low overall prevalence, rates in certain sub-populations can be very high.[3]

Both hepatitis B and hepatitis C are efficiently transmitted through contact with infected blood and can survive for prolonged periods outside the body. Hepatitis B can remain infectious even in dried blood for several weeks[4] and hepatitis C for up to 16 hours on environmental surfaces and up to 4 days' in blood samples.[5] The screening of blood for transfusion and use of sterile medical and injecting equipment are of particular importance to the prevention of hepatitis B and C as well as other infections in healthcare settings.

Blood transfusions were until recently a significant route of transmission. While improved screening techniques have substantively reduced transmission through blood transfusions, many do still occur and an estimated 6 million units of donated blood were not screened for hepatitis B or C (or HIV or syphilis) in 2000-2001.[6]

The use of unsterile syringes and needles accounts for an estimated 23 million new hepatitis B and hepatitis C infections worldwide each year.[7] 6.7 billion unsafe injections are estimated to be administered annually in low income countries; the highest rates of needle re-use have been found in the Eastern Mediterranean, South-East Asia and Western Pacific regions and many of these injections are not medically necessary.[8] Use of auto-disable syringes, which cannot be reused, is increasing and 62% of non-industrialised countries used these in routine immunisation programmes in 2004, a 20% increase on 2001.[9] Significant progress remains to be made, however; only 38% of these countries exclusively used auto-disable syringes for routine immunisation in 2004 and adoption outside of immunisation programmes remains low.[10]

Unsafe injecting practices among intravenous drug users (IDUs) are also a major contributor to the global incidence of hepatitis B and C and are associated with most hepatitis C infections in developed and transition economies.[11] They are transmissible through the sharing of needles as well as injecting paraphernalia and hepatitis C prevalence rates of up to 96% have been found in IDU populations even in countries with prevalence rates under 2% overall.[12]

The most effective method of prevention for hepatitis B is vaccination; no vaccine exists for hepatitis C. Vaccines for hepatitis B have been available for almost thirty years. Although initially these were expensive and adoption was slow, to date 88% of WHO Member States have introduced the vaccine for at least some of their population.[13] Infant vaccination programmes, the most widespread approach, are protecting the next generation from hepatitis B. This still leaves many people exposed to hepatitis infection. As hepatitis B can be transmitted through body fluids other than blood, high risk groups include the family and partners of people with hepatitis B, sex workers and victims of sexual assault as well as healthcare workers, IDUs and others likely to be exposed to blood and blood products.

Whereas infection with hepatitis C usually becomes chronic, whether this happens with hepatitis B infection is dependent on the age at which the infection occurs: the younger a person is infected, the more likely the infection will become chronic, while adults generally clear the virus after a period of acute infection. Deaths from acute hepatitis are relatively rare. The majority, at least 90%, of the morbidity and mortality associated with hepatitis B and C are manifested in conditions, particularly primary liver cancer and cirrhosis, that develop slowly during chronic infection. More than one in every forty deaths worldwide is caused by these two conditions, and the great majority of these result from hepatitis B or C infection.[14] Globally, 57% of cirrhosis and 78% of primary liver cancer is attributed to hepatitis B and C infections.[15] Hepatitis B causes 30% of cirrhosis and 53% of primary liver cancer and hepatitis C 27% of cirrhosis and 25% of primary liver cancer.

Treatment has been shown to be highly effective but is currently of limited availability in many parts of the world.[16] Effective treatment and management of chronic infection can substantially reduce or eliminate much of the morbidity and mortality that result from hepatitis B and C infections. HIV/AIDS co-infection and alcohol consumption are both believed to increase the likelihood of the development of liver cancer and cirrhosis in people with chronic viral hepatitis. Of the at least 33 million people estimated to have HIV/AIDS worldwide, 2-4 million are estimated to be co-infected with hepatitis B and another 4-5 million with hepatitis C.[17] Alcohol use is a growing global public health problem and a leading risk factor in global morbidity.[18] Some areas, such as parts of Eastern Europe and Africa, see high levels of alcohol consumption, viral hepatitis infection and HIV /AIDS in the same geographical area, although to date little research has examined the impact of the three together.

Awareness of viral hepatitis is low. This is important because knowledge of the risks and routes of transmission is essential to prevent continuing transmission. This is particularly relevant for hepatitis B and C, which are often asymptomatic for many years

Introduction

with the result that globally the majority of those infected are undiagnosed. Not only does this increase the likelihood that they will unwittingly infect others; in preventing them from accessing treatment or making lifestyle changes such as moderating alcohol intake, this greatly contributes to the significant global mortality and morbidity that result from hepatitis B and hepatitis C.

Effective control and prevention is often complex, requiring a variety of components including immunisation programmes, blood screening, injection and needle safety, services for intravenous drug users, public health awareness and education programmes, sexual health programmes, disease surveillance, and blood testing and treatment access. This may be one of the reasons that aggregate information on viral hepatitis policies is scarce at national and, even more so, at international level.

This research project was initiated in 2009 in order to map existing national government policies and programmes for viral hepatitis as well as to determine those areas where governments would like technical assistance from the WHO. The data generated provide an overall view of what is currently in place, together with gaps and needs, and thus will be able to inform planning at regional and global level, as well as providing governments with useful insights into how viral hepatitis can be addressed in different contexts. Additionally, drawing together data on the many elements necessary for effective control and prevention offers opportunities to ensure that interventions are coordinated and integrated so as to strengthen health systems overall.

This report provides an overview of the main dimensions of countries' viral hepatitis prevention and control programmes and policies, summarised at global and regional level and on a per-country basis. The first section sets out the methodology used in the study and the limitations of the data collected. Most prominently this highlights that the data, collected through a survey of governments, have not been validated and that the existence of a policy or programme cannot be taken as testament to its implementation, effectiveness or comprehensiveness. For example, 97% of responding countries have a vaccination policy and yet 40% feel they would benefit from technical assistance from the WHO in vaccination delivery.

Following the description of the methodology used, the responses received are outlined by geographical location and income group. The global and regional analyses then present the data collected under six themes: policy, awareness and education, surveillance, testing, treatment, and care and civil society engagement. The final part of each summary examines the areas in which countries would welcome assistance from the WHO.

The second section provides short descriptive summaries of the information received from each country that provided information to this study. Summaries of the data received from each country are set out according to the same themes used in the global and regional analyses, with the areas identified for WHO assistance separated out for ease of reference. Need as well as resources for the many dimensions of prevention and control for viral hepatitis vary considerably across countries and regions. We have therefore included a short overview of indicative health, economic and hepatitis-related mortality and morbidity data for each country at the beginning of each country profile. These data are provided as relative indicators, intended to provide a degree of context for the data collected in this study and to facilitate comparison, and should not be taken as official figures for the area or country. Accurate and current prevalence data for hepatitis B and hepatitis C is not often available.

[1]Lavanchy, D. Hepatitis B virus epidemiology, disease burden, treatment, and current and emerging prevention and control measures. Journal of Viral Hepatitis, 2004, 11 (2): 97-107

[2]Lavanchy, D. Chronic Viral Hepatitis as a Public Health issue in the World. Best Practice & Research Clinical Gastroenterology, 2008, 22 (6): 991-1008

[3]Ibid.

[4]Alter, M. Epidemiology of viral hepatitis and HIV co-infection. Journal of Hepatology, 2006, 44: S6-S9

[5]Kamili, S, K. Krawczynski, K McCaustland, X Li and M Alter. Infectivity of Hepatitis C virus in plasma after drying and storing at room temperature. Infection Control and Hospital Epidemiology, 2007,28: 519-524

[6]Lavanchy, 2008. op cit..

[7]World Health Organization. Viral Hepatitis: Report by the Secretariat, WHO EB126/15, 2009b

[8]Lavanchy, 2008. op cit..

[9]World Health Organization. Immunization Safety: Accomplishments, 2005 (http://www.who.int/immunization_safety/ispp/ispp_final_report_accomplishments/en/, accessed 22 March 2010)

[10]Ibid.

[11]Shepard, C, L Finelli, and M Alter. Global epidemiology of hepatitis C virus infection. Lancet Infectious Diseases, 2005, 5: 558-67

[12]Lavanchy, 2008. op cit..

[13]World Health Organization. Viral Hepatitis: Report by the Secretariat, WHO EB126/15, 2009b

[14]Ibid

[15]Perz, J.F, G. Armstrong, L Farrington, Y Hutin, B Bell. The contributions of hepatitis B virus and hepatitis C virus infections to cirrhosis and primary liver cancer worldwide. Journal of Hepatology, 2006, 45: 529–538

[16]Shepard, C, L Finelli, and M Alter. Global epidemiology of hepatitis C virus infection. Lancet Infectious Diseases, 2005, 5: 558-67

[17]Alter, 2006, op cit.

[18]World Health Organization. Global Health Risks: Mortality and burden of disease attributable to selected major risks. Geneva, Switzerland, World Health Organization, 2009a

Methodology

This study was conducted from July 2009 to March 2010 by the World Hepatitis Alliance in partnership with the World Health Organization (WHO).

The information used in this report was gathered through a survey of all WHO Member States. The survey was drafted by a project team at the World Hepatitis Alliance in consultation with the WHO. A glossary of working definitions of the terms used in the survey was also developed to be provided alongside it for reference. The survey was piloted across three WHO Member States and the resulting comments and amendments incorporated into the final version.

The study aimed to gather basic information on the policies and programmes that exist across WHO Member States for the prevention and control of hepatitis B and hepatitis C, focusing on government-sponsored education and awareness programmes, screening and testing programmes, disease surveillance, programme monitoring and evaluation and collaboration across sectors and with international and local organisations. While respondents were asked to provide additional comment and documentation wherever possible, the core survey was designed to capture this basic set of data without requiring excessive detail.

Responses to the survey were sought from the identified focal point for viral hepatitis at the Ministry of Health in each WHO Member State. These were identified both through direct communication with Ministries and through WHO international, regional and country offices. Contact was made via WHO offices where appropriate. The survey was made available online as well as in document form and every effort was made to encourage Ministries which did not initially complete the survey to respond. Although the survey was written and distributed in English, responses and supporting documentation were accepted in other languages.

The global, regional and country profiles were developed using the completed survey responses supplemented by any additional detail, comments and documentation received. Policies and strategies provided were examined and their content analysed according to a pre-defined set of variables. These had been identified a priori and agreed by the project team as constituting the major components for each type of policy and strategy. Where documents had been submitted in languages other than English, they were analysed directly from the original by a member of the project team familiar with that language or working with translators.

For analysis, countries have been grouped according to their WHO region and by income group according to the 2009 World Bank Country Classification, based on Gross National Income (GNI). Those countries without this classification were allocated a group based on their GNI for the purposes of this study. Additional data have been included to give an overview of the context in which policy and programme development takes place. These include data on health spends, life expectancy and population, all of which were drawn from the WHO Statistical Information System (WHOSIS) published database using the most recent data available. In addition, estimates of the mortality and morbidity associated with hepatitis B and hepatitis C and their sequelae from the WHO Global Burden of Disease 2004 study have been included.

Limitations

There are a number of limitations to the data collected and produced in the course of this study that should be borne in mind when examining its results.

While the data presented include information reported by the majority of WHO Member States, 58 countries were unable to submit the required data in time. In some cases the lack of any focal point or department which oversees viral hepatitis prevented a survey response from being obtained. Those countries from which no response was received may therefore be those in which less work is underway and as such the results contained in this report may suggest a greater degree of activity in the policy arena than in fact exists globally.

Furthermore, the data included in this study reflect only the extant policies, strategies and programmes at the national level as reported by governments and not their quality or effectiveness or indeed even implementation. It is therefore important to exercise caution in drawing service provision and delivery conclusions from the data included in this report.

Several linguistic and definitional considerations should also be highlighted. The survey being limited to the English language, although mitigated by many WHO country offices that provided assistance to respondents, may have affected both response rates and respondents' thorough and clear understanding of the variables involved. The definitions of many of the terms used in the survey, while addressed for the purposes of the study in the (English-language) glossary, will also vary across different regions and countries and may therefore have been interpreted in different ways.

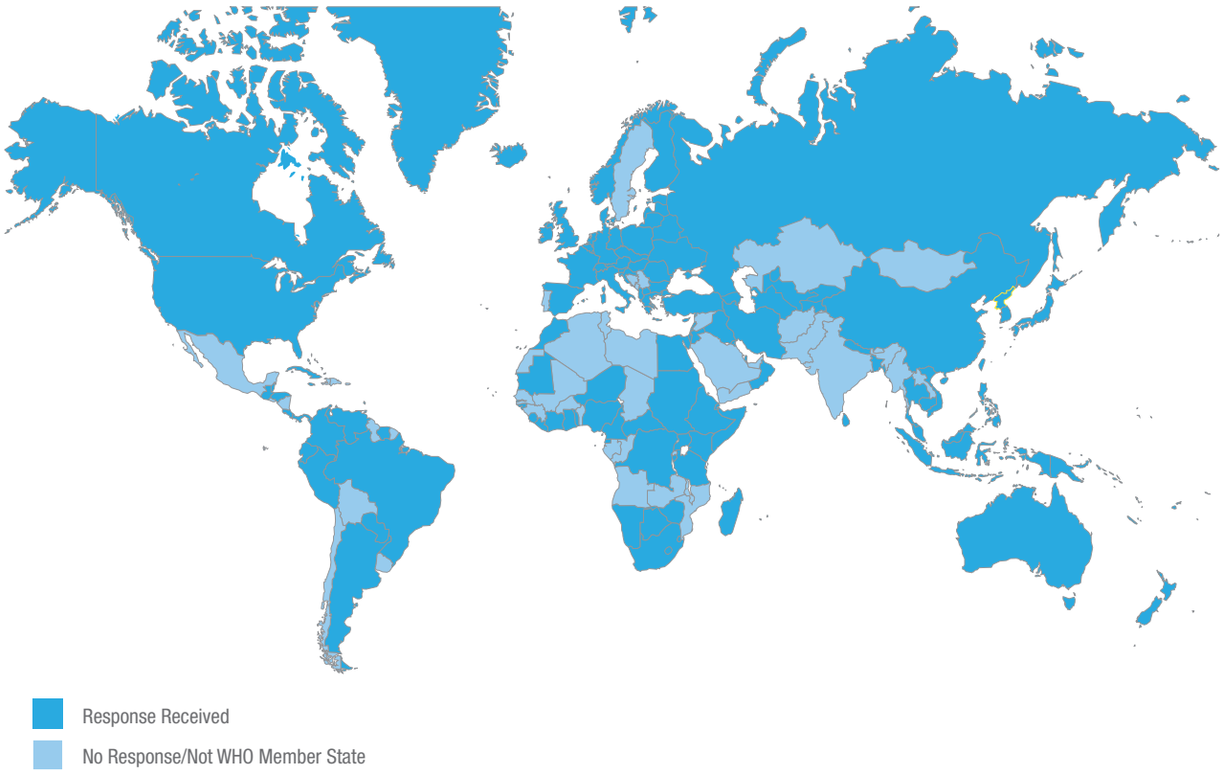
The questions included in the final survey were framed in a way that allowed respondents to answer 'Yes' or 'No' or to select from a few predefined variables. While this may assist with response rates and mitigate difficulties for respondents with limited English language, this approach allows less scope to capture the nuances within each variable. Although further clarification, detail and documentation were sought, these were not always available or provided.

To give an indication of the burden of hepatitis B and hepatitis C and their sequelae and co-factors, the 2004 mortality and morbidity estimates for hepatitis B, hepatitis C, liver cancer and cirrhosis have been included in the report. These were drawn from the WHO Global Burden of Diseases 2004 Update published database. It should be stressed, however, that accurate prevalence data on hepatitis is extremely limited especially in lower income countries and these estimates are therefore very difficult to validate. These data are provided as relative indicators, intended to provide a degree of context for the data collected in this study and to facilitate comparison, and should not be taken as official figures for the area or country. They may in many places not give a full picture of the burden attributable to hepatitis B and hepatitis C. This will be a valuable area for future research and we hope that future editions of the report will benefit from more accurate and comparable epidemiological data as these become available.

Finally, the data included here are those which have been reported by the identified focal point from each country's Ministry of Health. It was not possible to verify the data submitted prior to publication of this report. The documentation has been coded and summarised for ease of inclusion in this report and, although every effort has been made to ensure that all information correctly reflects countries' submissions throughout, it is possible that some inaccuracies have been included. We hope that governments will alert us to these so that they can be corrected in future editions.

Responses

Figure 1. *Map of global responses*



The information contained in this study reflects data gathered from a total of 135 (70%) of the 193 current WHO Member States (associate members, areas and territories were not included in the study). These are presented in the overview sections by WHO region as detailed below and by income group according to their World Bank 2009 country classification.[1] The response rate varied from 84% within the Europe region (including separate entries for England, Northern Ireland, Scotland and Wales) to just 57% in the Americas and Eastern Mediterranean regions. At least 59% of countries responded across each income group.

Table 1. *Cross tabulation of responses received by WHO region and income group*

	High income	Upper middle income	Lower middle income	Low income	**Total: Region**
Africa	1 (100%)	5 (71%)	5 (56%)	19 (66%)	**30 (65%)**
Americas	5 (83%)	10 (53%)	5 (56%)	0 (0%)	**20 (57%)**
Eastern Mediterranean	4 (67%)	1 (50%)	6 (60%)	1 (33%)	**12 (57%)**
Europe	26 (87%)*	8 (62%)	7 (100%)	3 (100%)	**44 (83%)***
South-East Asia**	n/a	n/a	5 (71%)	3 (75 %)**	**8 (72%)**
Western Pacific	6 (100%)	3 (60%)	10 (77%)	2 (67%)	**21 (78%)**
Total: Income group	**42 (86%)**	**27 (59%)**	**38 (69%)**	**28 (65 %)**	**135 (70%)**

*In addition to these separate responses were obtained from England, Northern Ireland, Scotland and Wales for the United Kingdom (counted as one entry); response rate 47/56, 84%.

**Data for the Democratic People's Republic of Korea is included in the South-East Asia Regional overview but not the global overview.

Responses

Member States within each WHO region

African Region

Data Submitted: Botswana, Burundi, Central African Republic, Cameroon, Comoros, Democratic Republic of the Congo, Côte d'Ivoire, Ethiopia, Equatorial Guinea, Eritrea, Gambia, Ghana, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Mauritania, Mauritius, Namibia, Niger, Nigeria, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zimbabwe.

Data not submitted: Algeria, Angola, Benin, Burkina Faso, Cape Verde, Chad, Congo, Gabon, Guinea, Malawi, Mali, Mozambique, Rwanda, Sao Tome and Principe, Senegal, Zambia

Region of the Americas

Data Submitted: Argentina, Bahamas, Barbados, Belize, Brazil, Canada, Colombia, Costa Rica, Cuba, Ecuador, Guatemala, Honduras, Jamaica, Panama, Paraguay, Peru, Suriname, Trinidad and Tobago, United States of America, Venezuela.

Data not submitted: Antigua and Barbuda, Bolivia, Chile, Dominica, Dominican Republic, El Salvador, Grenada, Guyana, Haiti, Mexico, Nicaragua, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Uruguay

Eastern Mediterranean Region

Data Submitted: Bahrain, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Morocco, Oman, Qatar, Somalia, Sudan (North)[1]

Data not submitted: Afghanistan, Djibouti, Libyan Arab Jamahiriya, Pakistan, Saudi Arabia, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen

European Region

Data Submitted: Albania, Andorra, Armenia, Austria, Azerbaijan, Belgium, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Republic of Moldova, Romania, Russian Federation, Slovakia, Slovenia, Spain, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom (England, Northern Ireland, Scotland, Wales)[1], Uzbekistan

Data not submitted: Belarus, Bosnia and Herzegovina, Kazakhstan, Monaco, Montenegro, Portugal, San Marino, Serbia, Sweden

South-East Asia Region

Data Submitted: Bangladesh, Democratic People's Republic of Korea,[1] Indonesia, Maldives, Nepal, Sri Lanka, Thailand, Timor-Leste

Data not submitted: Bhutan, India, Myanmar

Western Pacific Region

Data Submitted: Australia, Brunei Darussalam, Cambodia, China, Cook Islands, Fiji, Japan, Kiribati, Malaysia, Micronesia, Nauru, New Zealand, Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Viet Nam

Data not submitted: Lao People's Democratic Republic, Marshall Islands, Mongolia, Niue, Palau, Vanuatu

[1]While the data submitted by each of the United Kingdom Regions – England, Northern Ireland, Scotland and Wales – are provided in the country profiles, only the data for England are included in the global and regional summary statistics. Respondents in Sudan also initially requested to provide separate submissions for the North and South of the country. Data included here for Sudan reflect only that of the North; a full response was not obtained from the South of the country, although some basic information on the situation there was provided and is included in the country summary. This has been included in the global and regional analyses as well as informing the Sudan country profile. Data for the Democratic People's Republic of Korea was received only in time to include it in the South-East Asia regional summary, and not in the global summary.

Global Results

1. Policy

80% of responding countries report that hepatitis B and/or hepatitis C is considered an urgent public health issue by their government. These account for 91% of the population of responding countries. Almost all Africa region governments report that chronic viral hepatitis is considered an urgent public health issue, as well as more than 90% in the Eastern Mediterranean and Western Pacific. This reflects the regions in which the highest rates of endemicity are believed to occur. More low income (96%) than high income (66%) countries report that hepatitis B and/or hepatitis C is considered an urgent public health issue by their government.

Table 1. *Hepatitis B and/or C considered an urgent public health issue*

	Total countries	% of region
Africa	29	97%
Americas	15	75%
Eastern Mediterranean	11	92%
Europe	28	65%
South-East Asia	4	57%
Western Pacific	19	90%
World	106	80%

(N=133)

Where details were given, a heavy prevalence or incidence of viral hepatitis was often cited as the reason for this, usually in recognition of a particularly high burden of one of both of the viruses and their sequelae. Examples of this prioritisation include the addition of hepatitis B and/or C to official priority disease lists, their status as notifiable diseases and recent policy and programme development and reform.

National strategy

Table 2. *Presence of a national strategy for hepatitis B and/or C*

	Total countries	% of region
Africa	18	60%
Americas	16	80%
Eastern Mediterranean	10	83%
Europe	29	66%
South-East Asia	5	71%
Western Pacific	16	76%
World	94	70%

(N=134)

70% of responding governments, accounting for 87% of the population, report having a 'formulated, official national approach' for the prevention and control of hepatitis B and/or C. It should be noted however that, while the broad working definition used here allowed a greater breadth of data to be gathered, supporting information provided indicate that in a significant number of cases this strategy refers to a series of distinct policies and interventions rather than a unified and comprehensive approach to tackling chronic viral hepatitis.

62% of countries that report having a strategy in place state that there is a designated individual to lead its implementation. This varies markedly, however, from just 40% in South-East Asia and 41% in Europe regions to 75% of countries in the Americas and 100% of countries in the Eastern Mediterranean region. In a total of 12 countries, 21% of those which report having a designated lead, this person is reported to work exclusively on the hepatitis strategy.

Goals

Goals for the prevention and control of hepatitis B and/or C are reported to be present in 71% of countries, ranging from 60% in the Africa region to almost 90% in the South-East Asia region. Where further detail was provided, these goals tend to focus on reducing overall incidence rates for one or both viruses and on increasing hepatitis B vaccination coverage, particularly for infants.

Table 3. *Presence of national goals for prevention and control*

	Total countries	% of region
Africa	18	60%
Americas	14	74%
Eastern Mediterranean	8	67%
Europe	31	70%
South-East Asia	6	86%
Western Pacific	17	81%
World	94	71%

(N=132)

Just 59% of low income countries, accounting for 70% of population, report having goals in place. A total of 76% of lower and 81% of upper middle income countries report goals being in place, as do 67% of high income countries.

National hepatitis B vaccination policy

National hepatitis B vaccination policies are reported to be in place in almost all of the countries included in this study; 97% of countries accounting for 99% of the population. A total of four countries report their being no policy in place; none of these reports having a national strategy, formal goals, or a strategy to prevent infection in healthcare settings in place. Where further detail was provided, the hepatitis B vaccination policy usually constituted part of wider vaccination policies, often within the country's Expanded Programme on Immunisation (EPI).

Global Results

Infant immunisation is included in 95% of policies, the exceptions being four high income countries in the European region and two middle income countries in Africa and South-East Asia regions. Additional information and documentation submitted indicate that in many countries infants are the first target group for immunisation programmes, with adolescent programmes introduced later to increase coverage. This may explain some of the variance in coverage for this group (0-65%). Six of the seven hepatitis B vaccination policies reported in South-East Asia include infants but just two cover any other group, healthcare workers in both instances.

Less than two thirds of countries' hepatitis B vaccination policies are reported to cover healthcare workers and there is considerable divergence between regions, from 29% in South-East Asia and 32% in Africa regions to 90% in the Americas and 100% in the Eastern Mediterranean regions. Less than a quarter of countries include either travellers or military personnel and only half address vaccination for additional risk groups. Where reported, risk groups identified differ substantially. Those most often cited include dialysis patients, drug users, personal contacts of active cases of hepatitis B, non-medical employees working in healthcare settings, emergency services staff and medical and nursing students.

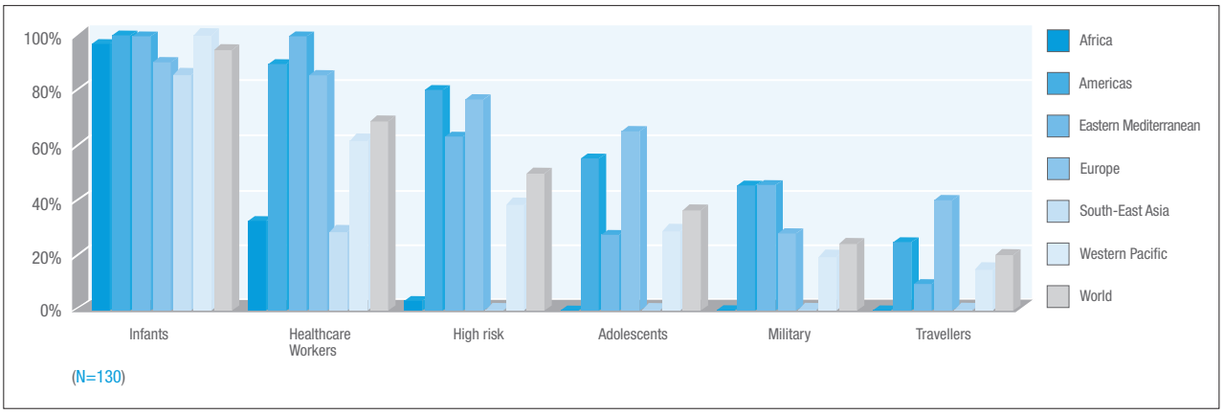
At least 95% of countries in all income groups report having a hepatitis B vaccination policy, although in lower income areas these again rarely cover groups other than infants; just 5 of 26 report including any other group. While 88% of high income countries report including healthcare workers, just 15% of those in low income countries cover this group. Additional risk groups are reported to be included in 85% of high income countries' policies but in just 4% of those in low income countries.

Table 4. *Presence of a hepatitis B vaccination policy*

	Total countries	% of region
Africa	28	93%
Americas	20	100%
Eastern Mediterranean	11	92%
Europe	43	98%
South-East Asia	7	100%
Western Pacific	21	100%
World	130	97%

(N=134)

Figure 1: *Groups covered by hepatitis B vaccination policies*



Global Results

Prevention in healthcare settings

A strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is reported to be in place in 82% of countries. This is considerably lower in the Africa region (66%) than in the Western pacific (90%) or the Eastern Mediterranean (92%) regions and in low income (62%) than in high income (88%) countries.

Table 5. *Presence of strategy to prevent infection in healthcare settings*

	Total countries	% of region
Africa	19	66%
Americas	17	85%
Eastern Mediterranean	11	92%
Europe	37	84%
South-East Asia	6	86%
Western Pacific	18	90%
World	108	82%

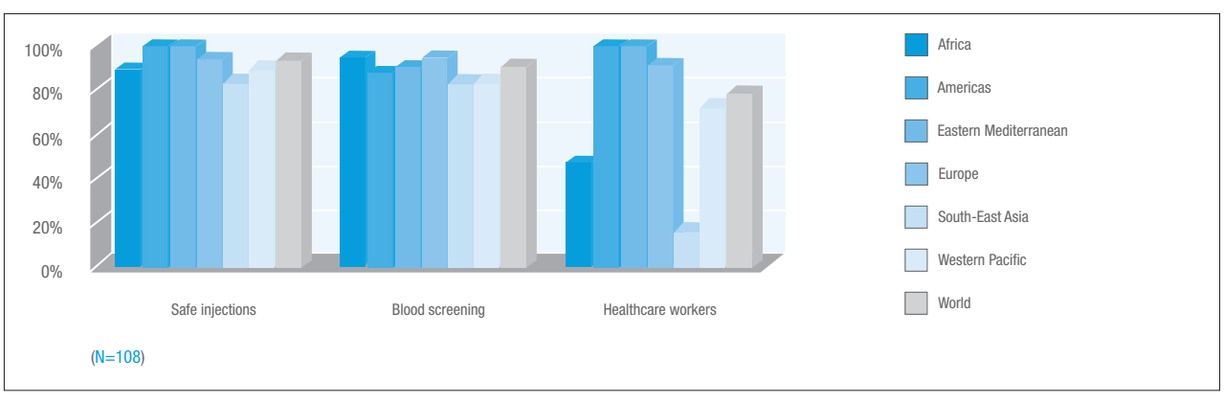
(N=132)

Overall, 94% of strategies are reported to cover safe injections, 91% blood screening and 79% vaccination of healthcare workers. Although 72% include all three components, over 50% in Africa region and over 80% in South-East Asia region do not include healthcare worker vaccination. In several instances injection safety was described only in relation to immunisation programmes and also several countries that report blood screening being in place note that blood is screened in some, but not all, parts of the country or healthcare facilities and/or is dependent upon the availability of testing kits and therefore not consistent practice. Given the high numbers of infections that are believed to occur in healthcare settings across the world, these inconsistencies and limitations may be considerably more widespread than reported.

Policy Development

Half of governments report that they currently consult other countries' policies to identify examples of good practice in the prevention and control of hepatitis B and/or hepatitis C. 91% of countries report that wider accessibility of examples of this would be beneficial to future policy development work.

Figure 2: *Components of strategy to prevent infection in healthcare settings*



(N=108)

2. Public awareness and education

Table 6. *Presence of government-funded public awareness campaigns*

	Total countries	% of region
Africa	7	25%
Americas	7	35%
Eastern Mediterranean	4	36%
Europe	20	45%
South-East Asia	3	43%
Western Pacific	13	62%
World	54	41%

(N=131)

Just 41% of all governments report having funded any public awareness campaign around hepatitis B and/or hepatitis C in the past five years. Only in the Western Pacific has this been done by the majority (62%) of governments. Where detail of these was provided, they have largely been aimed at healthcare workers and at antenatal mothers. Action to reduce the stigmatisation of, and discrimination against, people with hepatitis B and/or hepatitis C is also very rare. This has been undertaken by less than one third of all governments, including just 1 of 28 governments (3%) in the Africa region.

Table 7. *Presence of government action to reduce stigma and discrimination*

	Total countries	% of region
Africa	1	3%
Americas	5	25%
Eastern Mediterranean	5	50%
Europe	16	36%
South-East Asia	2	29%
Western Pacific	13	62%
World	42	32%

(N=131)

The great majority of this activity has taken place outside of low income countries: 81% of low income country governments have not funded any awareness work and 85% have not acted to reduce stigma. Only one low income country, Cambodia, reports having done both. Rates in middle and high income countries, while higher, remain low. An average of 40-50% of middle and high income countries report having funded public awareness work and 30% of middle and 48% of high income countries report having taken action to address stigma and discrimination. Almost half of all countries (61 of 131) report having undertaken neither activity.

Global Results

3. Surveillance

Disease surveillance for hepatitis B and/or hepatitis C is reported to be present in a total of 82% of countries. This ranges from an average of less than 60% in the Africa and South-East Asia regions to 90-100% in the Americas, Europe and the Eastern Mediterranean. Disease surveillance is reported to be present in 100% of high income countries, 89% of upper middle income countries, 74% of lower middle income countries and 58% of low income countries. 69% of the population of low income countries live in areas which report having no provision for the surveillance of hepatitis B or C in any form.

Prevalence estimates do not exist in one third of countries that report having a surveillance system in place. In 17% of countries in the Eastern Mediterranean and European regions no prevalence estimates are available; across Africa region countries this proportion rises to 71%.

Table 8. *Presence of disease surveillance for hepatitis B and/or C*

	Total countries	% of region
Africa	17	59%
Americas	18	90%
Eastern Mediterranean	12	100%
Europe	43	98%
South-East Asia	4	57%
Western Pacific	15	71%
World	109	82%

(N=133)

Of the countries in which disease surveillance is reported to be in place, 90% report there being standardised case definitions for chronic viral hepatitis and these exist in at least three quarters of countries in every WHO region. On average, laboratory confirmation of cases is required prior to reporting in 73% of countries, ranging from just 50% in the South-East Asia region to 86% in the Western Pacific region.

Figure 3: *Proportion of countries with surveillance systems in place in which prevalence estimates are available.*

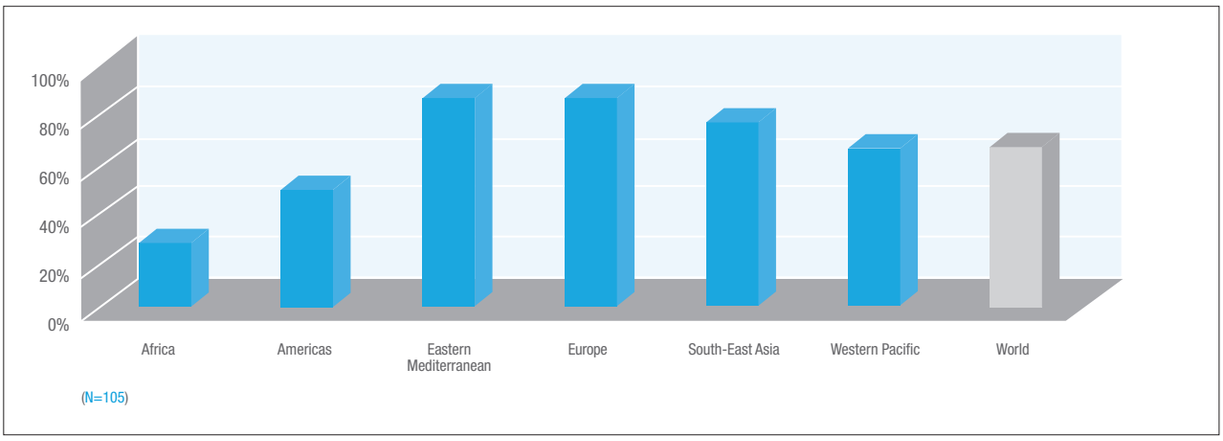
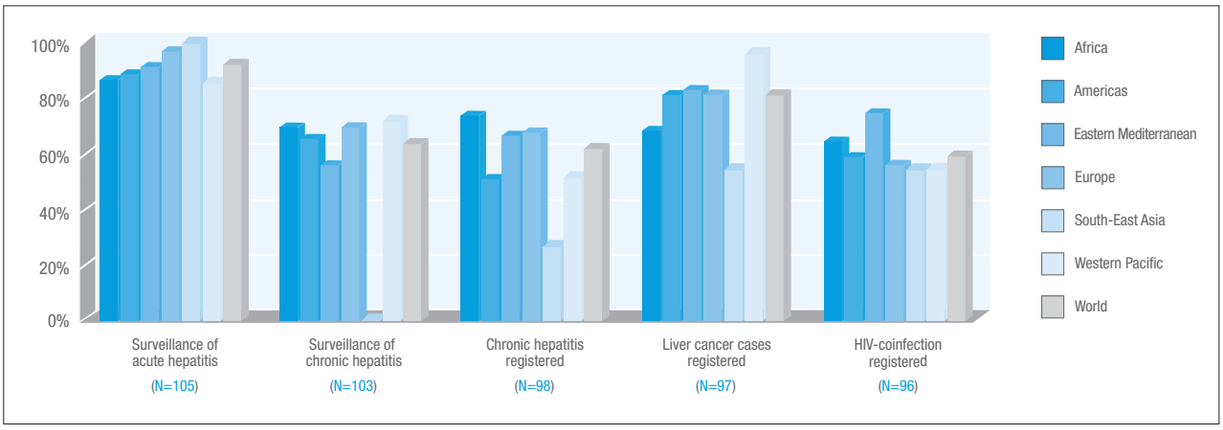


Figure4: *Components of national disease surveillance systems*



Global Results

4. Testing

Table 9. *Availability of testing for hepatitis B and/or C*

	Accessible to >50%		Anonymous/ Confidential		Free to all		Free to some	
	Total countries	% region	Total countries	% region	Total countries	% region	Total countries	% region
Africa	6	20%	12	40%	3	10%	8	27%
Americas	13	68%	9	47%	9	47%	5	26%
Eastern Mediterranean	10	83%	5	42%	4	33%	5	42%
Europe	38	86%	24	55%	12	27%	24	55%
South-East Asia	2	29%	2	29%	2	29%	1	14%
Western Pacific	13	62%	11	52%	10	48%	5	24%
Total	82	62%	63	47%	40	30%	48	36%

(N=133)

The availability of testing for hepatitis B and/or C varies substantially across the world. Significant barriers prevent access to testing for more than half of citizens in 80% of Africa region countries accounting for 89% of the population. This is also the case in 61% of South-East Asia countries accounting for 87% of population and in 38% of Western Pacific countries which also account for 87% of population. Globally 38% of countries, accounting for 59% of the population, report that testing is not accessible.

The accessibility of testing correlates with a country's wealth; 93% of high income, 77% of upper middle income, 53% of lower middle income and 11% of low income countries report that testing is accessible to more than half of the population. 84% of the population of lower middle income and 96% of the population of low income countries lives in areas where testing is reported as not being widely accessible.

Globally, 47% of countries report that testing is available anonymously and/or confidentially in either public or private facilities. This is reported to be available in slightly over half of high and upper middle income economies and in 40% of lower middle and low income economies.

Testing can be accessed free of charge by all citizens in 30% of countries. 66% of governments have some provision for free testing, though this ranges from 86% of high income to just 30% of low income countries. Globally 54% of people, ranging from 3% of the population of high income countries to 82% of that in low income countries, live in areas without any provision for free testing.

Testing is compulsory for some groups in 30% of countries, varying from none of those in the South-East Asia and 13% in the Africa regions to 48% of the Western Pacific and 50% of the Eastern Mediterranean regions. The range of people required to be tested is broad: groups most frequently identified in this area include healthcare workers and students or trainees, blood donors and antenatal mothers. In the majority of cases where testing is compulsory it is also provided free of charge to those groups, although when it is required for non-citizens for visa or immigration purposes this usually must be paid for. In several countries testing is compulsory for foreign nationals in applying for a visa or citizenship and, in some of these, those who test positive are repatriated.

5. Treatment and care

Patient pathway

A designated pathway for screening, diagnosis, referral and treatment is reported to be in place in 59% of countries, ranging from less than 40% in Africa region to 70% in the Western Pacific region. These countries account for 72% of the total population. On average, the presence of a pathway is reported in 33% of low, 60% of middle and 76% of high income countries.

Table 10. *Presence of a patient pathway for screening, diagnosis, referral and treatment*

	Total countries	% of region
Africa	11	37%
Americas	12	63%
Eastern Mediterranean	7	58%
Europe	30	68%
South-East Asia	4	57%
Western Pacific	14	70%
World	78	59%

(N=132)

A number of examples of pathways provided, however, consisted solely of a referral to a hospital or specialist, which may indicate a degree of over reporting of the presence of this.

Government Funding

Governments report that they provide some degree of funding for the treatment of hepatitis B and/or C in 69% of countries. While almost all countries in the Eastern Mediterranean report some provision for treatment costs, less than half those in the Africa region provide this. 41% of the population lives in the 31% of countries with no free treatment provision. On average 83% of high income, 77% of middle and 33% of low income countries report full or part government funding for treatment of hepatitis B and/or hepatitis C.

Table 11. *Presence of total or partial government funding of treatment for hepatitis B and/or C*

	Total countries	% of region
Africa	13	43%
Americas	33	95%
Eastern Mediterranean	18	75%
Europe	9	75%
South-East Asia	4	57%
Western Pacific	15	71%
World	92	69%

(N=133)

Global Results

6. Civil Society

Almost three quarters of governments report working with patient groups, international organisations and/or other non-state bodies in planning and implementing programmes for the prevention and control of hepatitis B and/or C. Of the sixty countries that report working with civil society organisations and provided detail of these, 44 list the WHO among the organisations they currently work with in this area and 18 list the GAVI Alliance, largely in the context of the procurement of vaccines and auto-disable syringes. A wide range of other Community Based Organisations, patient groups and Non-Governmental Organisations (NGOs) and International NGOs are also listed.

Table 12. *Work with non-state sector in programme development and implementation*

	Total countries	% of region
Africa	22	76%
Americas	11	61%
Eastern Mediterranean	11	92%
Europe	27	63%
South-East Asia	5	71%
Western Pacific	18	86%
World	94	72%

(N=130)

91% of countries report at least one area in which WHO assistance would benefit their work in the prevention and control of hepatitis B and/or hepatitis C. A quarter of countries report that WHO assistance would be beneficial in all 6 areas proposed: developing tools to assess the effectiveness of interventions, surveillance, developing goals for prevention and control, awareness raising, increasing access to treatment and delivery of vaccination. Ten European and two Western Pacific region countries did not identify any areas for assistance; all twelve are high income countries.

Overall, five of the six areas proposed for WHO assistance were identified by at least 50% of governments. In many instances governments identify areas for assistance where work is reported to already be underway, as well as where no activity has yet been initiate. This suggests widespread will to begin to tackle viral hepatitis and also to do so more effectively.

The most widely identified area for WHO assistance is in developing tools to assess the effectiveness of interventions, selected by 97 countries (73%).

Assistance with surveillance was identified by 69% of countries, including over 80% of countries in the Americas and Eastern Mediterranean regions and 90% of those in the Africa region. 88% of countries that report having no disease surveillance in place for hepatitis B and/or hepatitis C, and 76% of those that report not having prevalence estimates for their country, identified this area.

Developing goals for the prevention and control of hepatitis B and/or C is identified by two thirds of governments, including more than 80% of countries in the Africa region and over 90% of those in the Eastern Mediterranean region. 74% of countries that report having no goals currently in place identify this area for assistance as well as over 60% of those that do.

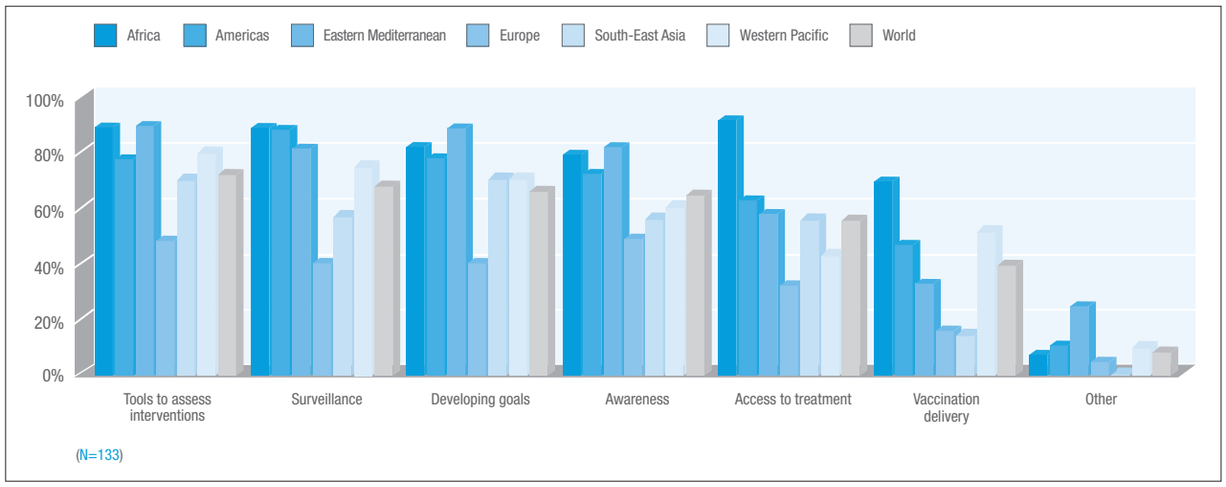
Almost two thirds of countries identify assistance with awareness raising, including 71% of those in which no government-funded awareness work has taken place in the past five years. 72% of governments that have yet to take any action to tackle stigma and discrimination also identify this area for assistance, as well as the majority of countries that report having recently undertaken this activity (57%).

Assistance in improving access to treatment is identified at very varied levels, from 93% of all Africa region countries to 32% of those in the European region. Over 80% of low income countries identify this compared with less than 30% of high income countries. 75% of governments which report testing not being accessible also report that WHO assistance with increasing access to treatment would be beneficial , indicating that in many instances medical services for viral hepatitis overall are limited.

In line with the findings around extant hepatitis B vaccination policies, the least commonly identified area and the only one selected by less than half of respondents is assistance with vaccination delivery. This area is still identified by 40% of countries overall however and 70% of those in the Africa region. Three of the four countries which report not having a hepatitis B vaccination policy in place identify this as an area in which WHO assistance would be beneficial, as well as 39% of those that report their being a vaccination policy in place.

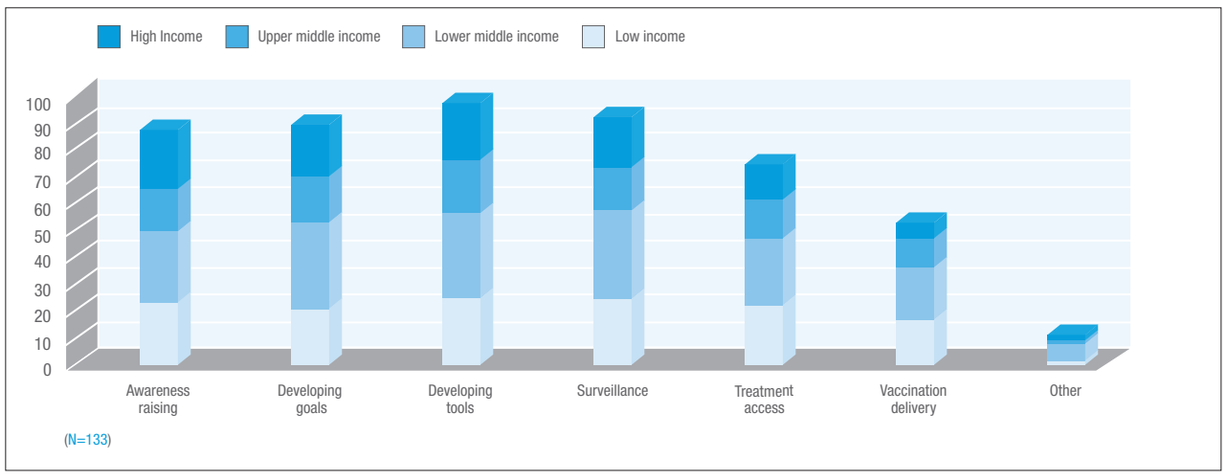
Every area proposed was selected by at least a quarter of countries in every income group, with the exception of increasing access to vaccination (selected by 14% of high income countries).

Figure 5: *Areas identified for WHO Assistance*



Assistance with developing tools for the assessment of interventions is either the most or the second-most widely selected area in every income group. Awareness raising is the most frequently identified area for assistance among high income countries, while in upper middle income areas developing tools to assess the effectiveness of interventions is more widely selected. Lower middle income countries identify surveillance most frequently and, among low income countries, both developing assessment tools and surveillance are identified by 89% of countries.

Figure 6: *Areas for WHO assistance, by number of countries and income group*



African Region

Table 1. *Statistical overview*

	Responding countries	Urgent PH issue	National strategy	National goals	Vaccination Policy HBV	Healthcare Strategy	Awareness	Surveillance	Accessible Testing	Treatment funding
High income	100% (1)	0%	0%	0%	0%	0%	0%	100%	0%	0%
Upper middle income	71% (5)	100%	80%	80%	100%	80%	25%	60%	80%	80%
Lower middle income	56% (5)	100%	80%	80%	80%	80%	60%	40%	0%	60%
Low income	66% (19)	100%	53%	53%	100%	61%	17%	61%	11%	32%
Total	65% (30)	97%	60%	60%	93%	66%	25%	59%	20%	43%

The Africa region has some of the highest prevalence levels for chronic viral hepatitis in the world, with rates of over 8% for hepatitis B and an hepatitis C prevalence that reaches 10% in some areas.[1] Infectious diseases transmissible through blood transfusion are highly prevalent in this region and in 2004 donated blood was not screened in 7% of countries for HIV /AIDS, in 22% of countries for hepatitis B and in 51% of countries for hepatitis C.[2] Inadequately sterilised needles and syringes cause up to 69% of infections in some places.[3] As the highest global prevalence of HIV/AIDS and 60% of global HIV/AIDS transmission occurs in the Africa region hepatitis-HIV/AIDS co-infection is an increasing challenge in many areas.[4]

Horizontal infection in the first five years of life is believed to be a prominent mode of transmission for hepatitis B in Africa, more so than perinatal transmission or that among older children or adults.[5] Infant hepatitis B vaccination programmes have been implemented in almost all of the 46 Africa region countries, 6 in the 1990s and at least 37 since 2000.[6]

Responses were received from 30 of the 46 (65%) Africa region countries, accounting for 77% of the regional population.

Policy

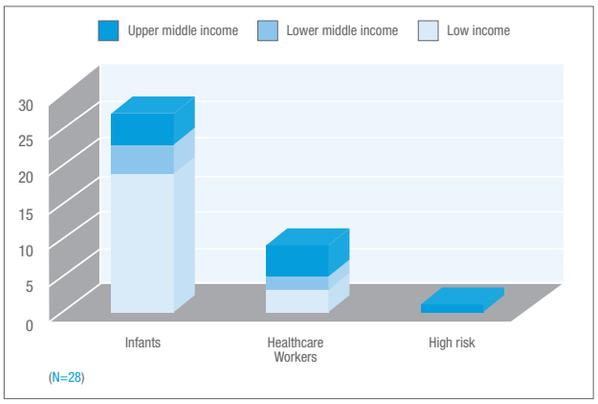
All governments in the region report that they consider hepatitis B and/or C to be an urgent public health issue with the exception of Guinea Bissau, the only high income economy, which also reports having no national strategy, national goals, hepatitis B policy or strategy to prevent infection in healthcare settings in place.

80% of middle income and just over half, 53%, of low income economies report that a national strategy is present. These countries account for 82% of the population, 98% in middle and 72% in low income countries. 56% of countries that report having a strategy in place also report that there is a designated individual to lead on its implementation. This person is not reported to focus exclusively on hepatitis in any country.

Several countries report having a national committee or programme to develop and oversee work in the prevention and control of viral hepatitis. In the Democratic Republic of Congo, for example, the *Programme National de Lutte contre les Hépatites Virales* (national programme to combat viral hepatitis, PNLHV) has been charged with developing policy for the prevention, control and monitoring of viral hepatitis since 2003, although its work has been limited by funding shortfalls. A PNLHV was also established in Côte d'Ivoire in 2008; this programme has developed a combined strategy for the prevention and control of hepatitis B and C in the country which at the time of study was due to be ratified by parliament.

National goals are reported to be in place in 80% of middle income and 53% of low income countries. In Ethiopia goals are not reported to be in place for hepatitis B and/or C, although national goals relating to the prevention of infectious diseases were reported to be under development at the time of study. Of those for which details were provided, the majority focus on increasing vaccination coverage. In addition, reduction of overall prevalence of hepatitis B is a reported goal in the Democratic Republic of Congo; increasing access to treatment and increasing awareness among risk groups are reported in the Côte d'Ivoire; and in the Seychelles goals also aim to improve case detection and disease surveillance.

Figure 1: *Groups covered by hepatitis B vaccination policies, by number of countries and income group*



All upper middle income and low income countries, and 80% of lower middle income countries, report having a hepatitis B vaccination policy in place. 96% of these cover infants and 36% healthcare workers. Just 3 of the 19 low income countries have a hepatitis B vaccination policy that covers healthcare workers. None covers adolescents and the single country to include additional high risk groups is the Seychelles, where vaccination of people with chronic conditions such as HIV/AIDS is also included in national policy.

African Region

Two out of three countries report having a strategy to prevent infection with hepatitis B and/or C in healthcare settings. In Ethiopia at the time of this study a working group formed across government and civil society organisations was revising the existing safety guidelines and training materials and developing a new national Infection Control and Patient Safety strategy as part of wider health sector reforms and restructure. The draft plans include the establishment of an Infection Prevention and Patient Safety Committee in all health facilities in the country.

90% of strategies are reported to cover safe injections and 95% blood screening. Responses received, however, suggest that national implementation of these strategies is incomplete in some countries. In the Central African Republic, for example, blood screening for hepatitis B and C can only be done at one facility in Bangui, the capital city. In line with the findings on hepatitis B vaccination policies, healthcare workers are much less widely included and only rarely in low income countries. Half of the population of responding countries is served by healthcare workers who are not routinely vaccinated.

Testing & Treatment

75% of countries report that no government-funded public awareness activity has taken place in the past five years. Where this has taken place and further detail is provided, these are reported to have been done through targeted information campaigns using printed media, meetings and large scale events. In 2008 the introduction of the hepatitis B vaccine in the Central African Republic EPI was marked with an event to raise awareness of the need for infants to be immunised and to enlist political and religious authorities in promoting the vaccine among their communities.

Just one country, Kenya, reports that work to combat stigma and discrimination against people affected by hepatitis B and/or C has taken place. These activities were undertaken as part of wider work to combat stigma and discrimination around infectious diseases and have been integrated with blood donation campaigns and in work with intravenous drug users.

Surveillance

17 of 29 countries, accounting for 60% of the population, report that routine disease surveillance for hepatitis B and/or C is in place. This does not appear to be implemented uniformly or universally throughout each country, however. In Uganda, for example, some hepatitis surveillance has been trialled in one hospital but the programme was discontinued due to lack of funds for testing equipment and in Tanzania surveillance for hepatitis B is carried out through some, but not all, HIV/AIDS surveillance programmes.

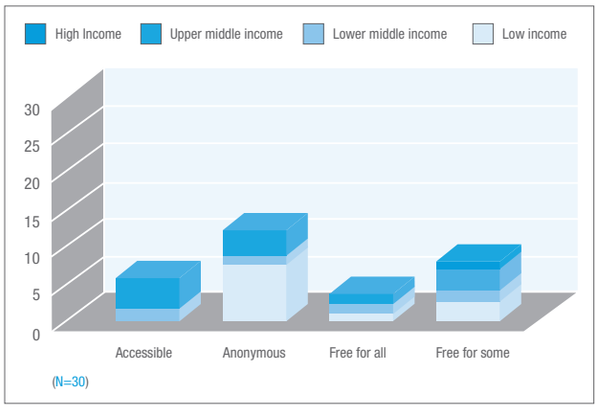
Where surveillance for hepatitis B and/or hepatitis C is reported to be in place, 71% of countries report having standardised case definitions. Clinical cases require laboratory confirmation in 41% of countries, ranging from approximately one third of low income to two thirds of upper middle income economies. Surveillance is reported to exist for acute hepatitis in 76% of countries and for chronic hepatitis in 65%.

Prevalence estimates are reported to exist in just 29% of countries. The reported prevalence of hepatitis B infection is estimated at 8-9% in the Democratic Republic of Congo. In Ghana it is estimated that between 8% and 20% of the adult population have chronic hepatitis B infection. Mauritanian surveillance of pregnant women has found 13% HBsAg, and in South Africa, an area of very high hepatitis B endemicity, more than 75% of adults have evidence of past or current infection. In the Seychelles two cases of hepatitis C were recorded in 2002, both cases of co-infection with HIV/AIDS; 32 new cases were recorded in 2009 and a further 7 in the first month of 2010, all of which were in intravenous drug users.

Public awareness and education

Testing is inaccessible in most of the Africa region. Only 20% of countries report that testing is accessible to more than 50% of their population. This includes just two of the 24 lower middle and low income countries (8%). Several submissions note that tests are available only in facilities in main cities or that accessibility of testing in rural areas is particularly low. Testing is reported to be available anonymously or confidentially in 40% of countries.

Figure 2: *Availability of testing, by number of countries and income group*



Three countries report that testing is provided free of charge to all citizens, and in a further 8 countries it is available free of charge to some groups, including infants, healthcare workers, blood donors, personal contacts of active cases of hepatitis B and people with HIV/AIDS. No free testing provision exists this has taken place and 63% of countries, accounting for 54% of the population. Testing is reported to be compulsory for some groups in 4 countries.

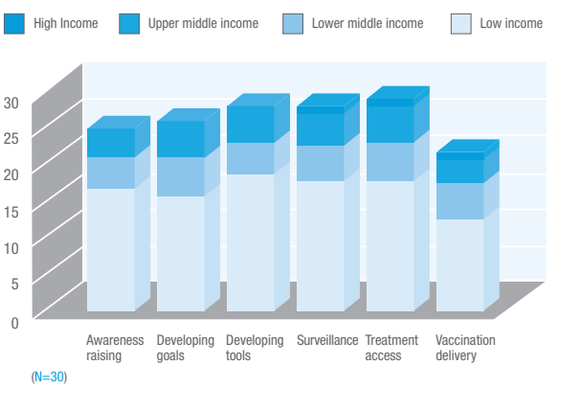
In less than half, 43%, of countries treatment is full or part funded by the government. 37% of countries report that they have a documented patient pathway for screening, diagnosis, referral and treatment.

African Region

Civil Society

More than three quarters of governments report that programmes for the prevention and control of hepatitis B and/or C are developed and implemented in collaboration with international organisations, NGOs, patient groups and other partners.

Figure 3: *Areas identified for WHO Assistance, by number of countries and income group*



Each of the areas proposed for WHO assistance was identified by at least two thirds of countries and all countries identified at least one area for WHO assistance. Fifteen governments (50%) identified all six proposed areas.

Increasing access to treatment was most widely selected, identified by 93% of governments including all of the high, upper middle and lower middle income governments. 96% of governments that report testing not being accessible selected this.

Developing tools for the assessment of interventions was identified by 90% of governments.

Assistance with surveillance was also selected by 90% of governments, including all 12 countries in which there is not currently surveillance in place for hepatitis B or C.

Assistance with developing goals for the prevention and control of hepatitis B and/or C was selected by over 80% of governments overall and by 83% of those that report not currently having goals for the prevention and control of hepatitis B or C.

Raising awareness was identified as an area in which assistance would be appreciated by 80% of countries in total including 81% of those governments that have not yet funded this.

Assistance with vaccination was identified by 70% of governments. Additional areas for assistance were proposed by two countries. These include the development of policy guidelines and training for the prevention and control of chronic viral hepatitis, for example through coordinated regional and international fora, and assistance with advocacy.

[1]Tapko JB, P Mainuka and A Diarra-Nama. Status of blood safety in the WHO African region: Report of the 2004 survey. Brazzaville, World Health Organization Regional Office for Africa, 2009.

[2]Ibid.

[3]World Health Organization Regional Committee for Africa. Patient safety in African health services: Issues and solutions. Report of the Regional Director. AFR/RC58/8, 2008.

[4]Tapko et al. Op cit.

[5]François, G, C Dochez, M Mphahlele, R Burnett, G Van Hal, André Meheus. Hepatitis B vaccination in Africa: mission accomplished? The Southern African Journal of Epidemiology and Infection, 2008, 23 (1): 24-28

[6]Ibid.

Region of the Americas

Table 1. *Statistical overview*

	Responding countries	Urgent PH issue	National strategy	National goals	Vaccination Policy HBV	Healthcare Strategy	Awareness	Surveillance	Accessible Testing	Treatment funding
High income	83% (5)	80%	80%	80%	100%	80%	40%	100%	100%	100%
Upper middle income	53% (10)	80%	80%	60%	100%	80%	30%	90%	60%	89%
Lower middle income	56% (5)	60%	80%	80%	100%	100%	40%	80%	40%	100%
Low income	0% (0)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Total	57% (20)	75%	80%	70%	100%	85%	35%	90%	65%	95%

The prevalence of hepatitis B in the Americas region is estimated as intermediate (2-8%) in Haiti, Domincan Republic, Northern Brazil, Guatemala, Honduras, Colombia, Suriname and Venezuela.[1] Elsewhere it is believed to be low (less than 2%) although in some areas, particularly in the Amazon basin regions of Brazil, Colombia, Venezuela and Peru, it reaches very high levels.[2] Approximately 400,000 new cases of hepatitis B are believed to occur in the region each year.[3] The most recent global estimates for hepatitis C indicate an overall prevalence of 1.7% in the Americas region.[4] This translates to over 15 million infected people. Hepatitis C prevalence among injecting drug users has been found at over 90% in both North and Latin America, with 16-33% co-infected with hepatitis C and HIV/AIDS.[5]

By 2005 hepatitis B vaccine had been included into childhood vaccination schedules in all countries except Haiti and Dominica, neither of which submitted responses to this study.[6]

Full responses were received from 19 of the 35 countries in the Americas region and one partial response, including data on policy, public awareness and surveillance only, was received from Argentina. These twenty countries account for 81% of the regional population.

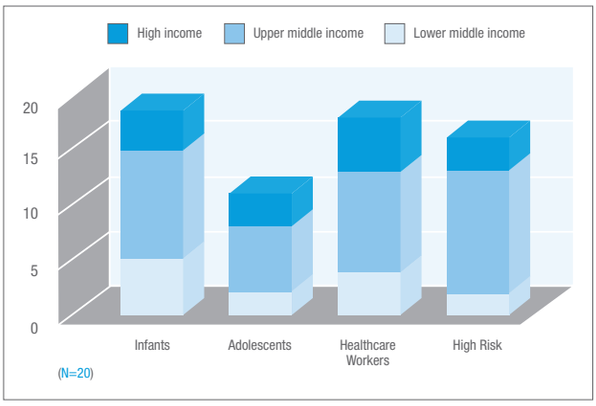
Policy

75% of governments in the Americas region report that they consider hepatitis B and/or hepatitis C to be an urgent public health issue. In Paraguay, while hepatitis prevalence is believed to be low and it is therefore not considered an urgent public health issue at present, much of the infrastructure central to prevention and control are reported to be in place through integration of hepatitis services with priority disease prevention and surveillance systems. In Canada the Hepatitis C Prevention, Support and Research Program was renewed in 2008 with annual funding of over C$10m. This funds interventions aimed at improving population health, decreasing health inequalities and reducing the burden associated with hepatitis C on the health system.

80% of countries in each income group report having a national strategy in place for hepatitis B and/or hepatitis C and there is reported to be a designated individual to lead these strategies, where they are in place, in 12 countries (75%). In five countries (42%) this person works exclusively on the hepatitis strategy.

Goals for the prevention and control of hepatitis B and/or hepatitis C are reported to be in place in 70% of countries. Where specified, the majority of these relate to hepatitis B vaccination coverage, for example in Honduras, Paraguay and Brazil aiming to reach at least 95% of infants and in Ecuador focused specifically on vaccination of infants, children and adolescents in the Amazonian region. Barbados has adopted a wider goal of reducing mortality from all communicable diseases, including hepatitis B and C, to under 5%, although whether this also includes the sequelae such as liver cancer and cirrhosis which account for more than 90% of the mortality associated with hepatitis B and C was not specified.

Figure 1: *Groups covered by hepatitis B vaccination policies, by number of countries and income group*



All countries in the Americas region report having a hepatitis B vaccination policy in place and all of these cover infants. Vaccination of healthcare workers is included in 90% of policies, in 100% of high, 90% of upper middle and 80% of lower middle income countries. Additional high risk groups, which include close contacts of people with hepatitis B, emergency services staff and dialysis patients, are also covered in 80% of countries. 60% of policies include adolescents in high and upper middle income economies and 40% in lower middle economies, military; personnel are included in 50% of policies and travellers in 25%.

Region of the Americas

There are varied programmes and policies in place across the region to increase vaccination coverage. In Trinidad and Tobago, for example, school admission is contingent upon having received certain vaccinations, including hepatitis B, and in Barbados adolescents must be vaccinated prior to entering tertiary education. In Peru the government and UNICEF have jointly developed a vaccination programme targeting remote indigenous populations in the Upper Amazon area. A new cold chain network was implemented and boats were provided to transport healthcare workers and vaccines. This has helped raise the proportion of infants born in the target communities that receive the first dose of hepatitis B vaccine within 24 hours of birth to 82%.[7]

85% of countries report having a strategy in place to prevent infection with hepatitis B and/or hepatitis C in healthcare settings. All of these are reported to cover safe injections and vaccination of healthcare workers and 88% to cover blood screening.

Public awareness and education

Government-funded public awareness campaigns around hepatitis B and/or hepatitis C are reported to have taken place in just 35% of countries. These have been integrated into wider EPI vaccination campaigns aimed at parents of young children and also delivered alongside awareness campaigns around HIV/AIDS and sexual health for health workers, young people and sex workers as well as people who have, are affected by, or are at risk of, hepatitis. At least two of these campaigns have been in collaboration with non-state sector organisations and utilised media including radio, television, newspapers, poster campaigns and events.

Action to combat stigma and discrimination is reported to be less common still, having taken place in only 20% of countries overall. In Brazil this work is undertaken in collaboration with civil society organisations and in Canada combating stigma around hepatitis C is a central feature of the Public Health Agency's Hepatitis C Prevention Support and Research Program strategy.

Surveillance

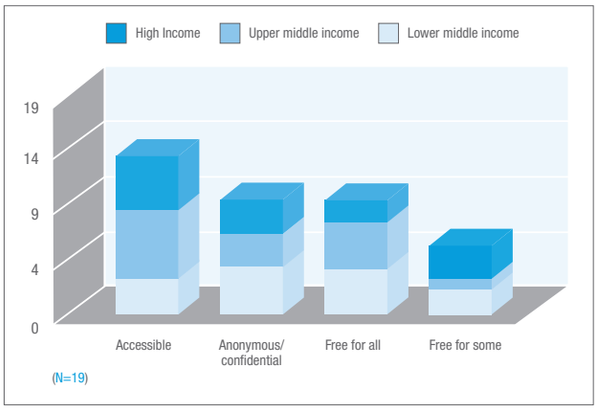
Disease surveillance that includes hepatitis B and/or hepatitis C is reported to be in place in 100% of high, 90% of upper middle and 80% of lower middle income economies. Of the 18 countries in which surveillance is reported to exist, it covers acute hepatitis in 83% of countries and chronic hepatitis in 61%. Chronic hepatitis infections are registered in 44% of countries overall and liver cancer cases in 61%.

Prevalence estimates are reported to exist in nine of the countries (58%) that provided information on this area.[8] Disease reports are published in 72% of countries and prevalence data were provided from three countries. 1,845 cases of hepatitis B were recorded in Colombia in 2009, a 34% increase in detected cases compared to the previous year. In Peru a study in 2000 found between 60% and 90% of haemodialysis patients to have hepatitis C antibodies and a 2006 study found evidence of past hepatitis B infection amongst indigenous populations in the Amazon basin estimated at 60%, with recent infections evident in 1.8% of the study population. An estimated 3,200-5,000 people are infected with hepatitis C each year in Canada; in total 242,500 people have hepatitis C in Canada (2007 data).

Testing & Treatment

Testing for hepatitis B and/or hepatitis C in the Americas region is reported to be available to more than half of the population without significant barriers in all high income countries, in 67% of upper middle and just 40% of lower middle income countries.

Figure 2: *Availability of testing, by number of countries and income group*



Testing is available free of charge to all citizens in 47% of countries and free to some groups in a further 26% of countries. Where additional detail was provided, groups able to access free testing include children, antenatal mothers, prisoners, people with HIV/AIDS, blood, tissue and organ donors and dialysis patients. Five countries have no provision for free testing for any citizens. Compulsory testing for some groups exists in 15% of countries, examples of which include blood donors and prisoners; where this occurs, testing is also reported to be free of charge for these individuals.

A patient pathway is reported to be in place in 63% of countries. As was found in other regions, examples provided included some that consist solely of a referral to hospital or a specialist and as such is it difficult to gauge the extent to which the full process from screening and diagnosis to treatment and care is comprehensively planned.

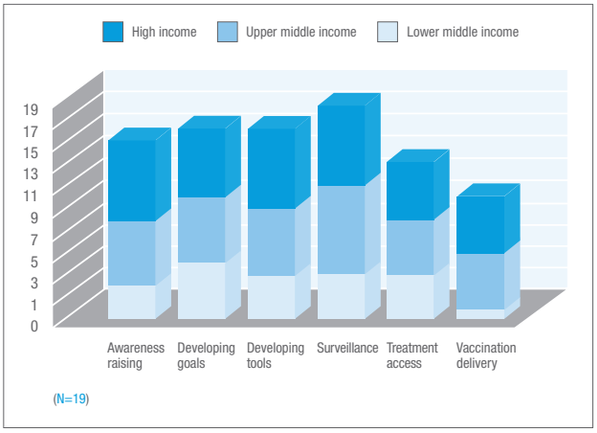
90% of countries, including all those in high and lower middle income economies and 80% of those in upper middle income countries report that treatment is funded or part-funded by the government. In the United States, the government funds care and treatment for hepatitis B and hepatitis C for those co-infected with HIV/AIDS and supports treatment and care for active and former military personnel and federal government employees, their

dependents and those eligible for federally-sponsored health care; the availability of treatments varies across programmes. In Peru, a pilot programme for treating hepatitis B in remote indigenous communities is planned to begin in 2010.

Civil Society

55% of countries report working with civil society organisations, international organisations and/or patient groups in the development and implementation of programmes for hepatitis B and/or hepatitis C.

Figure 3: *Areas identified for WHO Assistance, by number of countries and income group*



All of the 19 countries to provide full survey responses identified at least one area in which WHO assistance would benefit their work in the control and prevention of hepatitis B and/or C; eight countries (42%) identified all six proposed areas.

Assistance with disease surveillance was identified most widely, by 89% of countries, even though the presence of surveillance systems reported overall in this region is relatively high (90%). Sixteen of the seventeen governments that report having a surveillance system in place state that they would appreciate assistance with this, indicating both that those in place may need strengthening and that there is widespread political will to do this.

79% of countries identify a role for the WHO in developing tools for the assessment of interventions and the same proportion in developing goals for the prevention and control of hepatitis B and/or C. This area for assistance is identified equally among those countries that do not currently have goals in place and those that do, which suggests that there is considerable need and will to tackle viral hepatitis more effectively where work is already underway and to initiate this where it is not.

Assistance in raising awareness around hepatitis B and/or hepatitis C is also widely identified, by almost three quarters of the governments. More than half of these countries report not having carried out any government-funded awareness work in the past five years and almost 80% not having acted to tackle stigma and discrimination.

Increasing access to treatment was identified by almost a third of governments, including 80% of those in lower middle income countries.

In line with other regions, assistance with the delivery of vaccination was least frequently identified, although still this was reported by almost half of countries (45%) accounting for 85% of population. Additional areas for assistance were treatment for hepatitis B particularly and the standardisation of molecular tests for viral load.

[1]Dehesa-Violante, M and R Nuñez-Nateras. Epidemiology of Hepatitis Virus B and C. Archives of Medical Research, 2007, 38: 606-611

[2]Ibid.

[3]Ibid.

[4]World Health Organization. Weekly Epidemiological Record. N° 49. World Health Organization. 10 December 1999

[5]Shepard, C, L Finelli, and M Alter. Global epidemiology of hepatitis C virus infection. Lancet Infectious Diseases, 2005, 5: 558-67

[6]Ropero, A M, M Danovaro and JK Holliday, Andrus, Progress in vaccination against hepatitis B in the Americas. Journal of Clinical Virology, 2005, 34: S14-S19

[7]Data submitted; additional information from: UNICEF. UNICEF launches emergency vaccination campaign against hepatitis B in Peru. Geneva, UNICEF, 2003 (http://www.unicef.org/media/media_14757.html, accessed 10 March 2010)

[8]This information was only requested from countries in which surveillance systems are in place; two of these did not state whether prevalence estimates are available.

Eastern Mediterranean Region

Table 1. *Statistical overview*

	Responding countries	Urgent PH issue	National strategy	National goals	Vaccination Policy HBV	Healthcare Strategy	Awareness	Surveillance	Accessible Testing	Treatment funding
High income	66% (4)	75%	100%	75%	100%	100%	0%	100%	100%	100%
Upper middle income	50% (1)	100%	100%	100%	100%	100%	0%	100%	100%	100%
Lower middle income	60% (6)	100%	83%	67%	100%	100%	67%	100%	83%	67%
Low income	33% (1)	100%	0%	0%	0%	0%	0%	100%	0%	0%
Total	57% (12)	92%	83%	67%	92%	92%	36%	100%	83%	75%

The Eastern Mediterranean region has some of the highest prevalence rates for chronic viral hepatitis in the world. The estimated prevalence of chronic hepatitis B infection across Eastern Mediterranean region countries ranges from 2-3% to 7-10% and 4.3 million people are believed to become infected in the region each year.[1] 17 million people are estimated to be chronically infected with hepatitis C in the region and annual incidence is an estimated 800,000 people.[2] Egypt has the highest prevalence rates for hepatitis C in the world, reacing over 25% in some areas.[3] 75% of cirrhosis and hepatocellular carcinoma in the region is believed to be attributable to hepatitis B and C, equating to 60,000 of the 81,000 deaths due to these conditions in 2004.[4]

The high prevalence rates for hepatitis C in Egypt as well as Pakistan, which did not provide data to this study, are believed to result from vaccination campaigns carried out using unsterile syringes in 1960s-1970s.[5] More recently, a study in 2000 on the use of injections in healthcare settings estimated 70% of injections are given with re-used needles in low mortality Eastern Mediterranean countries.[6]

A 2009 regional resolution to address hepatitis B and C proposes a target for the reduction in prevalence of chronic hepatitis B to less than 1% among children below 5 years of age by 2015 and suggests a range of other measures for the prevention and control of hepatitis B and C.[7]

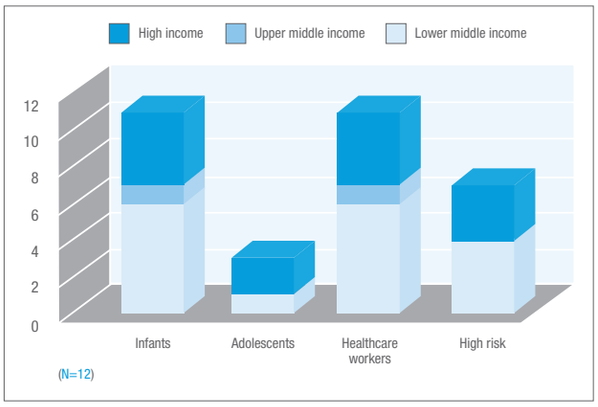
Responses were received from 12 of the 21 (57%) Eastern Mediterranean region countries, accounting for 49% of the total regional population. A full survey response was obtained from the North of Sudan, the data for which only represent that part of the country. Some additional information was obtained from South Sudan and is reported in the country summary.

Policy

92% of Eastern Mediterranean region governments report that hepatitis B and/or hepatitis C is considered an urgent public health issue. These account for more than 99% of population. National strategies are reported to exist in 83% of countries; all of these countries report that there is a designated individual to lead on this work nationally and in three of these countries (30%) that individual is reported to work solely on the hepatitis strategy. Three countries also report the existence of a national steering committee to guide work in the prevention and control of viral hepatitis.

In two thirds of countries goals are reported to be in place for the prevention and control of hepatitis B and/or hepatitis C. Among those for which further detail was provided there was a widespread focus on reducing overall prevalence rates as well as increasing vaccination coverage and improving education and awareness around hepatitis B and/or hepatitis C. In Egypt there are also specific goals for improving access to treatment facilities in underserved areas and for increasing the number of people receiving treatment.

Figure 1: *Groups covered by hepatitis B vaccination policies, by number of countries and income group*



A hepatitis B vaccination policy is reported to be in place in 11 countries (92%). All of these cover vaccination for infants and, more unusually, for healthcare workers. North Sudan reports both of these being in place, while in South Sudan the funding to implement hepatitis B vaccination has not yet been secured. 64% of policies identify additional risk groups which, where detailed, include intravenous drug users, contacts of active cases of hepatitis B, patients on dialysis and medical and nursing students. Five, 45%, of policies also include military personnel.

92% of countries report that they have a strategy in place to prevent infection in healthcare settings. All of these are reported to cover safe injections and the vaccination of healthcare workers, and 91% are reported to include blood screening. Dates of these strategies were not reported; the high rates of needle re-use found

Eastern Mediterranean Region

in some parts of this region may have provided impetus for this or they may indicate that these strategies are not fully or consistently implemented.

Public awareness and education

36% of governments report having funded public awareness campaigns in the past five years. Printed guidance and awareness materials are reported to have been produced for health professionals in Jordan and Iraq and the viral hepatitis section of the Iraqi Centre for Disease Control has also run public awareness campaigns through mass media and events for healthcare workers and general population. A programme of district-level events was held in Lebanon in 2009 to educate healthcare workers about the risks of transmission of viral hepatitis in healthcare settings.

Action to combat stigma and discrimination linked to hepatitis B and/or C is reported to have been undertaken in five countries, 50% of those that provided information on this area. In Egypt this has been done through a national hotline set up to provide information on hepatitis and other infectious diseases which is advertised through television, radio and print media.

Surveillance

Disease surveillance for hepatitis B and/or hepatitis C is reported to be in place in all countries. Standardised case definitions are used in 83% of these and in three quarters clinical cases require laboratory confirmation prior to reporting. Surveillance exists for acute hepatitis in 92% of countries but in only 42% for chronic hepatitis. Improved screening and surveillance are included among the national goals adopted by the government of Kuwait. These also aim to broaden existing surveillance to improve knowledge of the prevalence and incidence of hepatitis B and C and how these vary across the country.

Chronic hepatitis infections are registered in half of countries and liver cancer cases and cases of co-infection with HIV/AIDS in two thirds. 83% of countries report that prevalence estimates for their country exist and 91% that disease reports are published.

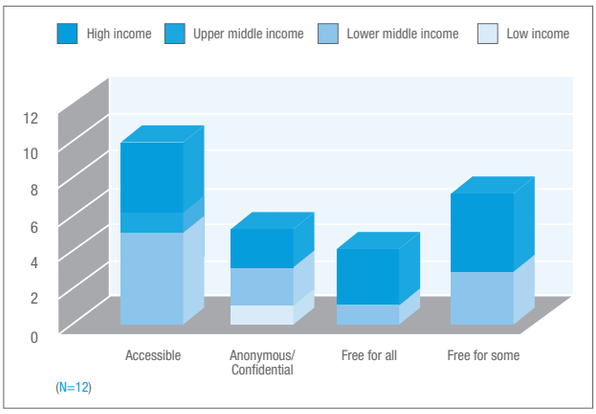
Testing & Treatment

83% of countries report that testing is accessible to at least half of their population without significant barriers. Work to increase coverage is also reported in several countries. In Egypt, for example, mobile testing units are used to increase the accessibility of testing in underserved areas and as part of targeted awareness campaigns. These have been implemented with UN funding and also offer counselling, testing for HIV/AIDS and tuberculosis and drug addiction services.

Testing is reported to be accessible confidentially or anonymously in 42% of countries, and provided free of charge to all citizens in 33%. A further 42% of countries have some provision of free testing for specified groups. Countries in which there is no provision for free testing account for 39% of the population.

Testing is reported to be compulsory for some groups in half of countries in the Eastern Mediterranean region. Groups for whom testing is compulsory include blood donors, healthcare staff, people applying for citizenship, and antenatal mothers.

Figure 2: *Availability of testing, by number of countries and income group*



75% of countries report that their government funds or part funds the treatment of hepatitis B and/or C and 58% report having a clear patient pathway for diagnosis, treatment and care. Increasing the numbers of people in treatment is an identified goal in Egypt's National Control Strategy on Viral Hepatitis; 16 National Treatment Reference Centres have been established in recent years and work to reduce the cost, and introduce a wider range, of drug treatments is also underway.

Civil Society

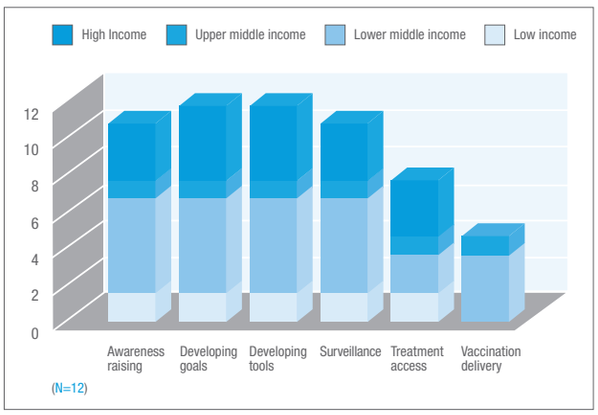
91% of governments report working with non-state sector organisations in developing and implementing interventions for hepatitis B and/or for hepatitis C. Those specified include the WHO and GAVI, as well as a range of local organisations and patient groups; in Kuwait the Ministry of Health has worked with the non-state sector in planning its overall approach to prevention and control of viral hepatitis and Egypt's National Committee on Viral Hepatitis, which developed their National Control Strategy for Viral Hepatitis (2008), includes several representatives from academia, local NGOs and from international organisations. The Egyptian national hepatitis strategy explicitly sets out to provide a unified framework for activity across the state and non-state sectors.

Eastern Mediterranean Region

All proposed areas in which WHO assistance might be of benefit were identified by at least one country, and all countries identified at least two areas for WHO assistance.

In line with the global findings, the most widely identified areas for WHO assistance were developing goals for the prevention and control of hepatitis B and/or C and developing tools for the assessment of interventions. These were each chosen by 91% of countries. Assistance with developing goals was selected by all countries that report not currently having these in place as well as 88% of those that do, suggesting strong commitment to both initiate and develop effective interventions for the prevention and control of viral hepatitis.

Figure 3: *Areas identified for WHO Assistance, by number of countries and income group*



Awareness raising was identified by 83% of countries, again consistently chosen across countries that have conducted this and those that have not, indicating widespread will for commencement and improvement of strategies to tackle viral hepatitis.

Assistance with disease surveillance for hepatitis B and/or hepatitis C was also identified by 83% of countries. As all of the countries report having a disease surveillance system in place, this suggests that these might be strengthened. Assistance with research into prevalence and epidemiology of hepatitis was an additional area for WHO assistance proposed by North Sudan (and agreed by South Sudan).

Increasing access to treatment was identified by 58% and assistance with the delivery of vaccination by a third of countries, all of which report having a hepatitis B policy in place.

In addition, assistance with coordinating regional approaches, and with training in infection control were also proposed by countries in this region.

[1]World Health Organization, Regional Committee for the Eastern Mediterranean. The growing threats of hepatitis B and C in the Eastern Mediterranean Region: a call for action. Resolution EM/RC56/R.5, 2009

[2]Ibid.

[3]Data submitted

[4]World Health Organization, Regional Committee for the Eastern Mediterranean, 2009. op cit.

[5]Shepard, C, L Finelli, and M Alter. Global epidemiology of hepatitis C virus infection. Lancet Infectious Diseases, 2005, 5: 558-67

[6]These are WHO Group D countries: Afghanistan, Djibouti, Egypt, Iraq, Morocco, Pakistan, Somalia, Sudan, Yemen. See: Hutin, Y, A M Hauri, G L Armstrong, Use of injections in healthcare settings worldwide, 2000: literature review and regional estimates. British Medical Journal. 2003: 327 (7423): 1075

[7]World Health Organization, Regional Committee for the Eastern Mediterranean, 2009. op cit.

European Region

Table 1. *Statistical overview*

	Responding countries	Urgent PH issue	National strategy	National goals	Vaccination Policy HBV	Healthcare Strategy	Awareness	Surveillance	Accessible Testing	Treatment funding
High income	87% (26)	64%	73%	65%	100%	88%	54%	100%	92%	72%
Upper middle income	62% (8)	50%	25%	88%	100%	88%	50%	100%	100%	100%
Lower middle income	100% (7)	86%	71%	71%	86%	71%	29%	86%	86%	71%
Low income	100% (7)	67%	100%	67%	100%	67%	0%	100%	0%	0%
Total	83% (44)	65%	66%	70%	98%	84%	45%	98%	86%	75%

Prevalence of hepatitis B is estimated to range from 0.1% to 8% in Europe and that of hepatitis C from 0.1% to 6%,[1] with the highest levels found in the Southern parts of Central and Eastern Europe.[2] In recent years hepatitis B prevalence is estimated to have decreased overall while that of hepatitis C to have increased.[3] Both hepatitis B and C are highly prevalent in certain sub-populations, particularly people who have immigrated from areas of high endemicity, current or former IDUs and people who are or have been in prison.[4] Prevalence of hepatitis C among IDUs in Europe has been found at up to 96%,[5] and a third of people living with HIV/AIDS in Europe are believed to be co-infected with Hepatitis C.[6]

The majority of Europe region countries have implemented universal vaccination for hepatitis B. Italy and Spain were among the first countries in the world to adopt this, while the UK, the Netherlands and several Nordic countries in the North of the region only vaccinate identified risk groups.[7]

Data was received from 44 of the 53 countries in the Europe region (83%), accounting for 94% of the population.

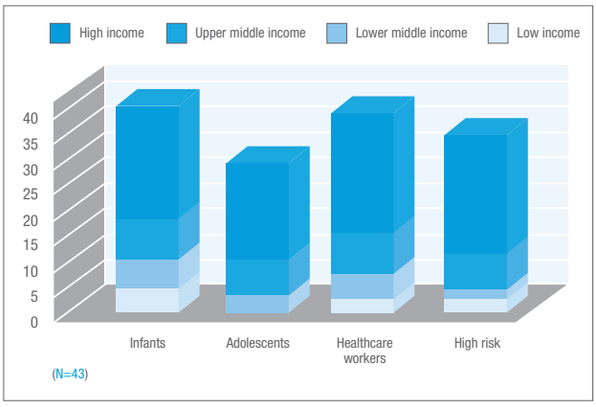
Policy

65% of governments report that hepatitis B and/or C is considered an urgent public health issue in their country.[8] Several countries list hepatitis B and C as notifiable diseases and a variety of committees, boards and governing bodies have been formed to oversee national development of hepatitis provision in countries across the region. In Turkey chronic viral hepatitis is reported to be considered a high public health priority but no longer urgent since introduction of hepatitis B vaccine in 1998 alongside other public health measures considerably reduced incidence and prevalence rates.

A strategy for hepatitis B and/or hepatitis C is reported to be in place in 66% of countries and in 41% of these a designated individual leads this work nationally. In two countries, France and Russia, this person is reported to work exclusively on the hepatitis strategy.

70% of countries report having national goals for the prevention and control of hepatitis B and/or hepatitis C. Where detailed, these focus on reducing the incidence of hepatitis B and reducing or controlling that of hepatitis C, increasing vaccination coverage among infants and among designated high risk groups and improvement of contact tracing systems. Goals for the number of people treated for hepatitis C in Scotland (United Kingdom) are based on disease surveillance figures. The target aims to quadruple the number of people in treatment to 2,000, the estimated number required to flatten the mortality curve in the region.[9]

Figure 1: *Groups covered by hepatitis B vaccination policies, by number of countries and income group*



98% of governments report having a hepatitis B vaccination policy in place and unusually almost as many cover healthcare workers (86%) as infants (91%). 77% also include additional groups considered to be high risk, including infants with one or both parents from intermediate or high endemicity areas, IDUs, sex workers, children with Down's syndrome, prisoners, contacts of active cases of hepatitis B, organ recipients and dialysis patients. Overall these policies include more, and more diverse, groups than those reported across other WHO regions and fewer cover infants than those reported in the majority of regions.

The presence of a strategy to prevent infection in healthcare settings is reported by 84% of countries, ranging from 88% of high income to 67% of low income countries and accounting for 98% and 31% of these populations respectively. 95% of these cover safe injecting, 95% blood screening and healthcare worker vaccination is reported to be included in 92%. 85% of countries report that all three areas are included in their strategy.

European Region

Public awareness and education

Less than half of countries, 45%, report any government-funded awareness campaigns having taken place in the past five years. Where detail was provided, these have largely been targeted at healthcare workers and specific risk groups such as IDUs and at populations from high endemicity countries. In the United Kingdom campaigns have also sought to raise awareness around hepatitis C among non-IDUs and among people who have injected drugs in the past, and a screening programme run in England (UK) by the government and NGOs found hepatitis C prevalence rates more than four times the national average in some British Pakistani communities.[10]

Awareness raising campaigns in the Europe region have utilised a range of broadcast and printed media as well as meetings and events. Part of the French viral hepatitis strategy includes an annual mass-media campaign targeted at the general public as well as specific campaigns to raise awareness among healthcare workers. Detection of cases has more than doubled since 2000 and liver cancer mortality has also significantly decreased.[11] In Poland, a campaign to raise awareness of hepatitis C among healthcare workers through an onsite training programme saw a 50% increase in hepatitis C cases reported from the areas where the campaigns were held. Similar increases in reporting have been seen following awareness work in the England (UK).

Action to tackle stigma and discrimination around hepatitis B and/or hepatitis C is reported to have been taken by 36% of countries in the region, over two thirds of which are high income. In Greece, the Ministry of Health and the Ministry of Education have produced combined guidelines for teachers to prevent social isolation of infected children and in France the government has provided support to patient organisations' campaigns to improve awareness and understanding of viral hepatitis.

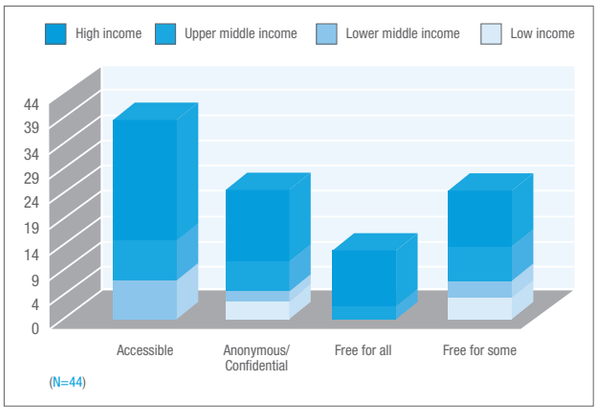
Surveillance

98% of Europe region countries report that disease surveillance exists for hepatitis B and/or hepatitis C. Surveillance exists for acute hepatitis infections in almost all of these (96%) and for chronic infections in 65%. Chronic hepatitis infections are registered in just over two thirds of countries and liver cancer cases in 78%. Prevalence estimates are reported to be available in 83% of countries and disease reports published in 92%. 37% of these are reported to be published on at least a monthly basis.

Testing & Treatment

86% of Europe region countries report that testing is accessible to at least 50% of their citizens, the highest average of any region. Half of the countries in which testing is not accessible are low income; no country in this income group reports that testing is accessible. Testing is available anonymously or confidentially in just over half (55%) of countries.

Figure 2: *Availability of testing, by number of countries and income group*



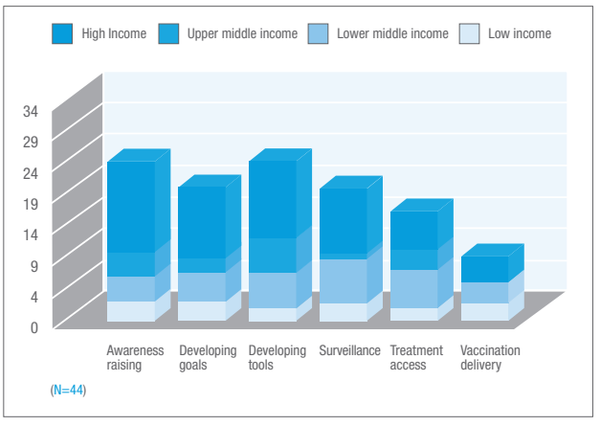
Testing is free of charge for all citizens in 27% and to designated groups in 55% of countries; 18% of countries report having no free testing provision for any citizens. Healthcare workers, pregnant women, people with HIV/AIDS, blood donors, blood recipients and patients with liver disease are among those for whom testing is provided free of charge in some countries.

68% of countries report having a patient pathway for diagnosis, treatment and care and 75% report some provision for government funding of treatment; 57% of governments report that both are in place.

Civil Society

63% of countries report working with patient groups, international organisations and NGOs in developing and implementing programmes for prevention and control of hepatitis B and/or C. This was more widely reported across low (67%) and lower middle income (100%) than high (58%) and upper middle (43%) income countries.

Figure 3: *Areas identified for WHO Assistance, by number of countries and income group*



All proposed areas for WHO assistance were identified by at least one country. Two low income countries identified all six options proposed as areas in which WHO assistance would be appreciated and ten high income countries did not identify any area.

Of those countries which provided data, assistance in raising awareness around hepatitis B and/or C was selected by 50%, in almost two thirds of which government-funded awareness raising activities is yet to take place.

Developing tools to assess the effectiveness of interventions was also selected by almost half of governments. More than half of middle income and all low income economies identified this.

Assistance with developing goals for hepatitis B and/or C was identified by 41% of governments, of whom more than half do not currently have these in place.

Assistance with surveillance, also identified by 41%, was selected by the one government that reports not currently undertaking disease surveillance for hepatitis B and/or C and by 75% of those which report not having prevalence estimates for their country, suggesting that in many areas where these are in place there is a need to strengthen them. All lower middle and low income economies identified this area for assistance.

Almost a third of governments identify assistance with improving access to treatment and seven (16%) with the delivery of vaccination. Assistance in ensuring the sustainability of interventions was also proposed.

[1]Study of EU, EEA and EAFTA countries: Rantala, M and M van de Laar. Surveillance and epidemiology of hepatitis B and C in Europe: A review. Eurosurveillance. 2008, 13 (4-6): 1-8

[2]Lavanchy, D. Hepatitis B virus epidemiology, disease burden, treatment, and current and emerging prevention and control measures. Journal of Viral Hepatitis, 2004, 11 (2): 97-107

[3]Study of EU, EEA and EAFTA countries: Rantala, M and M van de Laar. Surveillance and epidemiology of hepatitis B and C in Europe: A review. Eurosurveillance. 2008, 13 (4-6): 1-8

[4]Aceijas, C and T Rhodes. Global estimates of prevalence of HCV infection among injecting drug users. International Journal of Drug Policy. 2007, 18: 352–358

[5]Ibid.

[6]Rockstroha, JK and Prof U Spenglerb. HIV and hepatitis C virus co-infection. Lancet Infectious Diseases, 2004, 4 (6): 437-444

[7]Zanetti, A, P Van Dammeb and D Shouval. The global impact of vaccination against hepatitis B: A historical overview. Vaccine. 2008, 26: 6266–6273

[8]Of 43 countries; no response was received from the Netherlands on this variable.

[9]A separate response to this study was obtained from Scotland, as well as Northern Ireland and Wales as their health sectors are devolved from that of England.

[10]Taylor, D. Mosques play key role in raising awareness about hepatitis C. The Guardian. Wednesday 10 February 2010. (http://www.guardian.co.uk/society/2010/feb/10/hepatitis-screening-mosques-pakistani-communities, accessed 1 March 2010)

[11]Hainsworth, T. Improving identification and awareness of hepatitis C. Nursing Times. 2005, 101(42): 23

South-East Asia Region

Table 1. *Statistical overview*

	Responding countries	Urgent PH issue	National strategy	National goals	Vaccination Policy HBV	Healthcare Strategy	Awareness	Surveillance	Accessible Testing	Treatment funding
Lower middle income	71% (5)	40%	60%	60%	80%	80%	40%	80%	40%	60%
Low income	75% (3)	100%	100%	100%	100%	100%	67%	33%	33%	67%
Total	73% (8)	63%	75%	88%	100%	88%	50%	63%	37%	63%

78% of global carriers of hepatitis B reside in Asia and hepatitis B is highly endemic in much of the South-East Asia region. Hepatitis C estimates from the 1990s indicate over 25 million carriers, more than ten million of whom reside in the countries that participated in this study. This includes over five million people in Indonesia, three million in Bangladesh and 1.75 million in Thailand.[1] 21% of the global mortality and 26% of the morbidity associated with hepatitis B, hepatitis C, liver cancer and cirrhosis occurs in the South-East Asia region.[2]

National hepatitis B vaccination programmes were introduced in the Maldives, Indonesia and Thailand in the 1990s, in 2003 in Bangladesh, Nepal and Sri Lanka and in 2007 in Timor-Leste. The estimated coverage rate in India, which did not participate in this survey, for infant hepatitis B vaccination is 6%, leaving over 24 million infants unprotected from hepatitis B.[3] Although coverage is much higher in Indonesia, at 74%, an estimated 1.1 million infants still are not vaccinated there.[4]

Responses were received from 8 of the 11 South-East Asia region countries (73%). This accounts for 30% of the total regional population and 87% of the population outside India. Data from the Democratic People's Republic of Korea is included in this overview but not in the global overview; the data reported here therefore differ slightly from those included in the earlier section.

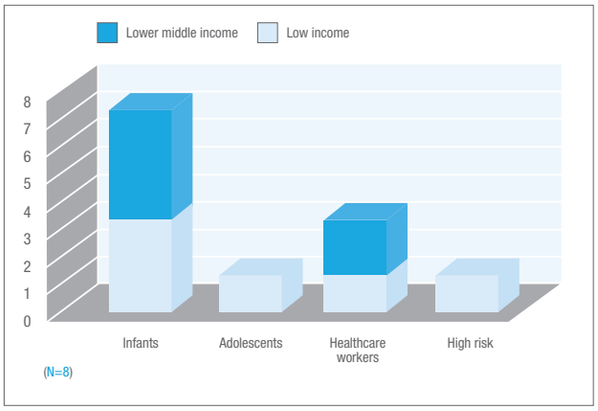
Policy

Hepatitis B and/or hepatitis C is reported to be considered an urgent public health issue in Bangladesh, Indonesia, Nepal, DPR Korea and Thailand while it is not in Timor-Leste, Sri Lanka and the Maldives. All those countries that consider it an urgent public health issue, along with Sri Lanka, have a national strategy in place. In Sri Lanka, DPR Korea and Bangladesh there is reported to be a designated individual to lead on this work and in all three countries this individual works only on the hepatitis strategy.

Seven of the eight countries report nationally-adopted goals for the prevention and control of hepatitis being in place; in Indonesia and Sri Lanka these focus on increasing immunisation coverage and in Sri Lanka these also address blood screening.

A hepatitis B vaccination policy is in place in all eight countries; seven of these cover infants, one healthcare workers only and those in Sri Lanka and the DPR Korea cover both infants and healthcare workers. In DPR Korea this also covers adolescents and people considered at high risk, although funding for the implementation of this policy for groups other than infants has not yet been obtained. In Indonesia, the government has adopted goals to increase accessibility and coverage of vaccination and in some rural areas outreach birth attendants have been given additional training so that they can administer the first dose of hepatitis B vaccine to infants born outside of healthcare settings.

Figure 1: *Groups covered by hepatitis B vaccination policies, by number of countries and income group*



Seven countries report having strategies to prevent infection in healthcare settings. Six of these include safe injections and six blood screening; in Sri Lanka and DPR Korea the provision of vaccination for healthcare workers is also included.

Public awareness and education

Government-funded awareness campaigns are reported to have taken place in four countries. Details were provided for those undertaken in Sri Lanka and DPR Korea, aimed at both the general public and specifically at healthcare workers, and in Indonesia, which focused on screening for hepatitis B and C. A community education strategy is currently being developed in Indonesia, as is a revised resource on chronic viral hepatitis for healthcare workers in Sri Lanka. Three countries, Timor-Leste, Nepal and DPR Korea, report having acted to reduce stigma and discrimination towards people who have hepatitis B and/or C.

South-East Asia Region

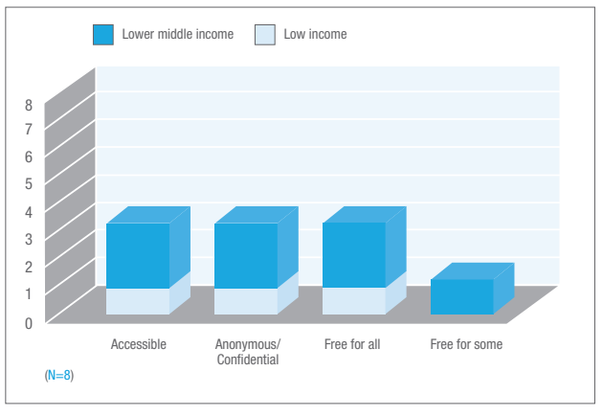
Surveillance

Four of the five middle income and only one of the low income economies in the region report having a disease surveillance system in place that includes hepatitis B and/or C. Surveillance for acute hepatitis is included in all of these policies, but DPR Korea is the only country in which surveillance exists for chronic hepatitis. Chronic infection, liver cancer and HIV/AIDS co-infection are all reported to be registered in Sri Lanka; only liver cancer cases are registered in Thailand and only cases of co-infection with HIV/AIDS in the Maldives. Prevalence estimates are reported to be available in four countries (50%). No official data on this were provided.

Testing & Treatment

Access to testing is very limited in the region. Significant barriers are reported to prevent more than half of the population accessing testing in five, 63%, of countries. These countries account for 83% of population.

Figure 2: *Availability of testing, by number of countries and income group*



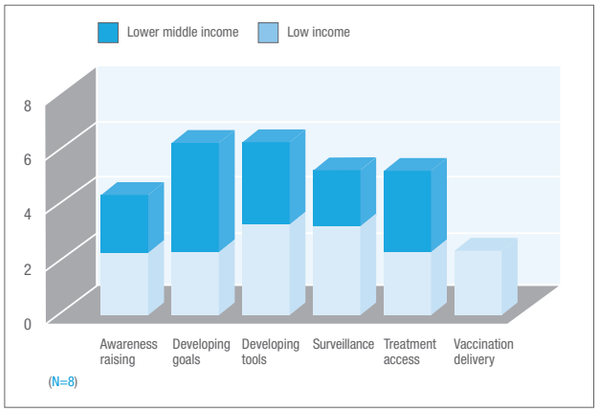
There is reported to be some provision for free testing in Indonesia and Thailand and testing is reported to be free for all citizens in DPR Korea, Sri Lanka and Timor-Leste. Testing is reported to be compulsory for some citizens for hepatitis B in DPR Korea only, where some compulsory screening programmes are in place. Five countries report having a patient pathway for diagnosis, treatment and care and five report some provision for government funding of treatment; three of these, Thailand, Indonesia and DPR Korea, report both being in place.

Civil Society

36% of countries report that they work with civil society and international organisations in developing and implementing programmes for hepatitis B and/or hepatitis C prevention and control.

All proposed areas in which WHO assistance might be of benefit were identified by at least one country, and all countries identified at least one area for WHO assistance.

Figure 3: *Areas identified for WHO Assistance, by number of countries and income group*



Assistance in developing tools and in developing goals were identified by the greatest number of countries (6/8 or 75%). In line with findings from other regions, this is identified by the majority of countries that already report already having these in place as well as the country that does not.

Assistance with surveillance and increasing access to treatment were selected by 63% of countries and awareness raising was also widely identified, by 50%. In Bangladesh and DPR Korea assistance with the delivery of vaccination was also identified. No additional areas for assistance were proposed.

[1]World Health Organisation, Regional Office for South-East Asia. Overview of Hepatitis C Problem in Countries of the South-East Asia Region. 1999. (http://www.searo.who.int/EN/Section10/Section17/Section58/Section220_217.htm, accessed 12 February 2010)

[2]World Health Organization. The global burden of disease: 2004 update. Geneva, World Health Organization, 2008

[3]World Health Organization. WHO vaccine-preventable diseases: monitoring system 2009 global summary. Geneva, World Health Organization, 2009c

[4]Ibid.

Western Pacific Region

Table 1. *Statistical overview*

	Responding countries	Urgent PH issue	National strategy	National goals	Vaccination Policy HBV	Healthcare Strategy	Awareness	Surveillance	Accessible Testing	Treatment funding
High income	100% (6)	67%	67%	67%	100%	100%	83%	100%	100%	100%
Upper middle income	60% (3)	100%	100%	100%	100%	100%	67%	100%	33%	67%
Lower middle income	77% (10)	100%	70%	80%	100%	89%	50%	60%	50%	50%
Low income	67% (2)	100%	100%	100%	100%	50%	50%	0%	50%	100%
Total	78% (21)	95%	76%	81%	100%	90%	62%	71%	62%	71%

Western Pacific Region countries account for 27% of the global population, but are estimated to suffer 38% of mortality and 32% of morbidity associated with acute hepatitis B and C, hepatocellular carcinoma and cirrhosis.[1] 890 deaths occur each day as a result of hepatitis B in the region.[2] It is estimated that the Western Pacific region is home to almost 160 million chronic carriers of hepatitis B[3] and 50 million chronic carriers of hepatitis C.[4] In China, with 75% of the region's population, there are estimated to be 30-60 million hepatitis C carriers[5] and 93 million hepatitis B carriers.[6]

Hepatitis B immunisation programmes were launched in most Western Pacific countries during the late 1980s and early 1990s and a WHO-coordinated regional hepatitis B control programme has been in place since 1995.[7] In China, the hepatitis B prevalence rate has been reduced from 9.8% in 1992 to 7.2% in 2006; across a population of 1.3 billion this equates to almost 34 million fewer people infected with hepatitis B.

Responses were received from 21 of the 27 Western Pacific Region countries, accounting for over 99% of the regional population.

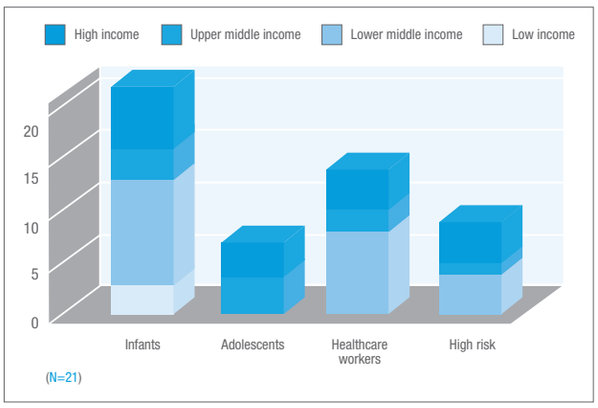
Policy

90% of Western Pacific countries, and all low and middle income countries in the region, consider hepatitis B and/or hepatitis C an urgent public health issue. Sixteen countries (76%) report having a national strategy in place and eleven of these a designated individual to lead the strategy. In the Republic of Korea and Cambodia this person works exclusively on the hepatitis strategy.

Goals for the prevention and control of hepatitis B and/or C are reported to be in place in 81% of countries. There is also a regional goal to reduce chronic hepatitis B infection rates to less than 2% among children over 5 years old by 2012. In some countries this has already been achieved. Further national goals include reducing overall prevalence rates, improving immunisation coverage and eliminating transmission of hepatitis B infection in healthcare settings.

All countries report having a hepatitis B vaccination policy in place and all of these cover infants. A regional plan for hepatitis B control through immunisation has also been in place since 2003 and was updated in 2007. Less than two thirds of policies include healthcare workers. Risk groups such as IDUs and people in prison are identified by just over a third of countries. To increase access to and coverage of vaccination, the government of China abolished all user fees for EPI vaccinations in 2005. The Republic of Korea has integrated free vaccination vouchers into hepatitis B awareness material provided to antenatal mothers who have hepatitis B so that this can be accessed through private as well as government clinics free of charge. All coupons that are used (currently estimated at 95%) are returned to and monitored by the Korean CDC as part of routine disease surveillance.

Figure 1: *Groups covered by hepatitis B vaccination policies, by number of countries and income group*



18 of 20 countries (90%) have strategies in place to prevent infection in healthcare settings. 89% of these cover safe injections, 83% blood screening and 72% healthcare worker vaccination. Some difficulties in implementation of these strategies were, however, reported and in at least 2 countries blood screening for hepatitis C is contingent upon the availability of testing kits which can be inconsistent.

Public awareness and education

Western Pacific Region countries report notably more activity in raising awareness and combating stigma and discrimination than other regions, although all levels remain low. 62% of countries report having funded awareness work and 62% having acted to reduce stigma; 81% of countries report having done at least one of these. The use of many forms of mass media, including leaflets

and posters, television, radio and meetings and events is reported in awareness raising activity and in China a particular target for awareness raising is included in the national hepatitis strategy. These have targeted the general public with specific campaigns for healthcare workers, the armed forced and emergency services and antenatal mothers. Stigma and discrimination is reported to be addressed through employment regulations and in disability legislation.

Surveillance

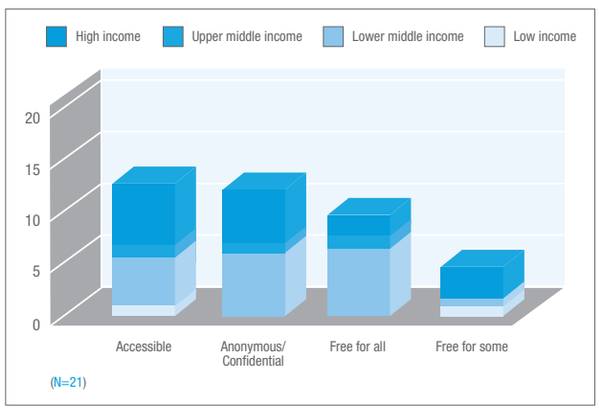
Surveillance that includes chronic viral hepatitis is reported to be in place in 100% of high and upper middle income countries, 60% of lower middle income countries and neither of the two low income countries. 86% of these monitor acute hepatitis and 71% chronic hepatitis infections. Liver cancer cases are reported to be registered in 93% of countries, and chronic hepatitis and HIV/AIDS co-infection are both registered in half of all countries.

Prevalence estimates are reported to be available in 67% of countries, ranging from an average of 83% across high income countries to just 50% across lower middle income areas, and disease reports published in all 15 countries to provide data on this.

Testing & Treatment

While 100% of high income Western Pacific Region countries report that testing is easily accessible to more than 50% of their population, this is the case in less than half of middle and low income economies. 87% of the total population reside in areas where testing is not accessible, mostly in China.

Figure 2: *Availability of testing, by number of countries and income group*



Testing is reported to be available confidentially in two thirds of high and upper middle income countries, half of lower middle income countries and in neither low income country. 48% of countries report some provision for compulsory testing; groups most frequently cited include blood donors, antenatal mothers and healthcare workers.

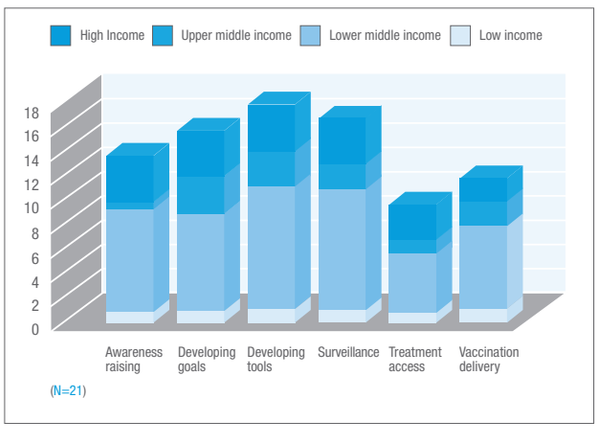
Testing is reported to be available free of charge to all citizens in 48% of countries, though again not in low income countries. It is reported to be available free of charge to some groups in a further 24% of countries.

Full or part funding for the treatment of hepatitis B and/or C is reported to be available in 71% of countries and a patient pathway implemented in 70%.

Civil Society

18 of 21 governments (86%) report working with civil society organisations in the development and implementation of programmes for hepatitis B and/or C. These include the WHO, GAVI and UNICEF as well as local NGOs and CBOs. These organisations are also reported to have been involved in strategy and policy development and in campaigns to increase awareness of viral hepatitis and to combat stigma and discrimination.

Figure 3: *Areas identified for WHO Assistance, by number of countries and income group*



All proposed areas for WHO assistance were identified by at least one country. Three countries identified all six as areas in which WHO assistance would be appreciated and two high income countries did not identify any areas.

In line with wider findings, developing tools to assess the effectiveness of interventions was the most widely identified area in which WHO assistance would be appreciated. This was selected by 17 of the 21 governments (81%).

Assistance with surveillance of hepatitis B and/or C and with developing goals for the prevention and control of hepatitis B and/or hepatitis C were also identified by the more than three quarters of countries. In both cases more than 70% of countries that report these already being in place indentify that area for assistance, suggesting significant will to strengthen and develop existing goals and surveillance systems.

Western Pacific Region

Almost two thirds of countries would like assistance with awareness rising for chronic viral hepatitis. Just over half, 52%, of countries identify assistance with vaccination delivery and 43% with increasing access to treatment.

Additional areas for WHO assistance were identified as developing contact tracing systems, developing vaccination protocols and guidance, in particular relating to the use of the booster dose and for cases of non sero-converters.

[1]World Health Organization. The global burden of disease: 2004 update. Geneva, World Health Organization, 2008

[2]World Health Organization Regional Office for the Western Pacific. Meeting Report: International Expert Meeting on Hepatitis B Control in The Western Pacific Region. Manila, World Health Organization, 2009

[3]Ibid.

[4]World Health Organization, Regional Committee for the Western Pacific. Hepatitis and Related Diseases. WPR/RC50/9, 1999.

[5]Nakano, T, L Lu, Y He,Y Fu, B Robertson and O Pybus. Population genetic history of hepatitis C virus 1b infection in China. Journal of General Virology. 2006, 87: 73–82

[6]Data submitted.

[7]Basuni, A, L Butterworth, G Cooksley, S Locarnini and W Carman. Prevalence of HBsAg mutants and impact of hepatitis B infant immunisation in four Pacific Island countries. Vaccine. 22 (21-22): 2791-2799

Country Summaries

Albania

Population (2006):	3,172,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$6,000
Total health spend as a % of GDP (2006):	6.2%
Per capita total health spend (2006):	$358
Per capita govt health spend (2006):	$127
Life Expectancy (f/m, 2006):	73 / 69
Healthy Life Expectancy (f/m, 2003):	63 / 59
Median Age (2006):	29

Estimated Mortality (2004)	Total
Acute hepatitis B	2.58
Acute hepatitis C	1.13
Liver cancer	127.74
Cirrhosis	-
Infectious diseases	0.49*
Non-communicable diseases	23*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	60
Acute hepatitis C	30
Liver cancer	1110
Cirrhosis	-
Infectious diseases	64*
Non-communicable diseases	370*

1-years olds immunised against hepatitis B (2007): 98%

*thousands

The government of Albania reports as follows:

Policy

The government of Albania considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

The Viral Hepatitis Control Strategy (2008). Components of this strategy include: advocacy, access, prevention, screening, surveillance. This addresses acute and chronic hepatitis B and C. Hepatitis B and C have also been included in the national public health strategy since 2003.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: The elimination of hepatitis B in children and adolescents; The control of hepatitis B in the general population and the reduction of prevalence rates; The control of hepatitis B in risk groups including healthcare workers.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Military personnel; Persons at high risk (injection drug users, people who have had multiple blood transfusions, dialysis patients).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. These have included campaigns to promote vaccination of newborn babies, children and adolescents. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on a monthly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include children, pregnant women, healthcare workers, intravenous drug users, people who have had multiple blood transfusions, blood donors.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Interferon is 100% government-funded.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO Albania country office and regional office for Europe and the GAVI Alliance.

WHO Assistance

The government of Albania would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Increasing access to treatment
- Developing tools to assess the effectiveness of interventions
- Surveillance

Andorra

Estimated Mortality (2004)	Total
Acute hepatitis B	0.16
Acute hepatitis C	0.92
Liver cancer	7.95
Cirrhosis	9.69
Infectious diseases	0.01*
Non-communicable diseases	01*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	0
Acute hepatitis C	10
Liver cancer	50
Cirrhosis	130
Infectious diseases	0*
Non-communicable diseases	07*

1-years olds immunised against hepatitis B (2007): 91%

*thousands

Population (2006):	74,000
Country Classification (2009):	High income
Gross National Income per capita (0):	-
Total health spend as a % of GDP (2006):	6.3%
Per capita total health spend (2006):	$2,910
Per capita govt health spend (2006):	$2,054
Life Expectancy (f/m, 2006):	85 / 78
Healthy Life Expectancy (f/m, 2003): 7	5 / 70
Median Age (0):	-

The government of Andorra reports as follows:

Policy

The government of Andorra considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are not registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are not currently published.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Andorra would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Surveillance

Argentina

Population (2006):	39,134,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$11,670
Total health spend as a % of GDP (2006):	10.1%
Per capita total health spend (2006):	$1,665
Per capita govt health spend (2006):	$758
Life Expectancy (f/m, 2006):	78 / 72
Healthy Life Expectancy (f/m, 2003):	68 / 62
Median Age (2006):	29

Estimated Mortality (2004)	Total
Acute hepatitis B	72.3
Acute hepatitis C	143.36
Liver cancer	1881.94
Cirrhosis	2440.85
Infectious diseases	15.25*
Non-communicable diseases	237*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	1030
Acute hepatitis C	1540
Liver cancer	14850
Cirrhosis	33340
Infectious diseases	827*
Non-communicable diseases	4548*

1-years olds immunised against hepatitis B (2007): 92%

*thousands

The government of Argentina reports as follows:

Policy

The government of Argentina considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Information was not available on whether the government has goals for the prevention and control of hepatitis B and/or hepatitis C.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Military personnel; Persons at high risk (not specified).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Vaccination of healthcare workers.

Policy development: Information was not available on whether other countries' policies relating to hepatitis B and/or hepatitis C are currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has, however, been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. No information was available on the central features of the national monitoring system as it relates to viral hepatitis.

Prevalence estimates: Information was not available on whether prevalence estimates exist.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

Access: No information was available on whether testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. No information was available on whether it can be accessed anonymously or confidentially.

Cost: No information was available on whether testing is available free of charge to any citizens.

Compulsory testing: No information was available on whether testing is compulsory for any groups.

Treatment and care

Pathway: No information was available on whether there is a clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C.

Funding: No information was available on whether the treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

No information was available on whether government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Argentina would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas: no information available.

Armenia

Estimated Mortality (2004)	Total
Acute hepatitis B	9.91
Acute hepatitis C	4.01
Liver cancer	165.73
Cirrhosis	942.46
Infectious diseases	0.71*
Non-communicable diseases	38*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	200
Acute hepatitis C	80
Liver cancer	1370
Cirrhosis	10350
Infectious diseases	68*
Non-communicable diseases	460*

1-years olds immunised against hepatitis B (2007): 85%

*thousands

Population (2006):	3,010,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$4,950
Total health spend as a % of GDP (2006):	4.7%
Per capita total health spend (2006):	$272
Per capita govt health spend (2006):	$112
Life Expectancy (f/m, 2006):	72 / 65
Healthy Life Expectancy (f/m, 2003):	63 / 59
Median Age (2006):	32

The government of Armenia reports as follows:

Policy

The government of Armenia considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

The Armenia Ministry of Health is currently developing a national programme for hepatitis B and hepatitis C prevention. A wide range of professionals are involved in the working group developing this programme.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers; Military personnel.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is compulsory for some groups. These include some healthcare workers such as dentists and surgeons.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the GAVI Alliance in the introduction of the national hepatitis B vaccination programme.

WHO Assistance

The government of Armenia would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Australia

Population (2006):	20,530,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$33,940
Total health spend as a % of GDP (2006):	8.7%
Per capita total health spend (2006):	$3,122
Per capita govt health spend (2006):	$2,097
Life Expectancy (f/m, 2006):	84 / 79
Healthy Life Expectancy (f/m, 2003):	74 / 71
Median Age (2006):	37

Estimated Mortality (2004)	Total
Acute hepatitis B	21.0
Acute hepatitis C	62.0
Liver cancer	921.0
Cirrhosis	1016.0
Infectious diseases	1.85*
Non-communicable diseases	120*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	280
Acute hepatitis C	940
Liver cancer	7420
Cirrhosis	15700
Infectious diseases	98*
Non-communicable diseases	1911*

1-years olds immunised against hepatitis B (2007): 94%

*thousands

The government of Australia reports as follows:

Policy

The government of Australia considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

National Strategies are in place for hepatitis C. All National Strategies were under review at the time of study and a new Hepatitis B Strategy being developed.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Travellers; Military personnel; Persons at high risk (not specified).

The National Immunisation Handbook details infant and adolescent vaccination. Employers are recommended to implement vaccination policies where appropriate. The new Hepatitis B Strategy will list priority populations and areas.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Local health authorities provide safe injecting equipment. The government funds the National Serology Reference Laboratory which oversees blood screening. Occupational Health and Safety for healthcare workers is managed locally; there are national guidelines.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. The government funds CBOs to deliver public awareness activity. This includes print and IT resources for public distribution. World Hepatitis Day activities have also been funded. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government. The Disability Discrimination Act includes under the definition of disability 'the presence in the body of organisms causing disease or illness'.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available. 2008 estimates indicate 284,000 (218,000–348,000) people infected with hepatitis C including 211,700 chronically infected.

Disease reporting: Disease reports are published on a weekly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include pregnant women, unaccompanied refugee children, children for adoption, visa applicants seeking employment as healthcare workers. Hepatitis B testing only is free of charge and compulsory for these groups.

Compulsory testing: Testing is compulsory for some groups (as above).

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place. There are many resources for this. The government also funded the development of the National Hepatitis C Resource Manual which covers this for hepatitis C.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. The government funds certain medications under the Highly Specialised Drugs (HSD) Program; hepatitis B and C medications fall under this. HSDs are medicines for the treatment of chronic conditions where provision requires specialist facilities.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include GAVI Alliance in developing vaccination programmes. The government funds a range of NGOs and CBOs and works with National Research Centres for evidence-based programme development.

WHO Assistance

The government of Australia would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Surveillance

Austria

Estimated Mortality (2004)	Total
Acute hepatitis B	38.19
Acute hepatitis C	266.41
Liver cancer	770.14
Cirrhosis	1680.91
Infectious diseases	0.59*
Non-communicable diseases	68*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	400
Acute hepatitis C	2640
Liver cancer	5830
Cirrhosis	23640
Infectious diseases	41*
Non-communicable diseases	873*

1-years olds immunised against hepatitis B (2007): 85%

*thousands

Population (2006):	8,327,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$36,040
Total health spend as a % of GDP (2006):	9.9%
Per capita total health spend (2006):	$3,545
Per capita govt health spend (2006):	$2,729
Life Expectancy (f/m, 2006):	83 / 77
Healthy Life Expectancy (f/m, 2003):	74 / 69
Median Age (2006):	40

The government of Austria reports as follows:

Policy

The government of Austria considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Travellers; Persons at high risk (not specified).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. Information for the public and health care workers is provided as leaflets and through the homepage of the Ministry of Health. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government. The public awareness work undertaken has also been aimed at tackling stigma and discrimination.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on a monthly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO, EU, European Commission, European Centre for Disease Control, European Medicines agency.

WHO Assistance

No areas for assistance were identified. The government of Austria already works in collaboration with international organisations in this area, including with the WHO.

Azerbaijan

Population (2006):	8,406,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$5,430
Total health spend as a % of GDP (2006):	3.4%
Per capita total health spend (2006):	$218
Per capita govt health spend (2006):	$67
Life Expectancy (f/m, 2006):	66 / 62
Healthy Life Expectancy (f/m, 2003):	59 / 56
Median Age (2006):	28

Estimated Mortality (2004)	Total
Acute hepatitis B	46.78
Acute hepatitis C	21.02
Liver cancer	163.89
Cirrhosis	1646.43
Infectious diseases	3.69*
Non-communicable diseases	54*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	1280
Acute hepatitis C	580
Liver cancer	1670
Cirrhosis	24040
Infectious diseases	441*
Non-communicable diseases	1051*

1-years olds immunised against hepatitis B (2007): 97%

*thousands

The government of Azerbaijan reports as follows:

Policy

The government of Azerbaijan does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are not available.

Disease reporting: Disease reports are published on a monthly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. This is done for hepatitis B treatment only.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of Azerbaijan would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Bahamas

Estimated Mortality (2004)	Total
Acute hepatitis B	1.44
Acute hepatitis C	0.57
Liver cancer	12.25
Cirrhosis	41.02
Infectious diseases	0.41*
Non-communicable diseases	01*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	30
Acute hepatitis C	-
Liver cancer	120
Cirrhosis	830
Infectious diseases	14*
Non-communicable diseases	36*

1-years olds immunised against hepatitis B (2007): 93%

*thousands

Population (2006):	327,000
Country Classification (2009):	High income
Gross National Income per capita (0):	-
Total health spend as a % of GDP (2006):	6.9%
Per capita total health spend (2006):	$1,516
Per capita govt health spend (2006):	$775
Life Expectancy (f/m, 2006):	77 / 71
Healthy Life Expectancy (f/m, 2003):	66 / 61
Median Age (2006):	28

The government of Bahamas reports as follows:

Policy

The government of Bahamas considers hepatitis B and/or hepatitis C to be an urgent public health issue.

Hepatitis B in particular in considered an urgent public health isssue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

The strategy focuses on prevention of hepatitis B through vaccination. There is currently no specific strategy for the prevention and control of hepatitis C other than routine blood donor screening to prevent transfusion-related hepatitis C.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. Those for hepatitis B include: Prevention through routine childhood vaccination; Prevention through the use of screening and vaccination; Prevention of transmission to health care workers through vaccination; Prevention of transmission to close contacts through contact tracing and vaccination. For hepatitis C: Prevention of transmission in blood transfusions through blood donor screening.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers; Persons at high risk (dialysis patients, persons exposed to active cases of hepatitis B).

Hepatitis B was identified as an urgent public health risk in 2000 and as a result the vaccine was added to the childhood immunization schedule. Pentavalent vaccine was introduced in 2001.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

This also includes the screening and vaccination of dialysis patients.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are not registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are not available.

Disease reporting: Disease reports are not currently published.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include dialysis patients, blood donors and people with HIV/AIDS for hepatitis B and C, as well as for children, antenatal clients, prisoners for hepatitis B only.

Compulsory testing: Testing is compulsory for some groups. These include prisoners and people employed in the uniformed services.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place. Patients with acute hepatitis B are referred to acute care hospitals for management, including appropriate testing. All cases are investigated and contact tracing undertaken to identify individuals for counselling, testing and treatment.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include PAHO and the Caribbean Regional Epidemiology Centre.

WHO Assistance

The government of Bahamas would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Bahrain

Population (2006):	739,000
Country Classification (2009):	High income
Gross National Income per capita (2005):	$34,310
Total health spend as a % of GDP (2006):	3.8%
Per capita total health spend (2006):	$1,008
Per capita govt health spend (2006):	$669
Life Expectancy (f/m, 2006):	76 / 74
Healthy Life Expectancy (f/m, 2003):	64 / 64
Median Age (2006):	29

Estimated Mortality (2004)	Total
Acute hepatitis B	13.37
Acute hepatitis C	1.76
Liver cancer	22.38
Cirrhosis	23.94
Infectious diseases	0.12*
Non-communicable diseases	02*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	190
Acute hepatitis C	30
Liver cancer	210
Cirrhosis	380
Infectious diseases	10*
Non-communicable diseases	66*

1-years olds immunised against hepatitis B (2007): 97%

*thousands

The government of Bahrain reports as follows:

Policy

The government of Bahrain does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

National hepatitis B strategy: Components of the draft National Hepatitis B Strategy include: advocacy, prevention, screening, surveillance and treatment. This addresses acute and chronic hepatitis B. Although this has not yet been formally adopted implementation is reported to have begun.

National hepatitis C strategy: Components of the draft National Hepatitis B Strategy include: advocacy, prevention, screening, surveillance and treatment. This addresses acute and chronic hepatitis C. Although this has not yet been formally adopted implementation is reported to have begun.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: Reduction of the prevelence of hepatitis B and hepatitis C by 10% by 2014, Prevention of complications of hepatitis B and C by early identification and treatment of cases and through continous follow up.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare Workers; Persons at high risk (IDUs, contacts of cases of hepatitis B or C, dialysis patients).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has, however, been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is compulsory for some groups. These include people on the pre-mariatal program, certain groups in pre-employment and blood donors.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place. Screening and diagnosis can be done at any government health facility for free. Where the results are positive they are reported to the communicable disease control unit (CDCU) in the department of public health. The CDCU refer the patients to a gasteroenterologist for further management and treatment.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Treatment is provided free of charge to all citizens.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO.

WHO Assistance

The government of Bahrain would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Bangladesh

Estimated Mortality (2004)	Total
Acute hepatitis B	2646.66
Acute hepatitis C	915.46
Liver cancer	1344.66
Cirrhosis	15662.77
Infectious diseases	260.33*
Non-communicable diseases	552*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	59240
Acute hepatitis C	19990
Liver cancer	17980
Cirrhosis	348530
Infectious diseases	19121*
Non-communicable diseases	16264*

1-years olds immunised against hepatitis B (2007): 90%

*thousands

Population (2006):	155,991,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$1,230
Total health spend as a % of GDP (2006):	3.1%
Per capita total health spend (2006):	$69
Per capita govt health spend (2006):	$26
Life Expectancy (f/m, 2006):	63 / 63
Healthy Life Expectancy (f/m, 2003):	53 / 55
Median Age (2006):	22

The government of Bangladesh reports as follows:

Policy

The government of Bangladesh considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of Bangladesh would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Barbados

Population (2006):	293,000
Country Classification (2009):	High income
Gross National Income per capita (2005):	$15,150
Total health spend as a % of GDP (2006):	6.7%
Per capita total health spend (2006):	$1,155
Per capita govt health spend (2006):	$722
Life Expectancy (f/m, 2006):	79 / 72
Healthy Life Expectancy (f/m, 2003):	68 / 63
Median Age (2006):	36

Estimated Mortality (2004)	Total
Acute hepatitis B	0.0
Acute hepatitis C	0.0
Liver cancer	14.1
Cirrhosis	22.02
Infectious diseases	0.18*
Non-communicable diseases	02*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	0
Acute hepatitis C	0
Liver cancer	120
Cirrhosis	350
Infectious diseases	07*
Non-communicable diseases	37*

1-years olds immunised against hepatitis B (2007): 93%

*thousands

The government of Barbados reports as follows:

Policy

The government of Barbados does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. The Ministry of Health's Strategic Goal for Communicable Diseases (2002-2012) is to reduce the morbidity and mortality of existing, new and re-emerging communicable diseases. One of the key indicators is to ensure that the case fatality rate of communicable diseases is less than five percent.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare Workers; Military personnel; Persons at high risk (sanitation workers and police men). All adolescents must be vaccinated before entry into tertiary education.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions do not currently exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Information was not available on whether liver cancer cases are registered
- Information was not available on whether cases of co-infection with HIV are registered

Prevalence estimates: Information was not available on whether prevalence estimates exist. However, in 2008 2 cases and in 2009 3 cases of hepatitis B and hepatitis C were reported.

Disease reporting: Disease reports are published on a monthly basis. A report on confirmed communicable diseases, including hepatitis, is provided to the Caribbean Epidemiology Centre every 4 weeks.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include all patients who access public services.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. This is done for the procurement of vaccines.

WHO Assistance

The government of Barbados would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Belgium

Estimated Mortality (2004)	Total
Acute hepatitis B	105.12
Acute hepatitis C	0.0
Liver cancer	667.9
Cirrhosis	1372.6
Infectious diseases	1.56*
Non-communicable diseases	94*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	930
Acute hepatitis C	0
Liver cancer	4400
Cirrhosis	20140
Infectious diseases	56*
Non-communicable diseases	1164*

1-years olds immunised against hepatitis B (2007): 86%

*thousands

Population (2006):	10,430,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$33,860
Total health spend as a % of GDP (2006):	9.5%
Per capita total health spend (2006):	$3,183
Per capita govt health spend (2006):	$2,264
Life Expectancy (f/m, 2006):	82 / 77
Healthy Life Expectancy (f/m, 2003):	73 / 69
Median Age (2006):	41

The government of Belgium reports as follows:

Policy

The government of Belgium does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

Several prevention strategies are in place, these focus on hepatitis B vaccination and prevention of hepatitis C among IDUs. These are integrated with work on HIV/AIDS prevention and risk reduction strategies.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include; Prevention of chronic hepatitis and hepatic cancer through vaccination.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Persons at high risk (infants born to HBsAg positive mothers, people likely to be exposed in occupational settings, hemodialysis patients, STI clinic patients, people with multiple sex partners, IDUs).

A universal vaccination programme for infants has been in place since 1999. Additional activity includes a catch-up programme for adolescents and screening for people considered at high risk.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Information was not available on whether liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on an annual basis.

Hepatitis B is a notifiable disease nationally; hepatitis C at some local levels.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

No areas for WHO assistance were identified

Belize

Population (2006):	282,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$7,080
Total health spend as a % of GDP (2006):	5.3%
Per capita total health spend (2006):	$426
Per capita govt health spend (2006):	$254
Life Expectancy (f/m, 2006):	74 / 65
Healthy Life Expectancy (f/m, 2003):	62 / 58
Median Age (2006):	21

Estimated Mortality (2004)	Total
Acute hepatitis B	0.96
Acute hepatitis C	0.0
Liver cancer	16.82
Cirrhosis	22.95
Infectious diseases	0.12*
Non-communicable diseases	01*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	10
Acute hepatitis C	0
Liver cancer	190
Cirrhosis	420
Infectious diseases	14*
Non-communicable diseases	29*

1-years olds immunised against hepatitis B (2007): 96%

*thousands

The government of Belize reports as follows:

Policy

The government of Belize does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants - Infants are immunised with DPT-HepB-Hib pentavalent vaccine.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are not registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are not available. Incidence rates are available.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include all except those who require it for nationality purposes.

Compulsory testing: Testing is compulsory for some groups. These include blood donors.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Interferon and Lamivudine are available to all needing treatment for Hepatitis B. Treatment is 100% funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Belize would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Other areas including: specific awareness raising strategies for healthcare workers; laboratory support with quality assurance

Botswana

Estimated Mortality (2004)	Total
Acute hepatitis B	2.93
Acute hepatitis C	1.32
Liver cancer	26.46
Cirrhosis	47.5
Infectious diseases	17.26*
Non-communicable diseases	05*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	60
Acute hepatitis C	30
Liver cancer	300
Cirrhosis	1020
Infectious diseases	670*
Non-communicable diseases	163*

1-years olds immunised against hepatitis B (2007): 85%

*thousands

Population (2006):	1,858,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$11,730
Total health spend as a % of GDP (2006):	7.2%
Per capita total health spend (2006):	$635
Per capita govt health spend (2006):	$487
Life Expectancy (f/m, 2006):	52 / 51
Healthy Life Expectancy (f/m, 2003):	35 / 36
Median Age (2006):	21

The government of Botswana reports as follows:

Policy

The government of Botswana considers hepatitis B and/or hepatitis C to be an urgent public health issue.

Hepatitis B in particular is considered an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally. This is in place for hepatitis B only.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare Workers.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of Botswana would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Brazil

Population (2006):	189,323,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$8,700
Total health spend as a % of GDP (2006):	7.5%
Per capita total health spend (2006):	$765
Per capita govt health spend (2006):	$367
Life Expectancy (f/m, 2006):	75 / 68
Healthy Life Expectancy (f/m, 2003):	62 / 57
Median Age (2006):	27

Estimated Mortality (2004)	Total
Acute hepatitis B	1021.02
Acute hepatitis C	1808.78
Liver cancer	3837.74
Cirrhosis	22713.65
Infectious diseases	100.6*
Non-communicable diseases	903*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	18420
Acute hepatitis C	23680
Liver cancer	40590
Cirrhosis	450890
Infectious diseases	7513*
Non-communicable diseases	22925*

1-years olds immunised against hepatitis B (2007): 95%

*thousands

The government of Brazil reports as follows:

Policy

The government of Brazil considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they work exclusively on the hepatitis strategy.

This is overseen by the National Viral Hepatitis Control Programme, created in 2003. The national Viral Hepatitis Strategy (2009) gives an overview of hepatitis B and C in Brazil. Components include prevention, screening, testing and treatment. Specific guidelines are given for the treatment of cases of co-infection with HIV.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: To vaccinate 95% of children and adolescents under 20 years of age against hepatitis B; to increase testing for hepatitis B to 17 in every 1,000 people; to treat 70% of patients with hepatitis C.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Travellers; Military personnel; Persons at high risk (not specified).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. These have been done through mass media campaigns using radio, television, newspapers and through partnership with civil society organisations. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government. These activities have been carried out in partnership with civil society organisations.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on a monthly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially. Test results are provided confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include a large number of civil society organisations across the country.

WHO Assistance

The government of Brazil would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Brunei Darussalam

Estimated Mortality (2004)	Total
Acute hepatitis B	1.4
Acute hepatitis C	2.27
Liver cancer	13.61
Cirrhosis	8.33
Infectious diseases	0.03*
Non-communicable diseases	01*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	20
Acute hepatitis C	30
Liver cancer	140
Cirrhosis	160
Infectious diseases	06*
Non-communicable diseases	31*

1-years olds immunised against hepatitis B (2007): 99%

*thousands

Population (2006):	382,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$49,900
Total health spend as a % of GDP (2006):	1.8%
Per capita total health spend (2006):	$394
Per capita govt health spend (2006):	$314
Life Expectancy (f/m, 2006):	79 / 76
Healthy Life Expectancy (f/m, 2003):	66 / 65
Median Age (2006):	26

The government of Brunei Darussalam reports as follows:

Policy

The government of Brunei Darussalam does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers; Persons at high risk (contacts of hepatitis B positive).

Hepatitis B vaccine has been included in the EPI free of charge since 1988. Universal antenatal screening is also in place.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

The Ministry of Health has written guidance on preventing occupational exposure and managing healthcare workers with HIV, hepatitis B and hepatitis C. Healthcare workers are advised to be vaccinated for hepatitis B during training.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. However hepatitis and other blood borne diseases are included in awareness campaigns for the annual Blood Donors' Day. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are not available.

Disease reporting: Disease reports are published on an annual basis.

Hepatitis A, B, C and others are notifiable under the Infectious Disease Order 2003.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include all Brunei citizens and permanent residents. Screening of blood donors and antenatal patients is free of charge.

Compulsory testing: Testing is compulsory for some groups. Screening of blood donors and antenatal patients is free of charge and compulsory.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place. Where positive cases are identified from screening or testing, notification is sent to the Disease Control Division at the Department of Health. Cases are recalled for counselling and contact tracing; all contacts traced are offered screening and vaccination. Acute and chronic cases are referred to a clinician for follow-up including treatment and routine screening for liver cirrhosis and HCC. Hepatitis A vaccination is given to all HBsAg positive individuals.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. All expenses incurred in treatment are fully government-funded for citizens and permanent residents.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO Western Pacific Region.

WHO Assistance

The government of Brunei Darussalam would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance
- Other areas including: vaccination protocols and guidance in particular relating to the booster dose of the vaccine and to address cases of non sero converters.

Bulgaria

Population (2006):	7,693,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$10,270
Total health spend as a % of GDP (2006):	6.9%
Per capita total health spend (2006):	$741
Per capita govt health spend (2006):	$443
Life Expectancy (f/m, 2006):	76 / 69
Healthy Life Expectancy (f/m, 2003):	67 / 63
Median Age (2006):	41

Estimated Mortality (2004)	Total
Acute hepatitis B	31.71
Acute hepatitis C	12.35
Liver cancer	849.37
Cirrhosis	1521.01
Infectious diseases	0.71*
Non-communicable diseases	105*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	640
Acute hepatitis C	250
Liver cancer	7260
Cirrhosis	21220
Infectious diseases	74*
Non-communicable diseases	1251*

1-years olds immunised against hepatitis B (2007): 95%

*thousands

The government of Bulgaria reports as follows:

Policy

The government of Bulgaria considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers; Military personnel.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Information was not available on whether other countries' policies relating to hepatitis B and/or hepatitis C are currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has, however, been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Information was not available on whether chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on a monthly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups (not specified).

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of Bulgaria would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Developing tools to assess the effectiveness of interventions
- Surveillance

Burundi

Estimated Mortality (2004)	Total
Acute hepatitis B	159.27
Acute hepatitis C	71.56
Liver cancer	577.55
Cirrhosis	286.42
Infectious diseases	52.33*
Non-communicable diseases	28*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	4610
Acute hepatitis C	2070
Liver cancer	7140
Cirrhosis	6810
Infectious diseases	3332*
Non-communicable diseases	821*

1-years olds immunised against hepatitis B (2007): 74%

*thousands

Population (2006):	8,173,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$320
Total health spend as a % of GDP (2006):	3.0%
Per capita total health spend (2006):	$15
Per capita govt health spend (2006):	$4
Life Expectancy (f/m, 2006):	50 / 48
Healthy Life Expectancy (f/m, 2003):	37 / 33
Median Age (2006):	17

The government of Burundi reports as follows:

Policy

The government of Burundi considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Vaccination of other groups such as healthcare workers and people who have been sexually assaulted also takes place though is not consistently available.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO.

WHO Assistance

The government of Burundi would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Surveillance

Cambodia

Population (2006):	14,197,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$1,550
Total health spend as a % of GDP (2006):	6.0%
Per capita total health spend (2006):	$167
Per capita govt health spend (2006):	$43
Life Expectancy (f/m, 2006):	65 / 59
Healthy Life Expectancy (f/m, 2003):	49 / 46
Median Age (2006):	20

Estimated Mortality (2004)	Total
Acute hepatitis B	812.85
Acute hepatitis C	229.43
Liver cancer	778.57
Cirrhosis	1221.74
Infectious diseases	41.61*
Non-communicable diseases	58*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	22790
Acute hepatitis C	5960
Liver cancer	11970
Cirrhosis	26240
Infectious diseases	2903*
Non-communicable diseases	1724*

1-years olds immunised against hepatitis B (2007): 82%

*thousands

The government of Cambodia reports as follows:

Policy

The government of Cambodia considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: Reduction of the prevalence rate of hepatitis B antigen among children aged 5 years old from 3.4% to less than 2% by the year 2012.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Hepatitis B vaccine was introduced in 2001 as part of the National Five Year Plan on Immunization 2001-2005. The National Vaccination Policy (2003) addresses access and coverage and includes vaccination delivery guidelines and the immunisation schedule.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. These have included the use of mass media - TV and radio - to raise awareness around hepatitis B. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government. This has been focused on ensuring equity in healthcare service provision.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

The government is currently planning a vaccination coverage survey to update existing information which was collected in 1995.

Prevalence estimates: Prevalence estimates for hepatitis B are provided in the strategy for the introduction of hepatitis B vaccine, although this notes that the actual burden of disease caused by hepatitis B in Cambodia is not known. This states that blood donor surveys have found HBsAg rates between 3.2% and 12.2%. In some areas rates of up to 19% have been found. A survey of carriage rates in one district found prevalence rates across different age groups at: 9-17 months: 3.1%; 4-5 years: 4.8%; 13-15 years: 8.6%; 20-35 years: 11.5%.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place. Although there is no screening for hepatitis B diagnosis and treatment services are available at public and private hospitals.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. At public hospitals services are free of charge for the poor who have exemptions and through the Health Equity Fund.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include WHO support for policy development, GAVI Alliance for vaccination programmes and vaccine introduction, PATH (NGO) for technical support in vaccine introduction.

WHO Assistance

The government of Cambodia would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Developing goals for the prevention and control of hepatitis B and hepatitis C

Cameroon

Estimated Mortality (2004)	Total
Acute hepatitis B	136.62
Acute hepatitis C	61.38
Liver cancer	3648.54
Cirrhosis	694.04
Infectious diseases	103.21*
Non-communicable diseases	71*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	3310
Acute hepatitis C	1490
Liver cancer	45010
Cirrhosis	12350
Infectious diseases	5485*
Non-communicable diseases	1897*

1-years olds immunised against hepatitis B (2007): 82%

*thousands

Population (2006):	18,175,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$2,060
Total health spend as a % of GDP (2006):	5.2%
Per capita total health spend (2006):	$80
Per capita govt health spend (2006):	$23
Life Expectancy (f/m, 2006):	52 / 50
Healthy Life Expectancy (f/m, 2003):	42 / 41
Median Age (2006):	19

The government of Cameroon reports as follows:

Policy

The government of Cameroon considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

A national programme was under development at the time of study; practitioners have formed a network to direct this.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These were being finalised at the time of study.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Blood screening. Blood screening exists for hepatitis B only.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of Cameroon would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Surveillance

Canada

Population (2006):	32,577,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$36,280
Total health spend as a % of GDP (2006):	10.0%
Per capita total health spend (2006):	$3,672
Per capita govt health spend (2006):	$2,585
Life Expectancy (f/m, 2006):	83 / 78
Healthy Life Expectancy (f/m, 2003):	74 / 70
Median Age (2006):	39

Estimated Mortality (2004)	Total
Acute hepatitis B	98.75
Acute hepatitis C	295.57
Liver cancer	1517.81
Cirrhosis	2367.46
Infectious diseases	3.72*
Non-communicable diseases	201*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	1330
Acute hepatitis C	3960
Liver cancer	11970
Cirrhosis	31040
Infectious diseases	166*
Non-communicable diseases	3230*

1-years olds immunised against hepatitis B (2007): 14%

*thousands

The government of Canada reports as follows:

Policy

The government of Canada considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they work exclusively on the hepatitis strategy.

National hepatitis C strategy: Updated in 2009, Components include advocacy and awareness, prevention, screening, testing, surveillance, service evaluation, treatment, multisectoral collaboration and access.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. The Hepatitis C Programme's goal is to improve population health, decrease health disparities and reduce associated burden on the health system by: Contributing to prevention in Canada and around the world; Supporting people infected with, affected by, at risk of and/or vulnerable to HCV; Providing a stronger evidence base for policy and programming decisions; Strengthening partners' capacity to address HCV.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare Workers; Travellers; Military personnel; Persons at high risk (people at risk due to percutaneous or mucosal exposure; close contacts of people with acute or chronic infection). The policy addresses access issues and provides immunisation schedules and delivery guidelines.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government. The Public Health Agency of Canada's Hepatitis C Prevention, Support and Research Program collaborates with NGOs in World Hepatitis Day campaigns, raising public consciousness, engaging broader audiences of people including all affected by or at risk of hepatitis and to augment understanding of the disease. Stigma and discrimination are also identified investment priorities in the Program's Strategic Framework 2009.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Information was not available on whether liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available. Hepatitis B prevalence is estimated at 0.7-0.9%. 242,500 reported cases of hepatitis C in 2007; 3,200-5,000 people are estimated to be newly infected each year.

Disease reporting: Disease reports are published; the frequency of this was not specified.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. The government is responsible for the provision of health care, including pharmaceutical treatments, for all federally incarcerated inmates and for armed forces personnel. For the general public, health care is the responsibility of the Provinces and Territories.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. The Public Health Agency of Canada's Hepatitis C Program works nationally and has regional delivery mechanisms. The programme works in partnership with other governments, community-based organizations, and international partners and organisations.

WHO Assistance

The government of Canada would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Developing tools to assess the effectiveness of interventions
- Surveillance

Central African Republic

Estimated Mortality (2004)	Total
Acute hepatitis B	21.72
Acute hepatitis C	9.76
Liver cancer	666.56
Cirrhosis	175.89
Infectious diseases	30.35*
Non-communicable diseases	18*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	490
Acute hepatitis C	220
Liver cancer	8850
Cirrhosis	3720
Infectious diseases	1606*
Non-communicable diseases	457*

1-years olds immunised against hepatitis B (2007): -

*thousands

Population (2006):	4,265,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$690
Total health spend as a % of GDP (2006):	3.9%
Per capita total health spend (2006):	$55
Per capita govt health spend (2006):	$20
Life Expectancy (f/m, 2006):	48 / 48
Healthy Life Expectancy (f/m, 2003):	38 / 37
Median Age (2006):	18

The government of Central African Republic reports as follows:

Policy

The government of Central African Republic considers hepatitis B and/or hepatitis C to be an urgent public health issue.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants

Infant vaccination was introduced in 2008. It is provided free of charge at 6, 10, 14 weeks.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. An event to mark the introduction of hepatitis B vaccine, encourage take-up and raise awareness was, however, held in 2008 and involved government figures and civil society organisations. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially. Testing can only be done at one facility in the capital city.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place. This is limited to one facility in the capital city.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Central African Republic would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

China

Population (2006):	1,328,474,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$4,660
Total health spend as a % of GDP (2006):	4.5%
Per capita total health spend (2006):	$342
Per capita govt health spend (2006):	$144
Life Expectancy (f/m, 2006):	75 / 72
Healthy Life Expectancy (f/m, 2003):	65 / 63
Median Age (2006):	33

Estimated Mortality (2004)	Total
Acute hepatitis B	20451.04
Acute hepatitis C	8521.78
Liver cancer	308904.73
Cirrhosis	122583.03
Infectious diseases	435.92*
Non-communicable diseases	7376*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	358650
Acute hepatitis C	149510
Liver cancer	3652330
Cirrhosis	1864080
Infectious diseases	31878*
Non-communicable diseases	141016*

1-years olds immunised against hepatitis B (2007): 92%

*thousands

The government of China reports as follows:

Policy

The government of China considers hepatitis B and/or hepatitis C to be an urgent public health issue.

Hepatitis B in particular is regarded as one of the key communicable disease to tackle in China.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

National hepatitis B strategy: Components of The National Hepatitis B Prevention and Control Plan (2006) include: advocacy, prevention, screening, testing, surveillance, service evaluation, treatment, and multisectoral collaboration. It details measures to prevent transmission in healthcare settings, to strengthen disease surveillance and increase awareness.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: Reduction of HBsAg prevalence among the general population to less than 7% by 2010; Reduction of HBsAg of among children under 5 to less than 1% by 2010; In provinces with HBsAg prevalence below 7%, reduction of overall rate by 1% by 2010.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents.

Free vaccination is provided to infants and children under 15, immunisation among adults at high risk, health workers, and travellers is encouraged.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. A guideline for hepatitis B vaccination and awareness has been developed by the MoH and distributed to provincial level authorities. Prevention has been included in the annual National Vaccination Day campaign since 2002. The national plan also sets goals for awareness among healthcare workers, and for awareness among the general public to reach more than 80%.

Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government. This includes the Infectious Disease Prevention Law (2004) and employment regulations which protect the rights of people with hepatitis B.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Information was not available on whether cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available. The National Hepatitis B Prevention and Control Plan details the results of a 1992-1995 serum epidemiological investigation. This estimated that there were 690 million people infected with hepatitis B, 120 million chronic carriers and approximately 20 million chronic hepatitis B patients.

Disease reporting: Disease reports are published on an annual basis .

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the GAVI Alliance, the WHO and the China Foundation of Hepatitis.

WHO Assistance

The government of China would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Delivery of vaccination
- Developing tools to assess the effectiveness of interventions
- Surveillance

Colombia

Estimated Mortality (2004)	Total
Acute hepatitis B	162.14
Acute hepatitis C	46.56
Liver cancer	697.99
Cirrhosis	2180.8
Infectious diseases	15.29*
Non-communicable diseases	146*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	3500
Acute hepatitis C	690
Liver cancer	7240
Cirrhosis	29470
Infectious diseases	1376*
Non-communicable diseases	4436*

1-years olds immunised against hepatitis B (2007): 93%

*thousands

Population (2006):	45,558,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$6,130
Total health spend as a % of GDP (2006):	7.3%
Per capita total health spend (2006):	$626
Per capita govt health spend (2006):	$534
Life Expectancy (f/m, 2006):	78 / 71
Healthy Life Expectancy (f/m, 2003):	66 / 58
Median Age (2006):	26

The government of Colombia reports as follows:

Policy

The government of Colombia does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Pentavalent vaccine was introduced in 2001. Delivery guidelines and the immunisation schedule are included in the national vaccination policy.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance does not exist for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available. These indicate a rate of 4.1 cases per 100,000 for hepatitis B in 2009, which suggests a marked increase in the past five years.

Disease reporting: reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Liver transplants and some drugs are included in the health insurance policy package.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Colombia would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Comoros

Population (2006):	818,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$1,140
Total health spend as a % of GDP (2006):	3.2%
Per capita total health spend (2006):	$35
Per capita govt health spend (2006):	$19
Life Expectancy (f/m, 2006):	67 / 62
Healthy Life Expectancy (f/m, 2003):	55 / 54
Median Age (2006):	19

Estimated Mortality (2004)	Total
Acute hepatitis B	6.12
Acute hepatitis C	2.75
Liver cancer	45.3
Cirrhosis	16.93
Infectious diseases	1.32*
Non-communicable diseases	02*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	160
Acute hepatitis C	70
Liver cancer	530
Cirrhosis	330
Infectious diseases	110*
Non-communicable diseases	69*

1-years olds immunised against hepatitis B (2007): 75%

*thousands

The government of Comoros reports as follows:

Policy

The government of Comoros considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

This is focused on prevention of hepatitis B through vaccination, safe injection practices and blood screening.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Auto-Disable syringes have been used in immunisation campaigns since 2001. The EPI Plan to Improve the Safety of Injections provides guidelines and directives for the safe administration of all vaccinations.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Information was not available on whether standard case definitions currently exist
- Information was not available on whether clinical cases require laboratory confirmation prior to reporting
- Information was not available on whether surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are registered
- Information was not available on whether liver cancer cases are registered
- Information was not available on whether cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are not available.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

No information on the accessibility or cost of testing or whether it is compulsory for any groups was available to this study.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO and the GAVI Alliance.

WHO Assistance

The government of Comoros would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Developing tools to assess the effectiveness of interventions
- Surveillance

Cook Islands

Estimated Mortality (2004)	Total
Acute hepatitis B	0.03
Acute hepatitis C	0.01
Liver cancer	0.79
Cirrhosis	0.44
Infectious diseases	0.01*
Non-communicable diseases	0*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	0
Acute hepatitis C	0
Liver cancer	10
Cirrhosis	10
Infectious diseases	01*
Non-communicable diseases	01*

1-years olds immunised against hepatitis B (2007): 99%

*thousands

Population (2006):	14,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (-):	-
Total health spend as a % of GDP (2006):	4.5%
Per capita total health spend (2006):	$566
Per capita govt health spend (2006):	$518
Life Expectancy (f/m, 2006):	75 / 71
Healthy Life Expectancy (f/m, 2003):	63 / 61
Median Age (-):	-

The government of Cook Islands reports as follows:

Policy

The government of Cook Islands considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

The strategy is reported to exist at the operational level but has not yet been developed into a formal written policy or strategic document. Hepatitis is included in the National Health Strategy 2006. The recent National Non-Communicable Diseases Strategy and Action Plan 2009-2014, and a Communicable Diseases Strategy and Action Plan, in early development at the time of this study, will incorporate hepatitis B and hepatitis C prevention and control.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These are outlined in the National Health Strategy 2006, to be reviewed for 2011 and supplemented with the National Communicable Disease Strategy.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

This exists as part of National Child Immunization Schedule. Policy directives include routine hepatitis B screening for all antenatal mothers and vaccination of all infants with three doses of hepatitis B vaccine.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening.

This exists at the operational level but has not yet been incorporated into a written policy or strategy. Donated blood is screened for hepatitis B and hepatitis C.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions do not currently exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance does not exist for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are not registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is compulsory for some groups. These include all antenatal mothers and blood donors.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include WHO and Cook Islands Red Cross. Recent collaborative work has however tended not to focus on hepatitis B or hepatitis C.

WHO Assistance

The government of Cook Islands would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Costa Rica

Population (2006):	4,399,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$9,220
Total health spend as a % of GDP (2006):	7.0%
Per capita total health spend (2006):	$743
Per capita govt health spend (2006):	$565
Life Expectancy (f/m, 2006):	80 / 76
Healthy Life Expectancy (f/m, 2003):	69 / 65
Median Age (2006):	26

Estimated Mortality (2004)	Total
Acute hepatitis B	13.07
Acute hepatitis C	0.0
Liver cancer	218.55
Cirrhosis	312.9
Infectious diseases	0.46*
Non-communicable diseases	15*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	250
Acute hepatitis C	0
Liver cancer	1880
Cirrhosis	5570
Infectious diseases	60*
Non-communicable diseases	401*

1-years olds immunised against hepatitis B (2007): 89%

*thousands

The government of Costa Rica reports as follows:

Policy

The government of Costa Rica considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare Workers; Persons at high risk (not specified).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Information was not available on whether other countries' policies relating to hepatitis B and/or hepatitis C are currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are not available.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Costa Rica would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Surveillance

Cote d'Ivoire

Estimated Mortality (2004)	Total
Acute hepatitis B	245.53
Acute hepatitis C	110.31
Liver cancer	1859.05
Cirrhosis	938.09
Infectious diseases	136.33*
Non-communicable diseases	82*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	7040
Acute hepatitis C	3160
Liver cancer	25840
Cirrhosis	21430
Infectious diseases	7362*
Non-communicable diseases	2329*

1-years olds immunised against hepatitis B (2007): 76%

*thousands

Population (2006):	18,914,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$1,580
Total health spend as a % of GDP (2006):	3.8%
Per capita total health spend (2006):	$66
Per capita govt health spend (2006):	$15
Life Expectancy (f/m, 2006):	55 / 50
Healthy Life Expectancy (f/m, 2003):	41 / 38
Median Age (2006):	19

The government of Côte d'Ivoire reports as follows:

Policy

The government of Côte d'Ivoire considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

The Côte d'Ivoire government established the Programme National de Lutte contre les Hépatites Virales (national programme to combat viral hepatitis, PNLHV) in 2008. This programme has developed three plans for prevention and control of viral hepatitis: the monitoring and surveillance policy, the prevention and treatment strategy for hepatitis B and C, and a public awareness strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. The overarching goals of the PNLHV include: Primary prevention of viral hepatitis; Increased awareness and uptake of testing, particularly among risk groups; improving access to treatment and providing good practice recommendations on care for people who have viral hepatitis.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Hepatitis B vaccination is included in the EPI. Infants are vaccinated at 6, 10 and 14 weeks.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Details of the areas covered by this strategy were not available to this study.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. Campaigns carried out in 2009 by the PNLHV have included awareness work targeted at the general public using public events and mass media, a workplace testing programme and an awareness campaign targeted at doctors and nurses. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Côte d'Ivoire would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance
- Other areas including: assistance with research, logistics and access to training

Croatia

Population (2006):	4,556,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$13,850
Total health spend as a % of GDP (2006):	7.5%
Per capita total health spend (2006):	$1,084
Per capita govt health spend (2006):	$869
Life Expectancy (f/m, 2006):	79 / 72
Healthy Life Expectancy (f/m, 2003):	69 / 64
Median Age (2006):	41

Estimated Mortality (2004)	Total
Acute hepatitis B	19.06
Acute hepatitis C	23.1
Liver cancer	468.91
Cirrhosis	1283.82
Infectious diseases	0.43*
Non-communicable diseases	47*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	270
Acute hepatitis C	360
Liver cancer	3600
Cirrhosis	16850
Infectious diseases	30*
Non-communicable diseases	609*

1-years olds immunised against hepatitis B (2007): 95%

*thousands

The government of Croatia reports as follows:

Policy

The government of Croatia considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Persons at high risk (those at risk of infection through occupational exposure, family members of people with hepatitis B).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Information was not available on whether other countries' policies relating to hepatitis B and/or hepatitis C are currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on a weekly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

No areas for WHO assistance were identified.

Cuba

Estimated Mortality (2004)	Total
Acute hepatitis B	76.53
Acute hepatitis C	43.16
Liver cancer	652.49
Cirrhosis	1096.28
Infectious diseases	0.88*
Non-communicable diseases	67*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	1190
Acute hepatitis C	520
Liver cancer	4980
Cirrhosis	15700
Infectious diseases	124*
Non-communicable diseases	1269*

1-years olds immunised against hepatitis B (2007): 93%

*thousands

Population (2006):	11,267,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (0):	-
Total health spend as a % of GDP (2006):	7.1%
Per capita total health spend (2006):	$363
Per capita govt health spend (2006):	$329
Life Expectancy (f/m, 2006):	80 / 76
Healthy Life Expectancy (f/m, 2003):	70 / 67
Median Age (2006):	36

The government of Cuba reports as follows:

Policy

The government of Cuba considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they work exclusively on the hepatitis strategy. The national viral hepatitis program has been in place since 1989.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Military personnel; Persons at high risk.

Hepatitis B vaccination has been included in the National Immunisation Programme since 1991. Vaccination includes all newborns, high risk groups and of the total population under twenty years of age in the year 2000. Vaccination for groups considered high risk, such as patients and staff in dialysis services, has been available since the 1980s. 95% reductions in hepatitis B prevalence have been achieved since its introduction. A sub-program for Prevention of Perinatal Transmission is also in place.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on a weekly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. All treatment is provided free of charge.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of Cuba would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Surveillance

Cyprus

Population (2006):	846,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$25,060
Total health spend as a % of GDP (2006):	6.3%
Per capita total health spend (2006):	$1,696
Per capita govt health spend (2006):	$759
Life Expectancy (f/m, 2006):	82 / 79
Healthy Life Expectancy (f/m, 2003):	68 / 67
Median Age (2006):	35

Estimated Mortality (2004)	Total
Acute hepatitis B	0.0
Acute hepatitis C	0.0
Liver cancer	56.74
Cirrhosis	33.44
Infectious diseases	0.08*
Non-communicable diseases	05*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	0
Acute hepatitis C	0
Liver cancer	420
Cirrhosis	370
Infectious diseases	07*
Non-communicable diseases	85*

1-years olds immunised against hepatitis B (2007): 93%

*thousands

The government of Cyprus reports as follows:

Policy

The government of Cyprus considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: 95% coverage for child immunisation against hepatitis B (target fulfilled); Blood donor screening.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Travellers; Persons at high risk.

Infants are immunised at 2, 4 and 6-8 months. Vaccination of healthcare workers is provided on a voluntary basis.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available. The latest prevalence estimates for both HBV and HCV are less than 0.1 %.

Disease reporting: Disease reports are published; frequency not specified.

Both hepatitis B and hepatitis C are notifiable diseases.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include people entitled to free medical care.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Treatment is provided free of charge those people entitled to free medical care.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

No areas for WHO assistance were identified.

Czech Republic

Estimated Mortality (2004)	Total
Acute hepatitis B	10.19
Acute hepatitis C	8.05
Liver cancer	962.62
Cirrhosis	1809.19
Infectious diseases	0.38*
Non-communicable diseases	97*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	160
Acute hepatitis C	100
Liver cancer	7660
Cirrhosis	29010
Infectious diseases	54*
Non-communicable diseases	1262*

1-years olds immunised against hepatitis B (2007): 99%

*thousands

Population (2006):	10,189,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$20,920
Total health spend as a % of GDP (2006):	6.8%
Per capita total health spend (2006):	$1,490
Per capita govt health spend (2006):	$1,309
Life Expectancy (f/m, 2006):	80 / 73
Healthy Life Expectancy (f/m, 2003):	71 / 66
Median Age (2006):	39

The government of Czech Republic reports as follows:

Policy

The government of Czech Republic considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: Reduction of hepatitis B incidence in population; Control of hepatitis C incidence in the population.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Persons at high risk (infants born to HBsAg positive mothers, haemodialysis patients, medical students, nursing students, social services staff in contact with human biological material, Integrated Rescue Service staff).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. These include publications, consultations, seminars, and conferences with a focus on hepatitis in high risk groups, particularly IDUs. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government. This has been done through Support of the National Monitoring Centre for Drugs and Drug Addition.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are not registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on a monthly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups (not specified).

Compulsory testing: Testing is compulsory for some groups (not specified).

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Drugs funded and the criteria for their provision include:Standard treatment policy.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO and the National Monitoring Centre for Drugs and Drug Addiction.

WHO Assistance

The government of Czech Republic would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Surveillance

Democratic People's Republic of Korea

Population (2006):	23,708,000
Country Classification (2009):	Low income
Gross National Income per capita (-):	-
Total health spend as a % of GDP (2006):	3.5%
Per capita total health spend (2006):	$49
Per capita govt health spend (2006):	$42
Life Expectancy (f/m, 2006):	68 / 64
Healthy Life Expectancy (f/m, 2003):	60 / 58
Median Age (2006):	32

Estimated Mortality (2004)	Total
Acute hepatitis B	1133.3
Acute hepatitis C	231.86
Liver cancer	3191.52
Cirrhosis	2825.73
Infectious diseases	26.89*
Non-communicable diseases	141*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	17210
Acute hepatitis C	3490
Liver cancer	38810
Cirrhosis	47810
Infectious diseases	1600*
Non-communicable diseases	3109*

1-years olds immunised against hepatitis B (2007): 92%

*thousands

The government of the Democratic People's Republic of Korea reports as follows:

Policy

The government of the Democratic People's Republic of Korea considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they work exclusively on the hepatitis strategy.

The strategy focuses on prevention through awareness raising, vaccination and blood and injecting safety, strengthening disease surveillance systems and improving coordination of this work under the National Hepatitis Programme (NHP). The National Hepatitis Research Center supports policy development and strategy implementation with the National and Provincial Hepatitis Prevention Hospitals. Implementation has been delayed by limited human and financial resources due to natural disasters in the 1990s.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. To reduce the prevalence of hepatitis B to under 2%; to reduce the incidence of hepatitis B and C; to reduce morbidity associated with hepatitis B and C.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Military personnel; Persons at high risk (not specified).

Universal hepatitis B vaccination is in place for infants and a catch-up programme is being implemented for adolescents. The policy also includes healthcare workers, military personnel and risk groups but funding has not yet been secured to implement this.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. These have been targeted at healthcare workers and the general public to raise awareness of hepatitis B and hepatitis C, however this work has been limited due to a lack of funding. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government. The NHP has produced educational publications and held activities and events.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Information was not available on whether cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available. Unofficial estimates indicate a rate of 12% for hepatitis B in 2001.

Disease reporting: Disease reports are not published.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially. Access to testing for hepatitis B is accessible to more than 50% of the population.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is compulsory for some groups (not specified).

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of the Democratic People's Republic of Korea would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Democratic Republic of the Congo

Estimated Mortality (2004)	Total
Acute hepatitis B	779.76
Acute hepatitis C	350.33
Liver cancer	8258.37
Cirrhosis	2133.02
Infectious diseases	444.73*
Non-communicable diseases	208*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	20810
Acute hepatitis C	9360
Liver cancer	130620
Cirrhosis	49790
Infectious diseases	27525*
Non-communicable diseases	6241*

1-years olds immunised against hepatitis B (2007): 87%

*thousands

Population (2006):	60,644,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$270
Total health spend as a % of GDP (2006):	4.3%
Per capita total health spend (2006):	$18
Per capita govt health spend (2006):	$7
Life Expectancy (f/m, 2006):	49 / 46
Healthy Life Expectancy (f/m, 2003):	39 / 35
Median Age (2006):	16

The government of Democratic Republic of the Congo reports as follows:

Policy

The government of Democratic Republic of the Congo considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

The Democratic Republic of Congo government established the Program National de Lutte contre les Hépatites Virales (national programme to combat viral hepatitis, PNLHV) in 2003. This programme develops prevention policies and monitors hepatitis cases , although there have been shortfalls in resources. The programme worked with the EPI to attain support for the integration of hepatitis B vaccine into the national immunisation programme. It now focuses on strategies for managing chronic cases as well as the new cases detected by the national centre for blood transfusion.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: Reduction of hepatitis B prevalence to under 3%.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Hepatitis B vaccine was integrated into the national immunisation programme in 2007. Infants are immunised with pentavalent vaccine at 6, 10 and 14 weeks.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are not registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available. These indicate a rate of 8-9% for hepatitis B. Disease reporting: Disease reports are published on a weekly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Cases of hepatitis B and hepatitis C are usually detected at the national blood transfusion laboratory in blood donors. Testing may also be accessed at the request of practitioners.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include WHO for technical support and the GAVI Alliance for the provision of hepatitis B vaccine.

WHO Assistance

The government of Democratic Republic of the Congo would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

In Addition, assistance to the PNLHV in managing chronic cases and cases newly detected.

Denmark

Population (2006):	5,430,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$36,190
Total health spend as a % of GDP (2006):	9.5%
Per capita total health spend (2006):	$3,349
Per capita govt health spend (2006):	$2,812
Life Expectancy (f/m, 2006):	81 / 76
Healthy Life Expectancy (f/m, 2003):	71 / 69
Median Age (2006):	40

Estimated Mortality (2004)	Total
Acute hepatitis B	14.46
Acute hepatitis C	6.97
Liver cancer	285.08
Cirrhosis	834.21
Infectious diseases	0.45*
Non-communicable diseases	52*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	270
Acute hepatitis C	120
Liver cancer	2130
Cirrhosis	14010
Infectious diseases	26*
Non-communicable diseases	647*

1-years olds immunised against hepatitis B (2007): 0%

*thousands

The government of Denmark reports as follows:

Policy

The government of Denmark considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

The government finances a national plan to combat hepatitis among IDUs.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Healthcare workers; Persons at high risk (close contacts of chronically infected).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. The Government supports and has initiated various preventive programs against hepatitis B and C and funds NGOs to carry out educational activities among the general population, as well as financing a national plan to fight hepatitis among IDUs. The government has funded local campaigns for IDUs and also supported the information work of national NGOs (patient organisations including for haemophiliacs). Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Information was not available on whether cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is compulsory for some groups. These include pregnant women and blood donors.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. All treatment is funded through public social security.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the Danish NGOs Hepatitisforeningen and Bløderforeningen (for haemophiliacs).

WHO Assistance

No areas for WHO assistance were identified.

Ecuador

Estimated Mortality (2004)	Total
Acute hepatitis B	20.24
Acute hepatitis C	6.13
Liver cancer	474.1
Cirrhosis	2169.96
Infectious diseases	7.54*
Non-communicable diseases	47*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	450
Acute hepatitis C	120
Liver cancer	4100
Cirrhosis	34910
Infectious diseases	569*
Non-communicable diseases	1361*

1-years olds immunised against hepatitis B (2007): 99%

*thousands

Population (2006):	13,202,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$6,810
Total health spend as a % of GDP (2006):	5.4%
Per capita total health spend (2006):	$297
Per capita govt health spend (2006):	$130
Life Expectancy (f/m, 2006):	76 / 70
Healthy Life Expectancy (f/m, 2003):	64 / 60
Median Age (2006):	24

The government of Ecuador reports as follows:

Policy

The government of Ecuador considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Persons at high risk (not specified).

The hepatitis B vaccination policy includes delivery guidelines and the immunisation schedule. Under the policy pentavalent hepatitis B vaccine is provided to all infants at 2, 4 and 6 months, and vaccination to healthcare workers and sex workers and to all children under 10 years of age in high prevalence areas such as the Amazon region.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. Campaigns have been held in schools integrated with HIV/AIDS work, directed at adolescents, healthcare workers and sex workers. Awareness and education around blood safely has been carried out in medical schools with the Ecuador Red Cross. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available. Hepatitis B prevalence is estimated at 36.2%, of which 6% are chronically infected. Estimated prevalence active hepatitis B infections in the Coastal and Amazon regions is 2.6%. In healthcare workers rates of 46% have been found with a chronic infection rate of 9.5%.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. In public hospitals treatment is free of charge for all.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO and international NGOs.

WHO Assistance

The government of Ecuador would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Egypt

Population (2006):	74,166,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$4,940
Total health spend as a % of GDP (2006):	6.3%
Per capita total health spend (2006):	$316
Per capita govt health spend (2006):	$129
Life Expectancy (f/m, 2006):	70 / 66
Healthy Life Expectancy (f/m, 2003):	60 / 58
Median Age (2006):	23

Estimated Mortality (2004)	Total
Acute hepatitis B	4417.44
Acute hepatitis C	2275.65
Liver cancer	2672.6
Cirrhosis	18926.12
Infectious diseases	31.13*
Non-communicable diseases	391*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	53300
Acute hepatitis C	27460
Liver cancer	34690
Cirrhosis	262080
Infectious diseases	3257*
Non-communicable diseases	8959*

1-years olds immunised against hepatitis B (2007): 98%

*thousands

The government of Egypt reports as follows:

Policy

The government of Egypt considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: Monitoring prevalence and incidence; Reduction of the prevalence of chronic hepatitis B and C in the 15-30 age group by 20% of 2008 levels by 2012; Expansion of access to treatment to within 100 km for all Egyptians; Treat 50% of those needing it by 2012; Continued high-quality scientific research; Ensure programmatic sustainability.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers; Persons at high risk (haemodialysis patients).

Hepatitis B vaccination is mandatory for all infants. Vaccination of all healthcare workers is planned to have taken place by the end of 2011.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

The strategy includes directives on blood screening (a legal obligation), equipment for blood banks, training for medical stuff, the development of an Infection Control department in each health facility and on the use of auto-disable syringes.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. This has included activities for World Hepatitis Day. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government. A national hotline to provide information on hepatitis and other infectious diseases has been introduced, which is advertised through mass media.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are not registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available. 1996 estimates indicate a HBsAg prevalence rate of 4.5% and a 14.5% hepatitis C prevalence; this is the highest estimated prevalence of hepatitis C in the region.

Disease reporting: Disease reports are published; frequency unspecified.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include people attending Voluntary Testing and Counselling services and patients who have medical insurance.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. More than 90% of the drug price is government-funded. The National Treatment Programme has goals to increase the number of people in and the accessibility of treatment. In 2007, 10 centres initiated treatment for approximately 20,000 patients and in 2008 16 centres did so for 40,000 patients. Four centres are planned for 2009.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO Eastern Mediterranean regional office, USAID and NGOs.

WHO Assistance

The government of Egypt would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Developing tools to assess the effectiveness of interventions
- Surveillance
- Other areas including: training in infection control.

Equatorial Guinea

Estimated Mortality (2004)	Total
Acute hepatitis B	9.5
Acute hepatitis C	4.27
Liver cancer	92.87
Cirrhosis	24.88
Infectious diseases	3.31*
Non-communicable diseases	02*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	280
Acute hepatitis C	130
Liver cancer	1280
Cirrhosis	440
Infectious diseases	186*
Non-communicable diseases	58*

1-years olds immunised against hepatitis B (2007): 0%

*thousands

Population (2006):	496,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$16,620
Total health spend as a % of GDP (2006):	1.5%
Per capita total health spend (2006):	$280
Per capita govt health spend (2006):	$219
Life Expectancy (f/m, 2006):	47 / 46
Healthy Life Expectancy (f/m, 2003):	46 / 45
Median Age (2006):	19

The government of Equatorial Guinea reports as follows:

Policy

The government of Equatorial Guinea does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is not in place.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Information was not available on whether other countries' policies relating to hepatitis B and/or hepatitis C are currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance does not exist for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Information was not available on whether chronic hepatitis infections are registered
- Liver cancer cases are not registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are not available.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include blood donors.

Compulsory testing: Testing is not compulsory for any groups. These include blood donors.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Equatorial Guinea would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Increasing access to treatment
- Delivery of vaccination
- Surveillance

Eritrea

Population (2006):	4,692,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$680
Total health spend as a % of GDP (2006):	4.5%
Per capita total health spend (2006):	$28
Per capita govt health spend (2006):	$10
Life Expectancy (f/m, 2006):	65 / 61
Healthy Life Expectancy (f/m, 2003):	51 / 49
Median Age (2006):	18

Estimated Mortality (2004)	Total
Acute hepatitis B	4.63
Acute hepatitis C	2.08
Liver cancer	211.48
Cirrhosis	96.9
Infectious diseases	10.47*
Non-communicable diseases	10*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	100
Acute hepatitis C	40
Liver cancer	2350
Cirrhosis	2230
Infectious diseases	729*
Non-communicable diseases	349*

1-years olds immunised against hepatitis B (2007): 97%

*thousands

The government of Eritrea reports as follows:

Policy

The government of Eritrea considers hepatitis B and/or hepatitis C to be an urgent public health issue.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Information was not available on whether any government-funded awareness campaigns have taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Eritrea would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Estonia

Estimated Mortality (2004)	Total
Acute hepatitis B	2.88
Acute hepatitis C	1.29
Liver cancer	86.59
Cirrhosis	308.19
Infectious diseases	0.19*
Non-communicable diseases	16*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	60
Acute hepatitis C	30
Liver cancer	620
Cirrhosis	5560
Infectious diseases	16*
Non-communicable diseases	198*

1-years olds immunised against hepatitis B (2007): 95%

*thousands

Population (2006):	1340000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$18090
Total health spend as a % of GDP (2006):	5.0%
Per capita total health spend (2006):	$989
Per capita govt health spend (2006):	$734
Healthy Life Expectancy (f/m, 2003):	69 / 59
Median Age (2006):	39
Life Expectancy (f/m, 2006):	79 / 67

The government of Estonia reports as follows:

Policy

Hepatitis B and/or hepatitis C is considered to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare Workers.

The hepatitis B vaccination policy includes universal infant vaccination. A catch-up campaign for adolescents was also underway at the time of study and one for healthcare workers had been completed.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are not registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available.

Surveillance of communicable diseases is guided by the Public Health Act (1995, 2004) and the Communicable Diseases Prevention and Control Act (2003). Estimated incidence rates for hepatitis B: 19.3 (1999), 32.8 (2001), 12.7 (2003). For hepatitis C: 16.8 (1999), 22.4 (2001), 11.3 (2003).

A 2009 study found that from 1992 to 1998 rates of hepatitis B increased from 6/100,000 to 34/100,000 and hepatitis C from 0.4/100,000 in 1992 to 25/100,000 in 1998. This is largely believed to be linked to significant increases in injecting drug use. The incidence of both has since decreased to a level of 3.3 and 2.7 cases per 100,000 respectively in 2007.

Disease reporting: Disease reports are published on a monthly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is accessible to more than 50% of the population without significant barriers. It is not accessible anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include antenatal mothers.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Estonia would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Surveillance

Ethiopia

Population (2006):	81,021,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$630
Total health spend as a % of GDP (2006):	4.9%
Per capita total health spend (2006):	$22
Per capita govt health spend (2006):	$13
Life Expectancy (f/m, 2006):	58 / 55
Healthy Life Expectancy (f/m, 2003):	42 / 41
Median Age (2006):	18

Estimated Mortality (2004)	Total
Acute hepatitis B	2227.45
Acute hepatitis C	1000.74
Liver cancer	3765.89
Cirrhosis	2522.23
Infectious diseases	425.34*
Non-communicable diseases	257*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	71090
Acute hepatitis C	31960
Liver cancer	42990
Cirrhosis	54380
Infectious diseases	26919*
Non-communicable diseases	7367*

1-years olds immunised against hepatitis B (2007): 73%

*thousands

The government of Ethiopia reports as follows:

Policy

The government of Ethiopia considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place. These exist as part of a general policy on infectious and communicable diseases and focus on infection prevention and patient safety.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

At the time of study a working group formed across government and civil society was revising existing safety guidelines and training materials and developing a new national Infection Control and Patient Safety strategy. The draft plans include the establishment of a Prevention and Patient Safety Committee in all health facilities in the country.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially. This is only available as part of blood screening programmes and for blood donors.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

No information was available on whether government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Ethiopia would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Fiji

Estimated Mortality (2004)	Total
Acute hepatitis B	0.59
Acute hepatitis C	0.0
Liver cancer	18.42
Cirrhosis	14.29
Infectious diseases	0.57*
Non-communicable diseases	04*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	20
Acute hepatitis C	0
Liver cancer	250
Cirrhosis	300
Infectious diseases	37*
Non-communicable diseases	99*

1-years olds immunised against hepatitis B (2007): 84%

*thousands

Population (2006):	833,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$4,450
Total health spend as a % of GDP (2006):	4.0%
Per capita total health spend (2006):	$280
Per capita govt health spend (2006):	$199
Life Expectancy (f/m, 2006):	72 / 66
Healthy Life Expectancy (f/m, 2003):	61 / 57
Median Age (2006):	24

The government of Fiji reports as follows:

Policy

The government of Fiji considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: The control of hepatitis B infection amongst Fiji's population; Zero infection rate for hepatitis B in blood transfusion services; Over 95% coverage for first dose of hepatitis B vaccine given within 24 hours of birth.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers.

Hepatitis B vaccine has been part of the national EPI programme for over ten years; healthcare workers must be vaccinated against hepatitis B upon entering the workforce.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. These have focused on all vaccinations included in the routine EPI and National Immunisation Weeks have also been held for the past 3 years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are not available.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is compulsory for some groups. Screening is mandatory for anyone donating blood for transfusion purposes.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place. For screening and diagnosis, there are guidelines and protocols. As for referral and treatment, there are no existing guidelines yet.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Health care for any disease, including hepatitis, is available free of charge in all public health facilities.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO, UNICEF and Japan International Cooperation Agency for immunisation activities related to the National EPI programme.

WHO Assistance

The government of Fiji would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Finland

Population (2006):	5,261,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$33,170
Total health spend as a % of GDP (2006):	7.6%
Per capita total health spend (2006):	$2,472
Per capita govt health spend (2006):	$1,940
Life Expectancy (f/m, 2006):	83 / 76
Healthy Life Expectancy (f/m, 2003):	74 / 69
Median Age (2006):	41

Estimated Mortality (2004)	Total
Acute hepatitis B	3.02
Acute hepatitis C	9.21
Liver cancer	379.78
Cirrhosis	980.13
Infectious diseases	0.36*
Non-communicable diseases	41*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	30
Acute hepatitis C	180
Liver cancer	2690
Cirrhosis	16570
Infectious diseases	26*
Non-communicable diseases	574*

1-years olds immunised against hepatitis B (2007): 0%

*thousands

The government of Finland reports as follows:

Policy

The government of Finland does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

The national hepatitis strategy is focused on IDUs. Low Threshold Health Service Centres (LTHSC) for IDUs function as needle exchanges and also offer hepatitis B and C testing and provide hepatitis B vaccinations to drug users and their close contacts.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Persons at high risk.

The targeted hepatitis B vaccination program provides free vaccination to all infants born to HBsAg-positive parents, close contacts of active cases of hepatitis B, IDUs and their close contacts, sex workers, healthcare workers who have been exposed, and medical students working in countries where this is required or who are considered at risk.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Information was not available on whether liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on an annual basis.

Hepatitis B and hepatitis C are notifiable infectious diseases.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially. It is free of charge and anonymous for all IDUs in Low Threshold Health Service Centres and in healthcare centres when ordered by a doctor.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. According the Communicable Diseases Act and Decree, hepatitis B and hepatitis C are notifiable infectious diseases. The treatment of all notifiable infectious diseases is 100% funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include Low Threshold Health Service Centres.

WHO Assistance

No areas for WHO assistance were identified.

France

Estimated Mortality (2004)	Total
Acute hepatitis B	195.27
Acute hepatitis C	622.12
Liver cancer	7968.86
Cirrhosis	8690.59
Infectious diseases	11.46*
Non-communicable diseases	475*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	2190
Acute hepatitis C	6350
Liver cancer	57380
Cirrhosis	122560
Infectious diseases	351*
Non-communicable diseases	6376*

1-years olds immunised against hepatitis B (2007): 29%

*thousands

Population (2006):	61,330,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$32,240
Total health spend as a % of GDP (2006):	11.1%
Per capita total health spend (2006):	$3,554
Per capita govt health spend (2006):	$2,833
Life Expectancy (f/m, 2006):	84 / 77
Healthy Life Expectancy (f/m, 2003):	75 / 69
Median Age (2006):	39

The government of France reports as follows:

Policy

The government of France considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they work exclusively on the hepatitis strategy.

The National Plan to Combat Hepatitis B and C (Plan national de lutte contre les hépatites B et C, 2009-2012) builds on two national plans in place from 1999. Components include advocacy and awareness, prevention, increasing access, screening, testing, surveillance, service evaluation, treatment and multisectoral collaboration.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. Goals and associated indicators and targets are detailed in the National Plan. These relate to reducing transmission, increased testing, increased access to care, treatment and care in prisons and surveillance. There are specific goals for increasing the proportion of people with hepatitis B and C who are aware that they are infected.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Travellers; Military personnel; Persons at high risk (these include close contacts of active cases, children and young people in care, children and adults in psychiatric services, IDUs).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Hepatitis B vaccination is obligatory for certain healthcare workers.

Policy development: Information was not available on whether other countries' policies relating to hepatitis B and/or hepatitis C are currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. These are carried out by the National institute for prevention and education in health (institut national de prévention et d'éducation à la santé). Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government. The government has supported campaigns by patient organisations.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available. These indicate 280,000 people are chronically infected with hepatitis B and 221,000 with hepatitis C. The frequency may be three times higher in people in an unstable living situation. HIV-hepatitis C co-infection is estimated at 25,000 to 32,000 and HIV-hepatitis B co-infection at 7,000 to 9,000.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens. For hepatitis C this is 100% covered by the government, and for hepatitis B 65%.

Compulsory testing: Testing is compulsory for some groups. These include expectant mothers and some healthcare workers.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Treatment for all long term conditions, including chronic hepatitis, liver cancer and cirrhosis, are 100% funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include SOS hépatites, Médecin du monde, Comede and the WHO.

WHO Assistance

The government of France would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions

Gambia

Population (2006):	1,663,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$1,110
Total health spend as a % of GDP (2006):	4.3%
Per capita total health spend (2006):	$56
Per capita govt health spend (2006):	$33
Life Expectancy (f/m, 2006):	61 / 57
Healthy Life Expectancy (f/m, 2003):	51 / 48
Median Age (2006):	20

Estimated Mortality (2004)	Total
Acute hepatitis B	17.62
Acute hepatitis C	7.92
Liver cancer	458.96
Cirrhosis	63.82
Infectious diseases	5.13*
Non-communicable diseases	07*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	500
Acute hepatitis C	230
Liver cancer	5600
Cirrhosis	1120
Infectious diseases	350*
Non-communicable diseases	171*

1-years olds immunised against hepatitis B (2007): 90%

*thousands

The government of Gambia reports as follows:

Policy

The government of Gambia considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Information was not available on whether prevalence estimates exist.

Disease reporting: Disease reports are not currently published.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include: Specific details of these were not available to this study.

WHO Assistance

The government of Gambia would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Georgia

Estimated Mortality (2004)	Total
Acute hepatitis B	4.34
Acute hepatitis C	1.95
Liver cancer	217.88
Cirrhosis	995.22
Infectious diseases	1.22*
Non-communicable diseases	35*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	100
Acute hepatitis C	50
Liver cancer	2060
Cirrhosis	12560
Infectious diseases	126*
Non-communicable diseases	554*

1-years olds immunised against hepatitis B (2007): 94%

*thousands

Population (2006):	4,433,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$3,880
Total health spend as a % of GDP (2006):	8.4%
Per capita total health spend (2006):	$355
Per capita govt health spend (2006):	$76
Life Expectancy (f/m, 2006):	74 / 66
Healthy Life Expectancy (f/m, 2003):	67 / 62
Median Age (2006):	36

The government of Georgia reports as follows:

Policy

The government of Georgia considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers; Persons at high risk (people with HIV/AIDS).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening.

The National Blood Safety Program includes testing of donated blood for hepatitis B, hepatitis C HIV and syphilis.

Policy development: Information was not available on whether other countries' policies relating to hepatitis B and/or hepatitis C are currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available. A 2008 study indicated that prevalence of hepatitis B in the general population is approximately 1.7%; incidence is estimated to be 20.1 per 100,000 population. The prevalence of chronic hepatitis C infection is approximately 6.7% of the general population. Among high risk groups, especially injecting drug users, this is much higher; estimated prevalence of hepatitis B is 9.8% and hepatitis C 68%.

Disease reporting: Disease reports are published, frequency not specified.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include pregnant women, people with HIV/AIDS and those who are considered at risk of having acquired hepatitis B or C.

Compulsory testing: Testing is compulsory for some groups. These include uniformed service personnel and blood donors.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place. This exists for hepatitis C only, and is detailed in The National Guideline on Clinical Management of Chronic HCV infection.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO, and local and international NGOs.

WHO Assistance

The government of Georgia would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Germany

Population (2006):	82,641,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$32,680
Total health spend as a % of GDP (2006):	10.4%
Per capita total health spend (2006):	$3,328
Per capita govt health spend (2006):	$2,548
Life Expectancy (f/m, 2006):	82 / 77
Healthy Life Expectancy (f/m, 2003):	74 / 70
Median Age (2006):	42

Estimated Mortality (2004)	Total
Acute hepatitis B	360.28
Acute hepatitis C	832.59
Liver cancer	6303.09
Cirrhosis	16737.17
Infectious diseases	11.84*
Non-communicable diseases	757*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	3720
Acute hepatitis C	8590
Liver cancer	45540
Cirrhosis	238420
Infectious diseases	403*
Non-communicable diseases	9346*

1-years olds immunised against hepatitis B (2007): 87%

*thousands

The government of Germany reports as follows:

Policy

The government of Germany considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: To prevent the transmission of hepatitis B by immunization of infants; To prevent transmission of hepatitis B and hepatitis C through screening of blood and blood products and through the treatment of patients; Surveillance and reporting.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: risk (dialysis patients, people with liver disease, patients haemophiliacs, pre-operative patients, people with HIV/AIDS, close contacts of HBsAg-positive persons, IDUs, prisoners, patients in psychiatric hospitals, health care and public safety workers at risk, infants born to HBsAg-positive mothers). In Germany, an experts´ committee, the Ständige Impfkommssion (Standing Vaccination Committee, STIKO) issues annual recommendations on vaccinations.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. Other countries' strategies for the prevention of hepatitis are mainly examined. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government. This is done in collaboration with NGOs and other non-state sector organisations.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on a weekly basis.

Both hepatitis B and hepatitis C are notifiable diseases in Germany.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include risk groups, pregnant women, blood donors and for diagnosis of suspected hepatitis under the health insurance scheme.

Compulsory testing: Testing is compulsory for some groups. These include blood donors and healthcare workers.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government. Health insurance is compulsory in Germany, and more than 95% of the population is covered.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the European Centre for Disease Prevention and Control, the WHO, European Monitoring Centre for Drugs and Drug Addiction, Deutsche Leberstiftung, Network of Competence for Hepatitis (Hep-Net).

WHO Assistance

The government of Germany would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions

Ghana

Estimated Mortality (2004)	Total
Acute hepatitis B	590.09
Acute hepatitis C	263.09
Liver cancer	2008.4
Cirrhosis	1785.68
Infectious diseases	91.63*
Non-communicable diseases	78*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	9160
Acute hepatitis C	4110
Liver cancer	26130
Cirrhosis	31950
Infectious diseases	4659*
Non-communicable diseases	2318*

1-years olds immunised against hepatitis B (2007): 94%

*thousands

Population (2006):	23,008,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$1240
Total health spend as a % of GDP (2006):	6.2%
Per capita total health spend (2006):	$100
Per capita govt health spend (2006):	$36
Healthy Life Expectancy (f/m, 2003):	50 / 49
Median Age (2006):	20
Life Expectancy (f/m, 2006):	58 / 56

The government of Ghana reports as follows:

Policy

The government of Ghana considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

The EPI Field Guide (2003) sets out the procedures for vaccination. This includes the immunisation schedule and delivery guidelines as well as safe injecting protocols, guidelines for needle disposal, vaccine storage, and details common reactions to vaccines and how these can be managed. Summary guidelines for hepatitis B were also produced when the vaccine was introduced in 2002.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Information was not available on whether surveillance exists for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are not registered
- Information was not available on whether cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are not available.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include blood donors.

Compulsory testing: Testing is compulsory for some groups. These include blood donors.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the GAVI Alliance, the WHO and UNICEF in the introduction of Hepatitis B vaccine into the country's EPI programme.

WHO Assistance

The government of Ghana would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Greece

Population (2006):	11123000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$30870
Total health spend as a % of GDP (2006):	9.9%
Per capita total health spend (2006):	$3101
Per capita govt health spend (2006):	$1317
Healthy Life Expectancy (f/m, 2003):	73 / 69
Median Age (2006):	40
Life Expectancy (f/m, 2006):	82 / 77

Estimated Mortality (2004)	Total
Acute hepatitis B	94.99
Acute hepatitis C	
Liver cancer	1667.1
Cirrhosis	721.68
Infectious diseases	0.75*
Non-communicable diseases	96*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	1120
Acute hepatitis C	
Liver cancer	10380
Cirrhosis	8170
Infectious diseases	55*
Non-communicable diseases	1153*

1-years olds immunised against hepatitis B (2007): 88%

*thousands

The government of Greece reports as follows:

Policy

The government of Greece considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

The strategy focuses on education of public, of healthcare professionals, and of high-risk groups about viral hepatitis.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: To reduce the incidence of new infections of hepatitis; To limit the disease burden from chronic hepatitis; To improve the quality of life of those chronically infected with hepatitis B and hepatitis C.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Travellers; Persons at high risk (people with hepatitis C, IDUs, sex workers, haemophiliacs, dialysis patients, prisoners and staff of prisons, close contacts of hepatitis B positive people).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. The Hellenic Center for Disease Control and Prevention within the Ministry of Health and Welfare organises national awareness campaigns for HIV and STDs, including hepatitis B. These campaigns target the general population as well as military personnel and adolescents. Educational material on viral hepatitis is available in 6 languages. Awareness campaigns are also carried out for the general population at municipal level. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government. Recommendations on prevention of transmission of HBV and HCV are given by the Ministry of Health in collaboration with the Ministry of Education, targeted at school teachers to avoid isolation of infected children.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are not currently published.

Hellenic Center of Disease Control and Prevention (part of the Ministry of Health and Welfare) has coordinated and sponsored a nationwide Hep Net Greece cohort study for hepatitis B and hepatitis C since 2003. The aim of this study is to evaluate the epidemiology and the course of chronic viral HBV and HCV infection in Greece and monitor longitudinal changes.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include all citizens with insurance cover.

Compulsory testing: Testing is not compulsory for any groups. It is recommended for all healthcare workers, IDUs and sex workers.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. All chronic diseases including hepatitis are treated free of charge.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of Greece would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Surveillance

Guatemala

Estimated Mortality (2004)	Total
Acute hepatitis B	5.92
Acute hepatitis C	0.18
Liver cancer	325.05
Cirrhosis	2555.49
Infectious diseases	10.63*
Non-communicable diseases	37*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	40
Acute hepatitis C	10
Liver cancer	3060
Cirrhosis	53750
Infectious diseases	1101*
Non-communicable diseases	1255*

1-years olds immunised against hepatitis B (2007): 82%

*thousands

Population (2006):	13029000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$5120
Total health spend as a % of GDP (2006):	5.3%
Per capita total health spend (2006):	$259
Per capita govt health spend (2006):	$98
Healthy Life Expectancy (f/m, 2003):	60 / 55
Median Age (2006):	18
Life Expectancy (f/m, 2006):	71 / 65

The government of Guatemala reports as follows:

Policy

The government of Guatemala considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally. This strategy exists for hepatitis B only.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers.

Infant vaccination is included in the national immunisation schedule. In 1998 a vaccination campaign was run to vaccinate 100% of healthcare workers, though in some areas this may not have been maintained.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Information was not available on whether other countries' policies relating to hepatitis B and/or hepatitis C are currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. This was done to promote vaccination for children under five years old. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. There is a national fund to purchase medical supplies, although advanced treatment and transplants are not yet available in the country.

Working with civil society

No information was available on whether government programmes for the prevention and control of hepatitis B and/or hepatitis C and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Guatemala would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Guinea-Bissau

Population (2006):	1646000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$460
Total health spend as a % of GDP (2006):	6.2%
Per capita total health spend (2006):	$40
Per capita govt health spend (2006):	$10
Healthy Life Expectancy (f/m, 2003):	41 / 40
Median Age (2006):	16
Life Expectancy (f/m, 2006):	51 / 46

Estimated Mortality (2004)	Total
Acute hepatitis B	60.65
Acute hepatitis C	27.25
Liver cancer	146.16
Cirrhosis	61.8
Infectious diseases	10.3*
Non-communicable diseases	06*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	1940
Acute hepatitis C	870
Liver cancer	1900
Cirrhosis	1140
Infectious diseases	694*
Non-communicable diseases	176*

1-years olds immunised against hepatitis B (2007): 0%

*thousands

The government of Guinea-Bissau reports as follows:

Policy

The government of Guinea-Bissau considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: Increase coverage for infant vaccination with pentavalent vaccine to 95%.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Hepatitis B vaccination policy includes universal infant vaccination at 6, 10 and 14 weeks.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are not registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are not available.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include blood donors and family members of active cases.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO, UNICEF, and PLAN Guinea-Bissau. No patient organisations are known to exist for viral hepatitis Guinea-Bissau.

WHO Assistance

The government of Guinea-Bissau would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing tools to assess the effectiveness of interventions
- Surveillance

Honduras

Estimated Mortality (2004)	Total
Acute hepatitis B	17.0
Acute hepatitis C	7.0
Liver cancer	214.0
Cirrhosis	1019.0
Infectious diseases	5.3*
Non-communicable diseases	28*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	600
Acute hepatitis C	250
Liver cancer	1880
Cirrhosis	17890
Infectious diseases	489*
Non-communicable diseases	692*

Infants receiving 3 doses HBV vaccination (2007): 85%

*thousands

Population (2006):	6,969,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$3,420
Total health spend as a % of GDP (2006):	7.4%
Per capita total health spend (2006):	$241
Per capita govt health spend (2006):	$116
Life Expectancy (f/m, 2006):	73 / 67
Healthy Life Expectancy (f/m, 2003):	61 / 56
Median Age (2006):	20

The government of Honduras reports as follows:

Policy

The government of Honduras considers hepatitis B and/or hepatitis C to be an urgent public health issue.

Hepatitis B in particular is considered an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy. This exists for hepatitis B only.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: 1. To control hepatitis B through vaccination of infants and risk groups, target: 95%; To increase this through vaccination of adolescents of 12 to 19 years of age in 2012.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare Workers; Military personnel; Persons at high risk (unspecified).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance does not exist for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are not registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are not available.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens. Tests for hepatitis B and hepatitis C are available through public and private facilities; tests are free at public facilities for all suspected cases.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place. This is in place for hepatitis B and also covers contact tracing and vaccination, case reporting, patient awareness and education and provides case definitions.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Honduras would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Surveillance

Hungary

Population (2006):	10,058,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$16,970
Total health spend as a % of GDP (2006):	7.6%
Per capita total health spend (2006):	$1,382
Per capita govt health spend (2006):	$978
Life Expectancy (f/m, 2006):	78 / 69
Healthy Life Expectancy (f/m, 2003):	68 / 62
Median Age (2006):	39

Estimated Mortality (2004)	Total
Acute hepatitis B	1.92
Acute hepatitis C	0.0
Liver cancer	964.28
Cirrhosis	5680.33
Infectious diseases	0.62*
Non-communicable diseases	120*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	60
Acute hepatitis C	-
Liver cancer	8110
Cirrhosis	89620
Infectious diseases	70*
Non-communicable diseases	1587*

1-years olds immunised against hepatitis B (2007): 0%

*thousands

The government of Hungary reports as follows:

Policy

The government of Hungary does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare Workers; Travellers; Persons at high risk (infants born to HBsAg positive mothers, haemodialysis patients, individuals at risk of occupational exposure).

Hepatitis B vaccination is mandatory at 14 years of age for adolescents, as well as for health care workers and medical students. Vaccination is also recommended for those at higher risk because of sexual behaviour, for IDUs, for onco-haematology patients, and for those with chronic hepatitis C infection. Health care including vaccination for military personnel is managed by the military public health authorities. Travellers are offered a combined hepatitis A and B vaccination if they are visiting higher risk areas.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years.

Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially. Anonymous testing is only available to IDUs.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. Testing is free when requested by a specialist for a symptomatic patient. Screening programmes for pregnant women and IDUs are free of charge.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. All treatment is funded 100% through national health insurance. However, IDUs with hepatitis C can get interferon treatment only if they are receiving substitution treatment or are fully recovered.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Hungary would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions

Iceland

Estimated Mortality (2004)	Total
Acute hepatitis B	-
Acute hepatitis C	0.32
Liver cancer	6.15
Cirrhosis	4.26
Infectious diseases	0.02*
Non-communicable diseases	02*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	-
Acute hepatitis C	-
Liver cancer	30
Cirrhosis	60
Infectious diseases	01*
Non-communicable diseases	25*

1-years olds immunised against hepatitis B (2007): -

*thousands

Population (2006):	298,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$33,740
Total health spend as a % of GDP (2006):	9.3%
Per capita total health spend (2006):	$3,319
Per capita govt health spend (2006):	$2,758
Life Expectancy (f/m, 2006):	83 / 79
Healthy Life Expectancy (f/m, 2003):	74 / 72
Median Age (2006):	35

The government of Iceland reports as follows:

Policy

The government of Iceland considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: Improving prevention through raising public awareness; Vaccination against hepatitis B for vulnerable persons and travellers to risk areas.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Healthcare Workers; Travellers; Persons at high risk (close contacts of active cases, MSM, IDUs)

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Information was not available on whether other countries' policies relating to hepatitis B and/or hepatitis C are currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available. Hepatitis B has a low prevalence and incidence, although high prevalence rates are found in some immigrant populations. Hepatitis C has a high incidence in IDUs.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include close contacts of active cases and all those tested as part of screening programmes for hepatitis B among immigrants from endemic countries and for hepatitis C among patients treated for drug addiction.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. All treatment is free of charge for patients with mandatory notifiable diseases including hepatitis B and hepatitis C.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Iceland would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising

Indonesia

Population (2006):	228,864,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$3,310
Total health spend as a % of GDP (2006):	2.2%
Per capita total health spend (2006):	$87
Per capita govt health spend (2006):	$44
Life Expectancy (f/m, 2006):	69 / 66
Healthy Life Expectancy (f/m, 2003):	59 / 57
Median Age (2006):	27

Estimated Mortality (2004)	Total
Acute hepatitis B	3475.61
Acute hepatitis C	1474.51
Liver cancer	17264.41
Cirrhosis	23983.63
Infectious diseases	243.53*
Non-communicable diseases	1036*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	60860
Acute hepatitis C	26210
Liver cancer	193360
Cirrhosis	473200
Infectious diseases	15382*
Non-communicable diseases	25623*

1-years olds immunised against hepatitis B (2007): 74%

*thousands

The government of Indonesia reports as follows:

Policy

The government of Indonesia considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: Increasing infant hepatitis B vaccination coverage overall; Increasing the proportion of infants receiving first dose DTP-HepB vaccine within 7 days' of birth.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Hepatitis B vaccine has been included in Indonesia's EPI since 1997.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening.

Policy development: Information was not available on whether other countries' policies relating to hepatitis B and/or hepatitis C are currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. These include a campaign for screening for hepatitis B and C targeted at the community; a community education strategy around hepatitis C is currently being developed. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are not registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially. This is available to blood donors through the Red Cross.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. This is available to goverment employes with health insurance.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO regional office for South-East Asia.

WHO Assistance

The government of Indonesia would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Developing goals for the prevention and control of hepatitis B and hepatitis C

Iran

Estimated Mortality (2004)	Total
Acute hepatitis B	604.07
Acute hepatitis C	312.02
Liver cancer	763.94
Cirrhosis	1524.17
Infectious diseases	16.3*
Non-communicable diseases	266*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	9470
Acute hepatitis C	4580
Liver cancer	9010
Cirrhosis	26590
Infectious diseases	2727*
Non-communicable diseases	7042*

1-years olds immunised against hepatitis B (2007): 97%

*thousands

Population (2006):	70,270,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$9,800
Total health spend as a % of GDP (2006):	7.8%
Per capita total health spend (2006):	$731
Per capita govt health spend (2006):	$406
Life Expectancy (f/m, 2006):	73 / 69
Healthy Life Expectancy (f/m, 2003):	59 / 56
Median Age (2006):	24

The government of the Islamic Republic of Iran reports as follows:

Policy

The government of the Islamic Republic of Iran considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place. It is, however, under development and there is a designated individual to lead this strategy nationally; this person does not work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare Workers; Military personnel; Persons at high risk (unspecified).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Information was not available on whether standard case definitions currently exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Information was not available on whether prevalence estimates exist.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of the Islamic Republic of Iran would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions

Iraq

Population (2006):	28,506,000
Country Classification (2009): Lower middle income	
Gross National Income per capita (-):	-
Total health spend as a % of GDP (2006):	3.8%
Per capita total health spend (2006):	$124
Per capita govt health spend (2006):	$90
Life Expectancy (f/m, 2006):	67 / 48
Healthy Life Expectancy (f/m, 2003):	51 / 49
Median Age (2006):	19

Estimated Mortality (2004)	Total
Acute hepatitis B	1967.05
Acute hepatitis C	947.69
Liver cancer	151.56
Cirrhosis	3915.74
Infectious diseases	40.92*
Non-communicable diseases	135*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	44470
Acute hepatitis C	21040
Liver cancer	2660
Cirrhosis	82840
Infectious diseases	5029*
Non-communicable diseases	4159*

1-years olds immunised against hepatitis B (2007): 58%

*thousands

The government of Iraq reports as follows:

Policy

The government of Iraq considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they work exclusively on the hepatitis strategy.

Objectives of The National Plan for Viral Hepatitis Control (2010) include: to control incidence through surveillance and prevention; to prevent transmission in healthcare settings, perinatally, nosocomially and iatrogenically and from foreign nationals; to increase vaccination coverage especially for risk groups; and to improve awareness among healthcare workers and the public.

The National Committee on Viral Hepatitis, headed by the General Director of Public Health, monitors epidemiological trends and formulates prevention and control plans. These are implemented provincially with oversight from the CDC.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: the prevention and control of the disease; education on hepatitis B and C; blood safety.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers; Military personnel; Persons at high risk (contacts of active cases, dialysis patients, people with inherited blood diseases).

National policy is to vaccinate all children under five and all high risk groups (including healthcare workers).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. An booklet has been produced for health institutes and the CDC Viral Hepatitis division has run public awareness campaigns through mass media and workshops for healthcare workers and the public. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available. Studies among the general population (2006-7) indicate a hepatitis B infection rate of 1.6% and a hepatitis C infection rate of 0.04%. Systems for surveillance are believed to still have some limitations. Current data on incidence, prevalence and genotype distribution may therefore not fully reflect the national situation.

Disease reporting: Disease reports are published on a monthly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens. Screening programmes also exist for pregnant women, foreign nationals, pre-marital couples and pre-operative patients.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Pegylated interferon, ribavirin and lamivudine are 100% government-funded.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO.

WHO Assistance

The government of Iraq would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance
- Other areas including: planning a regional approach to protection and control for viral hepatitis.

Ireland

Estimated Mortality (2004)	Total
Acute hepatitis B	12.47
Acute hepatitis C	-
Liver cancer	189.37
Cirrhosis	207.67
Infectious diseases	0.19*
Non-communicable diseases	26*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	260
Acute hepatitis C	-
Liver cancer	1330
Cirrhosis	3230
Infectious diseases	27*
Non-communicable diseases	413*

1-years olds immunised against hepatitis B (2007): -

*thousands

Population (2006):	4,221,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$34,730
Total health spend as a % of GDP (2006):	7.5%
Per capita total health spend (2006):	$3,082
Per capita govt health spend (2006):	$2,413
Life Expectancy (f/m, 2006):	82 / 77
Healthy Life Expectancy (f/m, 2003):	72 / 68
Median Age (2006):	34

The government of Ireland reports as follows:

Policy

The government of Ireland considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers; Travellers; Military personnel; Persons at high risk (these include persons with occupational risk of exposure, family and household contacts of active cases, IDUs and their contacts, those at risk due to medical conditions).

Under the policy all infants are offered HBV vaccine as part of routine childhood immunisation at 2, 4 and 6 months.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has, however, been taken by the government. There are guaranteed legal rights to treatment and other services for people who acquired hepatitis C through blood and blood products in healthcare settings in Ireland.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are not available.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Hepatitis B and hepatitis C are notifiable diseases in Ireland.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially. Testing can be accessed confidentially but not anonymously.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is compulsory for some groups. These include healthcare workers.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include local and national NGOs.

WHO Assistance

No areas for assistance were identified.

Israel

Population (2006):	6,810,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$23,840
Total health spend as a % of GDP (2006):	7.8%
Per capita total health spend (2006):	$2,263
Per capita govt health spend (2006):	$1,477
Life Expectancy (f/m, 2006):	82 / 79
Healthy Life Expectancy (f/m, 2003):	72 / 70
Median Age (2006):	29

Estimated Mortality (2004)	Total
Acute hepatitis B	33.12
Acute hepatitis C	108.34
Liver cancer	258.32
Cirrhosis	252.28
Infectious diseases	1.05*
Non-communicable diseases	31*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	350
Acute hepatitis C	1010
Liver cancer	1900
Cirrhosis	2910
Infectious diseases	44*
Non-communicable diseases	563*

1-years olds immunised against hepatitis B (2007): 99%

*thousands

The government of Israel reports as follows:

Policy

The government of Israel considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: morbidity reduction.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare Workers; Travellers; Persons at high risk (haemodialysis patients, those receiving regular blood transfusion, people with HIV/AIDS, STI patients, IDUs, MSM, people who have had more than one sexual partner during the last six months, close contacts of active cases of hepatitis B, victims of sexual assault, victims of terrorist attacks, chronic liver disease patients, prisoners, travellers to hyperendemic countries).

National policy is to vaccinate infants at birth and at one and six months. A catch-up campaign for adolescents up to 17 years of age is also underway.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has, however, been taken by the government. This has included official recommendations about hepatitis B and C carriers for healthcare workers.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are not available. 2008 disease reports indicate 53 cases of hepatitis B and 13 cases of hepatitis C nationally.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Both hepatitis B and hepatitis C are notifiable diseases.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups (unspecified)

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. According to the health insurance law, every citizen must have health insurance and belong to a sick fund. These sick funds provide treatment for hepatitis; this is included in the national health basket.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Israel would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Developing tools to assess the effectiveness of interventions
- Surveillance

Italy

Estimated Mortality (2004)	Total
Acute hepatitis B	1983.38
Acute hepatitis C	-
Liver cancer	10474.51
Cirrhosis	10840.67
Infectious diseases	5.56*
Non-communicable diseases	510*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	18660
Acute hepatitis C	-
Liver cancer	67920
Cirrhosis	109580
Infectious diseases	289*
Non-communicable diseases	5838*

1-years olds immunised against hepatitis B (2007): 96%

*thousands

Population (2006):	58,779,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	28,970
Total health spend as a % of GDP (2006):	9%
Per capita total health spend (2006):	$2,623
Per capita govt health spend (2006):	$2,022
Life Expectancy (f/m, 2006):	84 / 78
Healthy Life Expectancy (f/m, 2003):	75 / 71
Median Age (2006):	42

The government of Italy reports as follows:

Policy

The government of Italy does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare Workers; Military personnel; Persons at high risk (these include: relatives of HBsAg positive subjects; polytransfused patients, haemophiliacs, and haemodialysed patients; victims of needlestick injury; individuals with chronic eczema/psoriasis lesions on the hands; prison inmates and guards; nationals working in high endemicity areas; IDUs; MSM; sex workers; healthcare workers and students; staff and patients in psychiatric units; all police forces; fire brigade; waste disposal workers).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include: healthcare workers and students, pregnant women.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of Italy would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Developing tools to assess the effectiveness of interventions

Jamaica

Population (2006):	2,699,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$7,050
Total health spend as a % of GDP (2006):	5.1%
Per capita total health spend (2006):	$240
Per capita govt health spend (2006):	$127
Life Expectancy (f/m, 2006):	75 / 69
Healthy Life Expectancy (f/m, 2003):	66 / 64
Median Age (2006):	25

Estimated Mortality (2004)	Total
Acute hepatitis B	14.72
Acute hepatitis C	6.03
Liver cancer	101.97
Cirrhosis	186.17
Infectious diseases	1.83*
Non-communicable diseases	16*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	220
Acute hepatitis C	60
Liver cancer	740
Cirrhosis	2060
Infectious diseases	104*
Non-communicable diseases	273*

1-years olds immunised against hepatitis B (2007): 85%

*thousands

The government of Jamaica reports as follows:

Policy

The government of Jamaica considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare Workers; Military personnel; Persons at high risk (contacts of positive cases, firemen, police officers, janitorial service personnel).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on a weekly basis.

Hepatitis B and hepatitis C are listed as a Class 1 Notifiable Diseases.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Jamaica would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Japan

Estimated Mortality (2004)	Total
Acute hepatitis B	1254.64
Acute hepatitis C	4695.38
Liver cancer	34741.13
Cirrhosis	13045.12
Infectious diseases	22.66*
Non-communicable diseases	814*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	14880
Acute hepatitis C	38850
Liver cancer	239990
Cirrhosis	156070
Infectious diseases	809*
Non-communicable diseases	10961*

1-years olds immunised against hepatitis B (2007): -

*thousands

Population (2006):	127,953,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$32,840
Total health spend as a % of GDP (2006):	7.9%
Per capita total health spend (2006):	$2,514
Per capita govt health spend (2006):	$2,067
Life Expectancy (f/m, 2006):	86 / 79
Healthy Life Expectancy (f/m, 2003):	78 / 72
Median Age (2006):	43

The government of Japan reports as follows:

Policy

The government of Japan considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

The Hepatitis Control Act was approved in 2009 to establish a basic set of principles for hepatitis control and to take comprehensive measures against the disease. While there is no specific strategy for prevention and control there is a Basic Policy to Promote Hepatitis Control Programs and a Hepatitis Promotion Council. There is a designated individual to lead this work nationally who works exclusively on hepatitis.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

All pregnant women are offered testing for hepatitis B, and vaccination and HBIG has been provided free of charge to all infants born to HBsAg positive mothers since 1985.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening.

Guidelines are in place for transfusion and for safe injecting and prevention of transmission of infections in healthcare settings.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. An awareness campaign is run in the fourth week of May every year to promote understanding of liver disease and of how to prevent viral hepatitis. This is run jointly by the Ministry of Health, Labour and Welfare, the Viral hepatitis research foundation of Japan, patient organisations and local governments and includes events and the distribution of leaflets and educational materials. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government. In addition to the awareness campaigns, the government addresses this through their website and the production of educational materials.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered*
- Cases of co-infection with HIV are not registered

*This is carried out locally, not at the national level.

Prevalence estimates: Prevalence estimates for the country are not available. However, unofficial estimates indicate that hepatitis is one of the most common chronic infectious diseases in Japan, with 3 to 4 million chronic carriers.

Disease reporting: Disease reports are published on a weekly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place. The Ministry of Health, Labour and Welfare has produced a Guideline for Establishing Health Care Systems for Liver Disease Treatment in Prefectures and the pathway is included in this.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Patients currently pay a limited amount (co-payment with a maximum charge per month) for their treatment. The government is planning to introduce full funding for this.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the Viral hepatitis Research Foundation of Japan and patient organizations.

WHO Assistance

No areas for assistance were identified

Jordan

Population (2006):	5,729,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$4,820
Total health spend as a % of GDP (2006):	9.9%
Per capita total health spend (2006):	$611
Per capita govt health spend (2006):	$257
Life Expectancy (f/m, 2006):	74 / 69
Healthy Life Expectancy (f/m, 2003):	62 / 60
Median Age (2006):	21

Estimated Mortality (2004)	Total
Acute hepatitis B	129.79
Acute hepatitis C	22.44
Liver cancer	69.46
Cirrhosis	165.62
Infectious diseases	1.07*
Non-communicable diseases	16*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	2360
Acute hepatitis C	400
Liver cancer	840
Cirrhosis	2380
Infectious diseases	191*
Non-communicable diseases	501*

1-years olds immunised against hepatitis B (2007): 98%

*thousands

The government of Jordan reports as follows:

Policy

The government of Jordan considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy. A multisectoral national committee has also been formed to develop a consensus on the preventive and curative protocol for hepatitis B and hepatitis C.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare Workers; Military personnel; Persons at high risk (healthcare workers, prisoners, and patients on dialysis).

Hepatitis B vaccine has been included in the EPI since 1995. Vaccination is mandatory for workers and professionals in close contact with individuals with Hepatitis B or C and high risk groups.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. This has involved onsite training targeted at increasing public health officers' and gastroenterologists' awareness of hepatitis B and C surveillance. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups (unspecified)

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of Jordan would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Surveillance

Kenya

Estimated Mortality (2004)	Total
Acute hepatitis B	172.57
Acute hepatitis C	77.53
Liver cancer	894.32
Cirrhosis	856.56
Infectious diseases	230.66*
Non-communicable diseases	97*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	5570
Acute hepatitis C	2510
Liver cancer	9930
Cirrhosis	18320
Infectious diseases	10565*
Non-communicable diseases	2989*

1-years olds immunised against hepatitis B (2007): 81%

*thousands

Population (2006):	36,553,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$1,470
Total health spend as a % of GDP (2006):	4.6%
Per capita total health spend (2006):	$105
Per capita govt health spend (2006):	$51
Life Expectancy (f/m, 2006):	55 / 52
Healthy Life Expectancy (f/m, 2003):	45 / 44
Median Age (2006):	18

The government of Kenya reports as follows:

Policy

The government of Kenya considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

The strategy exists for hepatitis B only and focuses on prevention through immunisation of all Children under 5 years of age.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: Reduction of the burden of disease due to hepatitis B in Kenya through provision of vaccination to all children under 5 years of age; Improvement of infection prevention & control through the injection safety and blood transfusion safety practices in all hospitals.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

In public facilities immunisation against hepatitis B is only available to children under five years of age and through pentavalent vaccine. It is available to children under five free of charge in all public health immunisation centres. Other groups can access vaccination through private health centres.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening.

A programme has been established for the screening of all donated blood and injection safety practices in all health institusions in the country.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has, however, been taken by the government. Campaigns have been targeted at all infectious diseases contracted through blood transfusions, sexual intercourse and drug use. This has been done for Hepatitis in particular during blood donation campaigns by the Kenya Blood Donor Services and during campaigns against intravenous drug use.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. This is available in Government supported referral hospitals.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include through the GAVI Alliance for provision of vaccines, partners such as CDC Kenya in Blood transfusion services and the WHO for technical services.

WHO Assistance

The government of Kenya would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Kiribati

Population (2006):	94,000
Country Classification (2009): Lower middle income	
Gross National Income per capita (2006):	$6,230
Total health spend as a % of GDP (2006):	12.7%
Per capita total health spend (2006):	$290
Per capita govt health spend (2006):	$268
Life Expectancy (f/m, 2006):	68 / 63
Healthy Life Expectancy (f/m, 2003):	56 / 52
Median Age (-):	-

Estimated Mortality (2004)	Total
Acute hepatitis B	1.12
Acute hepatitis C	0.0
Liver cancer	3.62
Cirrhosis	11.51
Infectious diseases	0.11*
Non-communicable diseases	0*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	40
Acute hepatitis C	0
Liver cancer	40
Cirrhosis	370
Infectious diseases	07*
Non-communicable diseases	14*

1-years olds immunised against hepatitis B (2007): 96%

*thousands

The government of Kiribati reports as follows:

Policy

The government of Kiribati considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare Workers; Persons at high risk (prisoners).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Vaccination of healthcare workers.

The Kiribati Infection Control Manual details the strategy for infection control in healthcare settings. All blood and blood products are routinely screened for hepatitis B. Currently hepatitis C is not included in this routine screening.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Information was not available on whether surveillance exists for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available. These indicate that the HBsAg seroprevalence rate is approximately 25% (Global Database on Blood Safety for Kiribati, 2008).

Disease reporting: Disease reports are published, the frequency of publication was not specified.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is compulsory for some groups. These include: all blood donors, antenatal mothers, visa applicants and seafarers (hepatitis B only).

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Kiribati would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Kuwait

Estimated Mortality (2004)	Total
Acute hepatitis B	17.06
Acute hepatitis C	7.88
Liver cancer	53.21
Cirrhosis	33.93
Infectious diseases	0.13*
Non-communicable diseases	03*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	250
Acute hepatitis C	110
Liver cancer	590
Cirrhosis	560
Infectious diseases	29*
Non-communicable diseases	198*

1-years olds immunised against hepatitis B (2007): 99%

*thousands

Population (2006):	779,000
Country Classification (2009):	High income
Gross National Income per capita (2005):	$48,310
Total health spend as a % of GDP (2006):	2.2%
Per capita total health spend (2006):	$535
Per capita govt health spend (2006):	$422
Life Expectancy (f/m, 2006):	79 / 77
Healthy Life Expectancy (f/m, 2003):	67 / 67
Median Age (2006):	29

The government of Kuwait reports as follows:

Policy

The government of Kuwait considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: To maximise vaccination rates for hepatitis B; To increase screening for both hepatitis B and hepatitis C; To include more groups in screening (compulsory screening currently exists for pregnant women, people re-marrying, and people pre-employment).

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare Workers; Military personnel; Persons at high risk (medical and nursing students, close contacts of active cases).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Information was not available on whether any action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Information was not available on whether liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on a monthly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is compulsory for some groups. These include pregnant women, people re-marrying, and people pre-employment.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Treatment is free to all Kuwaiti citizens. Partial government support is provided to non-Kuwaiti citizens.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include local and national committees and the WHO.

WHO Assistance

The government of Kuwait would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Kyrgyzstan

Population (2006):	5,259,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$1,790
Total health spend as a % of GDP (2006):	6.4%
Per capita total health spend (2006):	$127
Per capita govt health spend (2006):	$55
Life Expectancy (f/m, 2006):	70 / 63
Healthy Life Expectancy (f/m, 2003):	58 / 52
Median Age (2006):	24

Estimated Mortality (2004)	Total
Acute hepatitis B	66.71
Acute hepatitis C	7.31
Liver cancer	153.24
Cirrhosis	2096.85
Infectious diseases	3.04*
Non-communicable diseases	35*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	1810
Acute hepatitis C	180
Liver cancer	1590
Cirrhosis	40220
Infectious diseases	334*
Non-communicable diseases	693*

1-years olds immunised against hepatitis B (2007): 94%

*thousands

The government of Kyrgyzstan reports as follows:

Policy

The government of Kyrgyzstan does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

An order issued by the Ministry of Health in 2009 specifies a need to conduct training on viral hepatitis for workers in primary health care services; to develop plan to increase etiologic diagnosis of viral hepatitis at primary health care level across the country; to organize training for laboratory specialists on etiologic diagnosis.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: to improve epidemiological surveillance and control of viral hepatitis.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Information was not available on whether other countries' policies relating to hepatitis B and/or hepatitis C are currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include infants.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Kyrgyzstan would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Latvia

Estimated Mortality (2004)	Total
Acute hepatitis B	9.96
Acute hepatitis C	4.47
Liver cancer	142.64
Cirrhosis	372.65
Infectious diseases	0.34*
Non-communicable diseases	29*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	180
Acute hepatitis C	80
Liver cancer	1350
Cirrhosis	6190
Infectious diseases	27*
Non-communicable diseases	355*

1-years olds immunised against hepatitis B (2007): 97%

*thousands

Population (2006):	2,289,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$14,840
Total health spend as a % of GDP (2006):	6.0%
Per capita total health spend (2006):	$974
Per capita govt health spend (2006):	$615
Life Expectancy (f/m, 2006):	76 / 65
Healthy Life Expectancy (f/m, 2003):	68 / 58
Median Age (2006):	40

The government of Latvia reports as follows:

Policy

The government of Latvia does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: To decrease the morbidity associated with hepatitis B by 90% among children under 18 years of age; To increase screening and prevention.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Persons at high risk (those at occupational risk).

Hepatitis B vaccination is mandatory for children and for those at risk of occupational exposure.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on a monthly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include blood donors, pregnant women (for hepatitis B only), and people with clinical signs of infection.

Compulsory testing: Testing is compulsory for some groups. These include blood donors and pregnant women.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Latvia would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Increasing access to treatment

Lebanon

Population (2006):	4,055,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$9,600
Total health spend as a % of GDP (2006):	8.9%
Per capita total health spend (2006):	$608
Per capita govt health spend (2006):	$285
Life Expectancy (f/m, 2006):	72 / 68
Healthy Life Expectancy (f/m, 2003):	62 / 59
Median Age (2006):	27

Estimated Mortality (2004)	Total
Acute hepatitis B	97.33
Acute hepatitis C	48.1
Liver cancer	16.67
Cirrhosis	656.92
Infectious diseases	1.05*
Non-communicable diseases	23*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	1200
Acute hepatitis C	590
Liver cancer	350
Cirrhosis	8570
Infectious diseases	126*
Non-communicable diseases	483*

1-years olds immunised against hepatitis B (2007): 74%

*thousands

The government of Lebanon reports as follows:

Policy

The government of Lebanon considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

The National Hepatitis Programme was created in 2007, which oversees the implementation of the strategy. The programme aims to reduce the incidence of hepatitis in Lebanon and to reduce the disease burden associated with chronic infection.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: the to reduce risks for acquiring viral hepatitis through primary prevention; to reduce risks and complications resulting from chronic hepatitis through secondary prevention; to conduct disease surveillance and monitor disease trends and to evaluate the effectiveness of prevention activities; to educate professionals and the public. Several specific goals exist for each of these areas.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers.

All nurses, laboratory staff and medical staff are vaccinated against hepatitis B.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has, however, been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Information was not available on whether surveillance exists for chronic hepatitis
- Information was not available on whether chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available. These indicate a rate of 4.1 per 100,000 for hepatitis B (2007) and 1.39 per 100,000 for hepatitis C (2007).

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups (not specified).

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place. Guidelines were being updated at the time of study.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. The government part-funds treatment for patients that do not have social security.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO.

WHO Assistance

The government of Lebanon would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

[1]Document supplied: Tohme, R. Viral Hepatitis In Lebanon: A Situation Assessment, 2007. Unpublished.

Lesotho

Estimated Mortality (2004)	Total
Acute hepatitis B	2.25
Acute hepatitis C	1.01
Liver cancer	129.16
Cirrhosis	53.73
Infectious diseases	17.34*
Non-communicable diseases	06*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	40
Acute hepatitis C	20
Liver cancer	1300
Cirrhosis	980
Infectious diseases	610*
Non-communicable diseases	161*

1-years olds immunised against hepatitis B (2007): 85%

*thousands

Population (2006):	1,995,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$1,810
Total health spend as a % of GDP (2006):	6.7%
Per capita total health spend (2006):	$143
Per capita govt health spend (2006):	$88
Life Expectancy (f/m, 2006):	44 / 40
Healthy Life Expectancy (f/m, 2003):	33 / 30
Median Age (2006):	19

The government of Lesotho reports as follows:

Policy

The government of Lesotho considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is not in place.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Lesotho would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Liberia

Population (2006):	3,579,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$260
Total health spend as a % of GDP (2006):	5.6%
Per capita total health spend (2006):	$39
Per capita govt health spend (2006):	$25
Life Expectancy (f/m, 2006):	46 / 43
Healthy Life Expectancy (f/m, 2003):	37 / 34
Median Age (2006):	16

Estimated Mortality (2004)	Total
Acute hepatitis B	149.84
Acute hepatitis C	67.32
Liver cancer	180.74
Cirrhosis	119.06
Infectious diseases	26.83*
Non-communicable diseases	11*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	4700
Acute hepatitis C	2120
Liver cancer	3230
Cirrhosis	2450
Infectious diseases	1795*
Non-communicable diseases	366*

1-years olds immunised against hepatitis B (2007): 0%

*thousands

The government of Liberia reports as follows:

Policy

The government of Liberia considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions do not currently exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance does not exist for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are not available.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Liberia would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Lithuania

Estimated Mortality (2004)	Total
Acute hepatitis B	4.29
Acute hepatitis C	7.12
Liver cancer	152.01
Cirrhosis	767.79
Infectious diseases	0.52*
Non-communicable diseases	35*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	70
Acute hepatitis C	100
Liver cancer	1320
Cirrhosis	14200
Infectious diseases	37*
Non-communicable diseases	477*

1-years olds immunised against hepatitis B (2007): 96%

*thousands

Population (2006):	3,408,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$14,550
Total health spend as a % of GDP (2006):	6.2%
Per capita total health spend (2006):	$1,041
Per capita govt health spend (2006):	$728
Life Expectancy (f/m, 2006):	77 / 65
Healthy Life Expectancy (f/m, 2003):	68 / 59
Median Age (2006):	38

The government of Lithuania reports as follows:

Policy

The government of Lithuania considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Travellers; Military personnel; Persons at high risk (not specified).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on a monthly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups (not specified).

Compulsory testing: Testing is compulsory for some groups. These include blood donors and healthcare workers.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Treatment of hepatitis B with a combination of pegylated interferon and ribavirin is fully government-funded. 80% of the cost of treatment for hepatitis C is provided by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Lithuania would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Increasing access to treatment
- Developing tools to assess the effectiveness of interventions

Luxembourg

Population (2006):	461,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$60,870
Total health spend as a % of GDP (2006):	7.2%
Per capita total health spend (2006):	$5,773
Per capita govt health spend (2006):	$5,233
Life Expectancy (f/m, 2006):	83 / 77
Healthy Life Expectancy (f/m, 2003):	74 / 69
Median Age (2006):	38

Estimated Mortality (2004)	Total
Acute hepatitis B	1.42
Acute hepatitis C	3.94
Liver cancer	33.17
Cirrhosis	68.78
Infectious diseases	0.07*
Non-communicable diseases	03*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	10
Acute hepatitis C	50
Liver cancer	240
Cirrhosis	1020
Infectious diseases	03*
Non-communicable diseases	47*

1-years olds immunised against hepatitis B (2007): 87%

*thousands

The government of Luxembourg reports as follows:

Policy

The government of Luxembourg considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally. This is focused on hepatitis B vaccination.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare Workers.

Vaccination is provided free of charge to children and adolescents.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. These have included the production of written information for the public about all vaccines including hepatitis B. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions do not currently exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance does not exist for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are not registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on a monthly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include local centers for infectious deseases.

WHO Assistance

The government of Luxembourg would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions

Madagascar

Estimated Mortality (2004)	Total
Acute hepatitis B	118.91
Acute hepatitis C	53.42
Liver cancer	1367.63
Cirrhosis	622.17
Infectious diseases	48.86*
Non-communicable diseases	65*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	2870
Acute hepatitis C	1290
Liver cancer	15520
Cirrhosis	11280
Infectious diseases	4111*
Non-communicable diseases	1863*

1-years olds immunised against hepatitis B (2007): 82%

*thousands

Population (2006):	19,159,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$870
Total health spend as a % of GDP (2006):	3.2%
Per capita total health spend (2006):	$34
Per capita govt health spend (2006):	$21
Life Expectancy (f/m, 2006):	61 / 57
Healthy Life Expectancy (f/m, 2003):	50 / 47
Median Age (2006):	18

The government of Madagascar reports as follows:

Policy

The government of Madagascar considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

The strategy focuses on prevention of hepatitis B through vaccination, healthcare safety and public awareness and education.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: To achieve 90% overall coverage for third dose hepatitis B vaccination by 2010; to achieve at least 80% coverage for third dose hepatitis B vaccination in every district.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Infant vaccination was introduced in 2002 and is provided free of charge at 6, 10 and 14 weeks. Auto-disable syringes have been used in vaccination programmes since 2005. Some clinicians can also access free vaccination, and a campaign to vaccinate healthcare workers was carried out at the main national hospital in 2005.

Hepatitis B vaccination is included in the national EPI Policy (2007). Components include advocacy and awareness, increasing access, service evaluation and multisectoral collaboration. The policy also outlines vaccination delivery and the immunisation schedule.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include blood donors (for whom it is also compulsory).

Compulsory testing: Testing is compulsory for some groups. These include blood donors (for whom it is also free of charge).

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place. There is a follow-up and treatment protocol for hepatitis B.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO, UNICEF, USAID, the Japan International Cooperation Agency (JICA) and the GAVI Alliance in the EPI and vaccine introduction. The Madagascar Pasteur Institute works with government in research and the Paediatric Medicine Society and Association of Hepato-Gastroenterologists do so in clinical work.

WHO Assistance

The government of Madagascar would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Increasing access to treatment
- Developing tools to assess the effectiveness of interventions
- Surveillance

Malaysia

Population (2006):	26,114,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$12,160
Total health spend as a % of GDP (2006):	4.3%
Per capita total health spend (2006):	$500
Per capita govt health spend (2006):	$226
Life Expectancy (f/m, 2006):	74 / 69
Healthy Life Expectancy (f/m, 2003):	65 / 62
Median Age (2006):	25

Estimated Mortality (2004)	Total
Acute hepatitis B	889.23
Acute hepatitis C	398.42
Liver cancer	1323.77
Cirrhosis	1851.09
Infectious diseases	15.83*
Non-communicable diseases	90*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	12820
Acute hepatitis C	5720
Liver cancer	14590
Cirrhosis	32800
Infectious diseases	810*
Non-communicable diseases	2486*

1-years olds immunised against hepatitis B (2007): 87%

*thousands

The government of Malaysia reports as follows:

Policy

The government of Malaysia considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

The strategic plan for hepatitis B is still in draft form. Activities have been carried out by several units and departments.

There is a designated individual to lead the strategy nationally; they do not work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: To reduce the prevalence of all forms of hepatitis to less than 9.7/100,000 population. This is the Director-General of Health's Key Performance Indicator (KPI).

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare Workers; Persons at high risk (blood donors, IDUs, and uniformed personnel on special humanitarian missions).

The Hepatitis B Vaccination Program for newborns was introduced in 1989 as part of the EPI. Screening for hepatitis B and C is mandatory for all blood donors. IDUs are screened and hepatitis B vaccination is given to those who test sero negative or HBsAg negative.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

All healthcare workers are vaccinated against hepatitis B.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. These have used posters, banners and pamphlets aimed at raising awareness among the general public and among healthcare workers. A needle stick injury awareness campaign for has also been carried out for healthcare workers. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government. This includes ensuring confidentiality of cases and for positive HBsAg health care workers; reallocation of roles is done while maintaining confidentiality and rights of the patient.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on an annual basis.

Both hepatitis B and hepatitis C are notifiable diseases under the Prevention and Control of Communicable Disease Act 1988.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include healthcare workers and IDUs.

Compulsory testing: Testing is compulsory for some groups. These include healthcare workers and blood donors as well as students undertaking selected medical-related courses i.e. medicine, nursing, dentistry.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place. Suspected cases are screened for hepatitis A, B and C. Where the result is positive the patient will be referred to a hepatologist or a gastrologist (in certain referral centres) to develop a plan for managing their condition and/or treatment.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the Malaysian Liver Foundation, the National Cancer Registry and the National Drug Agency.

WHO Assistance

The government of Malaysia would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions

Maldives

Estimated Mortality (2004)	Total
Acute hepatitis B	3.32
Acute hepatitis C	1.36
Liver cancer	64.27
Cirrhosis	49.6
Infectious diseases	0.17*
Non-communicable diseases	01*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	60
Acute hepatitis C	20
Liver cancer	650
Cirrhosis	770
Infectious diseases	17*
Non-communicable diseases	31*

1-years olds immunised against hepatitis B (2007): 98%

*thousands

Population (2006):	300,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$4,740
Total health spend as a % of GDP (2006):	10.1%
Per capita total health spend (2006):	$882
Per capita govt health spend (2006):	$742
Life Expectancy (f/m, 2006):	73 / 72
Healthy Life Expectancy (f/m, 2003):	57 / 59
Median Age (2006):	22

The government of Maldives reports as follows:

Policy

The government of Maldives does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Blood screening.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are not registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are not available.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Maldives would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Malta

Population (2006):	405,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$20,990
Total health spend as a % of GDP (2006):	8.3%
Per capita total health spend (2006):	$1,825
Per capita govt health spend (2006):	$1,419
Life Expectancy (f/m, 2006):	81 / 77
Healthy Life Expectancy (f/m, 2003):	73 / 70
Median Age (2006):	38

Estimated Mortality (2004)	Total
Acute hepatitis B	1.33
Acute hepatitis C	1.78
Liver cancer	14.6
Cirrhosis	26.19
Infectious diseases	0.02*
Non-communicable diseases	03*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	20
Acute hepatitis C	20
Liver cancer	120
Cirrhosis	360
Infectious diseases	02*
Non-communicable diseases	40*

1-years olds immunised against hepatitis B (2007): 82%

*thousands

The government of Malta reports as follows:

Policy

The government of Malta does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

There is a overarching Communicable Disease Strategy and a Strategy for the Prevention of Transmission of Hepatitis B among Healthcare Workers.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: Early detection of acute cases within high risk groups; Contact tracing of family members of confirmed cases; Assessment of healthcare workers according to risk status.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare Workers; Persons at high risk.

All children under the age of 18 years of age have been vaccinated. The vaccine given at 15 months as part of national immunisation schedule.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available. A study from 2001 found a hepatitis B prevalence rate of 1-2% .

Disease reporting: Disease reports are published on a monthly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is compulsory for some groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. All secondary care is provided free of charge in Malta.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Malta would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Mauritania

Estimated Mortality (2004)	Total
Acute hepatitis B	15.45
Acute hepatitis C	6.94
Liver cancer	264.88
Cirrhosis	107.58
Infectious diseases	9.29*
Non-communicable diseases	12*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	390
Acute hepatitis C	180
Liver cancer	3040
Cirrhosis	1900
Infectious diseases	650*
Non-communicable diseases	290*

1-years olds immunised against hepatitis B (2007): 74%

*thousands

Population (2006):	3,044,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$1,970
Total health spend as a % of GDP (2006):	2.2%
Per capita total health spend (2006):	$45
Per capita govt health spend (2006):	$31
Life Expectancy (f/m, 2006):	60 / 55
Healthy Life Expectancy (f/m, 2003):	46 / 43
Median Age (2006):	20

The government of Mauritania reports as follows:

Policy

The government of Mauritania considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Hepatitis B vaccination was introduced into the national EPI programme in 2005 as a result of epidemiological studies finding a high prevalence of hepatitis B infection in the country.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available. Studies of rates of hepatitis B in expectant mothers indicate a HBsAg prevalence of 13%.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the GAVI Alliance.

WHO Assistance

The government of Mauritania would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Increasing access to treatment
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Mauritius

Population (2006):	1,252,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$10,640
Total health spend as a % of GDP (2006):	4.3%
Per capita total health spend (2006):	$581
Per capita govt health spend (2006):	$292
Life Expectancy (f/m, 2006):	76 / 69
Healthy Life Expectancy (f/m, 2003):	65 / 60
Median Age (2006):	31

Estimated Mortality (2004)	Total
Acute hepatitis B	1.56
Acute hepatitis C	0.0
Liver cancer	44.5
Cirrhosis	209.06
Infectious diseases	0.14*
Non-communicable diseases	08*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	10
Acute hepatitis C	-
Liver cancer	420
Cirrhosis	4120
Infectious diseases	31*
Non-communicable diseases	159*

1-years olds immunised against hepatitis B (2007): 97%

*thousands

The government of Mauritius reports as follows:

Policy

The government of Mauritius considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare Workers.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Information was not available on whether any government-funded awareness campaigns have taken place in the past five years. Information was not available on whether action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions do not currently exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are not available.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of Mauritius would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Increasing access to treatment
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions

Micronesia, Federated States of

Estimated Mortality (2004)	Total
Acute hepatitis B	0.32
Acute hepatitis C	0.15
Liver cancer	5.32
Cirrhosis	3.51
Infectious diseases	0.09*
Non-communicable diseases	0*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	10
Acute hepatitis C	10
Liver cancer	80
Cirrhosis	80
Infectious diseases	05*
Non-communicable diseases	11*

1-years olds immunised against hepatitis B (2007): 90%

*thousands

Population (2006):	111,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$6,070
Total health spend as a % of GDP (2006):	12.0%
Per capita total health spend (2006):	$491
Per capita govt health spend (2006)	$444
Life Expectancy (f/m, 2006):	70 / 67
Healthy Life Expectancy (f/m, 2003):	58 / 57
Median Age (2006):	20

The government of the Federated States of Micronesia reports as follows:

Policy

The government of Micronesia considers hepatitis B and/or hepatitis C to be an urgent public health issue.

Hepatitis B in particular in considered an urgent public health issue in the Federated States of Micronesia.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare Workers.

National policy is for all healthcare workers and those at high risk of contracting hepatitis B to be vaccinated. All infants born to mothers with hepatitis B are provided with HBIG at birth and then at 2 and 6 months. Children and adolescents must have completed three dose hepatitis B vaccination prior to entering pre-school and high school.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

These are however some weaknesses in implementation, and although all blood is screened for hepatitis B screening for hepatitis C is only done if diagnostic reagents are available.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has, however, been taken by the government. This has been done for hepatitis B, which is largely perceived as a disease that runs in the family, and focused on improving understanding of transmission routes particularly that it can be sexually transmitted.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of the Federated States of Micronesia would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance
- Other areas including: assistance with developing and implementing contact tracing systems for families and partners.

Morocco

Population (2006):	30,853,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$3,860
Total health spend as a % of GDP (2006):	5.1%
Per capita total health spend (2006):	$273
Per capita govt health spend (2006):	$98
Life Expectancy (f/m, 2006):	74 / 70
Healthy Life Expectancy (f/m, 2003):	61 / 59
Median Age (2006):	25

Estimated Mortality (2004)	Total
Acute hepatitis B	289.38
Acute hepatitis C	147.11
Liver cancer	213.63
Cirrhosis	4662.58
Infectious diseases	12.14*
Non-communicable diseases	120*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	3390
Acute hepatitis C	1710
Liver cancer	2500
Cirrhosis	58640
Infectious diseases	1524*
Non-communicable diseases	2930*

1-years olds immunised against hepatitis B (2007): 86%

*thousands

The government of Morocco reports as follows:

Policy

The government of Morocco considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare Workers; Military personnel.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has, however, been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Information was not available on whether standard case definitions currently exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance does not exist for acute hepatitis
- Information was not available on whether surveillance exists for chronic hepatitis
- Information was not available on whether chronic hepatitis infections are registered
- Information was not available on whether liver cancer cases are registered
- Information was not available on whether cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on a monthly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is compulsory for some groups. These include blood donors.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of Morocco would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Namibia

Estimated Mortality (2004)	Total
Acute hepatitis B	2.2
Acute hepatitis C	0.99
Liver cancer	24.98
Cirrhosis	43.99
Infectious diseases	11.29*
Non-communicable diseases	05*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	50
Acute hepatitis C	20
Liver cancer	250
Cirrhosis	860
Infectious diseases	418*
Non-communicable diseases	147*

1-years olds immunised against hepatitis B (2007): 0%

*thousands

Population (2006):	2,047,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$4,770
Total health spend as a % of GDP (2006):	4.9%
Per capita total health spend (2006):	$338
Per capita govt health spend (2006):	$218
Life Expectancy (f/m, 2006):	63 / 59
Healthy Life Expectancy (f/m, 2003):	44 / 43
Median Age (2006):	20

The government of Namibia reports as follows:

Policy

The government of Namibia considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Healthcare Workers.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups (not specified).

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of Namibia would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Nauru

Population (2006):	10,000
[1]Country Classification (2009):	n/a
Gross National Income per capita (-):	-
Total health spend as a % of GDP (2006):	10.8%
Per capita total health spend (2006):	$803
Per capita govt health spend (2006):	$444
Life Expectancy (f/m, 2006):	64 / 59
Healthy Life Expectancy (f/m, 2003):	57 / 53
Median Age (-):	-

[1]For the purposes of this study Nauru was classified as a Lower Middle Income economy and is included in global and regional analyses for this category.

Estimated Mortality (2004)	Total
Acute hepatitis B	2.29
Acute hepatitis C	0.03
Liver cancer	0.29
Cirrhosis	2.12
Infectious diseases	0.01*
Non-communicable diseases	0*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	60
Acute hepatitis C	0
Liver cancer	0
Cirrhosis	50
Infectious diseases	01*
Non-communicable diseases	02*

1-years olds immunised against hepatitis B (2007): 99%

*thousands

The government of Nauru reports as follows:

Policy

The government of Nauru considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: To maintain high immunisation coverage for hepatitis B; To reduce rates of hepatitis B transmission.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants, Healthcare Workers.

Hepatitis B vaccine has been introduced into the national EPI programme. Coverage is 100%. The first dose of hepatitis vaccine is provided within 24 hours of birth. There is a specific vaccination programme for healthcare workers and uniformed personnel.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Details of the groups covered by this strategy were not available to this study.

Policy development: Information was not available on whether other countries' policies relating to hepatitis B and/or hepatitis C are currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. These have been targeted at healthcare workers and at the police and fire brigade (identified risk groups). Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Information was not available on whether chronic hepatitis infections are registered
- Information was not available on whether liver cancer cases are registered
- Information was not available on whether cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are not available.

Disease reporting: Disease reports are published on a monthly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO and Suva, Fiji.

WHO Assistance

The government of Nauru would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Nepal

Estimated Mortality (2004)	Total
Acute hepatitis B	1019.64
Acute hepatitis C	284.57
Liver cancer	357.69
Cirrhosis	2628.1
Infectious diseases	49.76*
Non-communicable diseases	104*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	22400
Acute hepatitis C	6010
Liver cancer	4730
Cirrhosis	55330
Infectious diseases	3845*
Non-communicable diseases	3034*

1-years olds immunised against hepatitis B (2007): 82%

*thousands

Population (2006):	27,641,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$1,010
Total health spend as a % of GDP (2006):	5.7%
Per capita total health spend (2006):	$78
Per capita govt health spend (2006):	$24
Life Expectancy (f/m, 2006):	63 / 62
Healthy Life Expectancy (f/m, 2003):	51 / 52
Median Age (2006):	20

The government of Nepal reports as follows:

Policy

The government of Nepal considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

The National Immunization Program oversees hepatitis B immunisation and there is a designated hepatitis unit in a main national hospital.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has, however, been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place. All hepatitis cases are managed at one national hospital, a tertiary government hospital which has a hepatology unit and registers and manages all hepatitis cases. Hepatitis cases are also treated in a national Ayurvedic hospital.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of Nepal would welcome assistance from the WHO in the prevention and control of hepatitis B and/or

- Developing tools to assess the effectiveness of interventions
- Surveillance

Netherlands

Population (2006):	16,379,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$37,940
Total health spend as a % of GDP (2006):	9.3%
Per capita total health spend (2006):	$3,383
Per capita govt health spend (2006):	$2,768
Life Expectancy (f/m, 2006):	82 / 78
Healthy Life Expectancy (f/m, 2003):	73 / 70
Median Age (2006):	39

Estimated Mortality (2004)	Total
Acute hepatitis B	25.56
Acute hepatitis C	29.52
Liver cancer	592.98
Cirrhosis	839.58
Infectious diseases	2.08*
Non-communicable diseases	123*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	380
Acute hepatitis C	310
Liver cancer	4510
Cirrhosis	12310
Infectious diseases	94*
Non-communicable diseases	1674*

1-years olds immunised against hepatitis B (2007): -

*thousands

The government of Netherlands reports as follows:

Policy

Information was not available on whether the government of the Netherlands considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

This strategy focuses on the prevention of hepatitis B through vaccination, screening and sexual health programmes.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers; Travellers; Persons at high risk (MSM, IDUs, sex workers).

Infant vaccination is only provided to those at higher risk of infection (Infants of HBsAg-positive mothers, with a parent born in a middle- or high-prevalence country and children with Down's Syndrome). MSM, IDUs and sex workers receive free vaccination, as do other risk groups including close contacts of active cases of hepatitis B, people with liver disease, those who regularly receive blood products and/or undergo dialysis and those travelling to high endemicity areas. Employers are responsible for ensuring those at risk in occupational settings are vaccinated; there are national guidelines for this.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Information was not available on whether other countries' policies relating to hepatitis B and/or hepatitis C are currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government. Activities to raise awareness and combat stigma and discrimination have primarily been targeted at risk groups and include online informational resources in several languages.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups (not specified).

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Treatment is funded through the general structures for health care delivery which is primarily based on obligatory insurance through health insurance companies. The Government provides some financial contribution to this system.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the National Hepatitis Centre, Soa Aids Nederland, Schorer Foundation, Mainline, European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

WHO Assistance

The government of Netherlands would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment

New Zealand

Estimated Mortality (2004)	Total
Acute hepatitis B	9.87
Acute hepatitis C	10.7
Liver cancer	145.87
Cirrhosis	107.05
Infectious diseases	0.16*
Non-communicable diseases	25*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	140
Acute hepatitis C	200
Liver cancer	1290
Cirrhosis	1580
Infectious diseases	19*
Non-communicable diseases	402*

1-years olds immunised against hepatitis B (2007): 88%

*thousands

Population (2006):	4,140,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$25,750
Total health spend as a % of GDP (2006):	9.4%
Per capita total health spend (2006):	$2,447
Per capita govt health spend (2006):	$1,905
Life Expectancy (f/m, 2006):	82 / 78
Healthy Life Expectancy (f/m, 2003):	72 / 69
Median Age (2006):	36

The government of New Zealand reports as follows:

Policy

The government of New Zealand does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Travellers; Military personnel; Persons at high risk (these include close contacts of carriers, adults at risk because of their occupation, those undergoing renal dialysis, adults with chronic liver disease, MSM, people in prison).

Vaccination is provided free of charge to infants, adolescents and close contacts of active cases.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. This has included TV awareness advertisements for hepatitis C and general promotion as part of immunisation schedule for hepatitis B. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on a monthly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the Hepatitis B Foundation.

WHO Assistance

No areas for assistance were identified.

Niger

Population (2006):	13,737,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$630
Total health spend as a % of GDP (2006):	4.0%
Per capita total health spend (2006):	$27
Per capita govt health spend (2006):	$14
Life Expectancy (f/m, 2006):	43 / 42
Healthy Life Expectancy (f/m, 2003):	35 / 36
Median Age (2006):	16

Estimated Mortality (2004)	Total
Acute hepatitis B	592.89
Acute hepatitis C	266.37
Liver cancer	1839.32
Cirrhosis	617.92
Infectious diseases	117.47*
Non-communicable diseases	63*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	18060
Acute hepatitis C	8120
Liver cancer	23510
Cirrhosis	11670
Infectious diseases	7919*
Non-communicable diseases	1536*

1-years olds immunised against hepatitis B (2007): -

*thousands

The government of Niger reports as follows:

Policy

The government of Niger considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: To immunise 95% of infants by 2010.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Infants only are vaccinated. This is done using DTC-HepB-Hib pentavalent vaccine in all immunisation centres across the country as part of the national EPI programme.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. These were carried out during for introduction of DTC-HepB-Hib vaccine in 2008. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO, UNICEF, the GAVI Alliance for the implementation of hepatitis B vaccine into the routine EPI.

WHO Assistance

The government of Niger would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Nigeria

Estimated Mortality (2004)	Total
Acute hepatitis B	2462.59
Acute hepatitis C	1106.38
Liver cancer	9032.04
Cirrhosis	5596.78
Infectious diseases	974.54*
Non-communicable diseases	552*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	73040
Acute hepatitis C	32840
Liver cancer	111210
Cirrhosis	106680
Infectious diseases	55793*
Non-communicable diseases	16648*

1-years olds immunised against hepatitis B (2007): 41%

*thousands

Population (2006):	144,720,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$1,410
Total health spend as a % of GDP (2006):	4.1%
Per capita total health spend (2006):	$50
Per capita govt health spend (2006):	$15
Life Expectancy (f/m, 2006):	49 / 48
Healthy Life Expectancy (f/m, 2003):	42 / 41
Median Age (2006):	18

The government of Nigeria reports as follows:

Policy

The government of Nigeria considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Central dimensions of the strategy are reported as: Increasing access to hepatitis B Vaccination (conducting fixed, outreach and mobile sessions); strengthening surveillance system on hepatitis B Infection; strengthening the monitoring and supervision system; undertaking communication & advocacy activities to increase demand for hepatitis B vaccination; and improving programme management

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: To improve and then sustain routine immunisation coverage of hepatitis B vaccine at 90% by the year 2020; To achieve 90% coverage with pentavalent and other vaccines in 80% of the Local Government Areas by 2014; To develop and promote immunisation programmes geared towards reduction of childhood morbidity and mortality through adequate hepatitis B vaccination.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare Workers.

National policy is to provide immunisation services and vaccines to the population at risk (healthcare workers). This is achieved through the National Primary Health Care Development Agency, other tiers of government and stakeholders.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. These have been integrated into in Supplemental Immunization Campaigns and Immunization Plus Days conducted at National, State, Local Government Area and Ward (district) levels. These deliver routine antigens administered with the Oral Polio vaccines as well as other child survival interventions such as antihelminthics, vitamin A, and the distribution of insecticide-treated nets. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Information was not available on whether chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on a monthly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include infants of 0-11 months and healthcare workers.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the GAVI Alliance, the WHO, UNICEF, European Union Partnership to Reinforce Immunisation Efficiency (EU-PRIME) Project, Community Based Organizations and the European Union.

WHO Assistance

The government of Nigeria would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Norway

Population (2006):	4,669,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$50,070
Total health spend as a % of GDP (2006):	8.7%
Per capita total health spend (2006):	$4,521
Per capita govt health spend (2006):	$3,780
Life Expectancy (f/m, 2006):	83 / 78
Healthy Life Expectancy (f/m, 2003):	74 / 70
Median Age (2006):	38

Estimated Mortality (2004)	Total
Acute hepatitis B	4.38
Acute hepatitis C	13.93
Liver cancer	143.69
Cirrhosis	273.52
Infectious diseases	0.65*
Non-communicable diseases	37*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	80
Acute hepatitis C	190
Liver cancer	830
Cirrhosis	3750
Infectious diseases	19*
Non-communicable diseases	472*

1-years olds immunised against hepatitis B (2007): -

*thousands

The government of Norway reports as follows:

Policy

The government of Norway does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

This focuses on prevention of hepatitis B and is included in the national Strategy for the Prevention of HIV and STIs and in hepatitis B vaccination guidelines.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers; Travellers; Military personnel; Persons at high risk (these include MSM, sex workers, dialysis patients, people with Down's Syndrome, close contacts of active cases).

The Norwegian hepatitis B vaccination policy is targeted at specific groups. These people receive the vaccine free of charge (paid for by the government). Military personnel serving abroad are offered vaccination free of charge, and healthcare workers at risk of exposure may be offered free vaccination by their employer. Travellers visiting high-endemicity areas must pay for vaccination.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are not registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available. These indicate anti-HCV prevalence at 0.7% among pregnant women and 0.55 % in the general adult population. Robust prevalence data for hepatitis B is not available.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. The costs of treatment (and testing) for all conditions that are legally regarded as serious communicable diseases, including hepatitis B and C, are met by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

No areas for WHO assistance were identified.

Oman

Estimated Mortality (2004)	Total
Acute hepatitis B	7.64
Acute hepatitis C	1.68
Liver cancer	68.46
Cirrhosis	61.26
Infectious diseases	0.29*
Non-communicable diseases	06*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	210
Acute hepatitis C	30
Liver cancer	750
Cirrhosis	1030
Infectious diseases	45*
Non-communicable diseases	212*

1-years olds immunised against hepatitis B (2007): 99%

*thousands

Population (2006):	2,546,000
Country Classification (2009):	High income
Gross National Income per capita (2005):	$19,740
Total health spend as a % of GDP (2006):	2.3%
Per capita total health spend (2006):	$382
Per capita govt health spend (2006):	$321
Life Expectancy (f/m, 2006):	77 / 72
Healthy Life Expectancy (f/m, 2003):	65 / 63
Median Age (2006):	23

The government of Oman reports as follows:

Policy

The government of Oman considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Components of the national hepatitis B policy include prevention, screening, surveillance and service evaluation.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: To reduce the incidence of HBsAg to less than 1% among people under 21 years of age at the national level.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers; Persons at high risk (not specified).

Hepatitis B was introduced into the EPI schedule in 1990. Infant hepatitis B vaccination is given at 1, 2 and 6 months.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Safe Injection procedures are followed and safe disposal boxes are consistently available and disposed of in incinerators. All blood is screened for hepatitis B and C and HIV. Vaccination for healthcare workers is mandatory and provided free of charge.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on a weekly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Oman would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Increasing access to treatment
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions

Panama

Population (2006):	3,288,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$8,690
Total health spend as a % of GDP (2006):	7.3%
Per capita total health spend (2006):	$721
Per capita govt health spend (2006):	$495
Life Expectancy (f/m, 2006):	79 / 74
Healthy Life Expectancy (f/m, 2003):	68 / 64
Median Age (2006):	26

Estimated Mortality (2004)	Total
Acute hepatitis B	12.8
Acute hepatitis C	4.04
Liver cancer	59.48
Cirrhosis	225.02
Infectious diseases	1.46*
Non-communicable diseases	10*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	240
Acute hepatitis C	60
Liver cancer	580
Cirrhosis	2870
Infectious diseases	110*
Non-communicable diseases	295*

1-years olds immunised against hepatitis B (2007): 88%

*thousands

The government of Panama reports as follows:

Policy

The government of Panama considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

This is largely focused on hepatitis B. The main documented guideline in this area is the national vaccination schedule, which includes hepatitis B vaccine. Additional contributory work focused on condom use is carried out within the HIV/AIDS and sexual health divisions.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare Workers; Persons at high risk.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are not available.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Panama would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Developing tools to assess the effectiveness of interventions
- Surveillance

Papua New Guinea

Estimated Mortality (2004)	Total
Acute hepatitis B	196.02
Acute hepatitis C	42.74
Liver cancer	362.29
Cirrhosis	551.87
Infectious diseases	13.94*
Non-communicable diseases	18*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	5260
Acute hepatitis C	1030
Liver cancer	6200
Cirrhosis	14950
Infectious diseases	942*
Non-communicable diseases	596*

1-years olds immunised against hepatitis B (2007): 59%

*thousands

Population (2006):	6,202,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$1,630
Total health spend as a % of GDP (2006):	3.2%
Per capita total health spend (2006):	$134
Per capita govt health spend (2006):	$111
Life Expectancy (f/m, 2006):	64 / 60
Healthy Life Expectancy (f/m, 2003):	52 / 51
Median Age (2006):	20

The government of Papua New Guinea reports as follows:

Policy

The government of Papua New Guinea considers hepatitis B and/or hepatitis C to be an urgent public health issue.

Hepatitis B in particular is considered an urgent public health issue in Papua New Guinea.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: To achieve hepatitis B control by 2012 by increasing the birth dose administered within 24 hours to 80%; to increase coverage of the third dose of hepatitis B vaccine to at least 80% in all districts.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. These have included campaigns targeted at healthcare workers and focused on delivery of the birth dose of hepatitis B vaccine within 24 hours of birth. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include blood donors (for whom it is also compulsory).

Compulsory testing: Testing is compulsory for some groups. These include blood donors (for whom it is also free of charge).

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Treatment for hepatitis B mainly consists of support with managing the condition.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO, the GAVI Alliance, the Burnet Institute of Australia and Save the Children International.

WHO Assistance

The government of Papua New Guinea would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing tools to assess the effectiveness of interventions
- Surveillance

Paraguay

Population (2006):	6,016,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$4,040
Total health spend as a % of GDP (2006):	7.6%
Per capita total health spend (2006):	$342
Per capita govt health spend (2006):	$131
Life Expectancy (f/m, 2006):	78 / 72
Healthy Life Expectancy (f/m, 2003):	64 / 60
Median Age (2006):	22

Estimated Mortality (2004)	Total
Acute hepatitis B	7.28
Acute hepatitis C	-
Liver cancer	122.11
Cirrhosis	299.89
Infectious diseases	2.6*
Non-communicable diseases	22*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	120
Acute hepatitis C	-
Liver cancer	1210
Cirrhosis	4570
Infectious diseases	270*
Non-communicable diseases	559*

1-years olds immunised against hepatitis B (2007): 66%

*thousands

The government of Paraguay reports as follows:

Policy

The government of Paraguay does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: To achieve at least 95% coverage in all districts in the country.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers.

The vaccination policy applies universally to infants and healthcare workers and partially to adolescents.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting*
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

*Laboratory confirmation is done where facilities are in place.

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. All health services are provided free of charge in Paraguay.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the Pan-American Health Organization (PAHO).

WHO Assistance

The government of Paraguay would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Increasing access to treatment
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Peru

Estimated Mortality (2004)	Total
Acute hepatitis B	651.44
Acute hepatitis C	42.81
Liver cancer	1156.31
Cirrhosis	5697.23
Infectious diseases	20.13*
Non-communicable diseases	100*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	14880
Acute hepatitis C	590
Liver cancer	12230
Cirrhosis	81000
Infectious diseases	1320*
Non-communicable diseases	2914*

1-years olds immunised against hepatitis B (2007): 90%

*thousands

Population (2006):	27,589,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$6,490
Total health spend as a % of GDP (2006):	4.3%
Per capita total health spend (2006):	$300
Per capita govt health spend (2006):	$171
Life Expectancy (f/m, 2006):	75 / 71
Healthy Life Expectancy (f/m, 2003):	62 / 60
Median Age (2006):	25

The government of Peru reports as follows:

Policy

The government of Peru considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

This strategy focuses on the prevention of hepatitis B through vaccination.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Travellers; Military personnel; Persons at high risk (not specified).

Hepatitis B vaccination has been included in the EPI since 2003, and a mass campaign was held in 2008 to vaccinate all people under 18 years of age across the country.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers. All blood is screened for hepatitis B and C.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. These have been focused on hepatitis B vaccination. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available. Prevalence of hepatitis B overall in the country is intermediate, but it is hyperendemic in some parts of the Amazonian and Andean areas.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially. Testing in accessible in health services when testing kits are available, which is not always the case.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups (not specified).

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. A programme is being implemented to pilot treatment for hepatitis B in remote parts of the country.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include PAHO.

WHO Assistance

The government of Peru would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance
- Other areas including: delivery of treatment for hepatitis B in endemic zones; the standardisation of molecular tests for viral load

Philippines

Population (2006):	86,264,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$3,430
Total health spend as a % of GDP (2006):	3.3%
Per capita total health spend (2006):	$223
Per capita govt health spend (2006):	$88
Life Expectancy (f/m, 2006):	71 / 64
Healthy Life Expectancy (f/m, 2003):	62 / 57
Median Age (2006):	22

Estimated Mortality (2004)	Total
Acute hepatitis B	658.62
Acute hepatitis C	295.9
Liver cancer	4260.71
Cirrhosis	6138.95
Infectious diseases	78.58*
Non-communicable diseases	280*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	11440
Acute hepatitis C	5150
Liver cancer	61980
Cirrhosis	126460
Infectious diseases	5570*
Non-communicable diseases	9188*

1-years olds immunised against hepatitis B (2007): 88%

*thousands

The government of Philippines reports as follows:

Policy

The government of Philippines considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

The strategy focuses on prevention of hepatitis B through vaccination.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

A policy for vaccination of travellers is at draft stage.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Information was not available on whether surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Information was not available on whether cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: No information was available on whether there is a clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Philippines would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Poland

Estimated Mortality (2004)	Total
Acute hepatitis B	107.39
Acute hepatitis C	133.08
Liver cancer	2159.45
Cirrhosis	6089.7
Infectious diseases	2.69*
Non-communicable diseases	332*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	1170
Acute hepatitis C	1540
Liver cancer	17170
Cirrhosis	105350
Infectious diseases	267*
Non-communicable diseases	4763*

1-years olds immunised against hepatitis B (2007): 98%

*thousands

Population (2006):	38,140,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$14,250
Total health spend as a % of GDP (2006):	6.2%
Per capita total health spend (2006):	$910
Per capita govt health spend (2006):	$636
Life Expectancy (f/m, 2006):	80 / 71
Healthy Life Expectancy (f/m, 2003):	68 / 63
Median Age (2006):	37

The government of Poland reports as follows:

Policy

The government of Poland does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: The immunisation of all newborn babies and all persons in at risk groups.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Persons at high risk.

Vaccination is mandatory and free of charge under the policy for all infants, children of twelve years old who have not previously been vaccinated, medical professionals and students, people with chronic liver or kidney disease, close contacts of active cases of hepatitis B, people with HIV and other immune deficiencies.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. The campaign "We can combat HCV infections" (HCV mozna pokonać) aimed at healthcare providers involved on-site training and the provision of information material for 6,000 participants. Following this there was a 50% increase in hepatitis C notifications in the five regions where the campaign was held. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on a twice-weekly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. The cost of treatment is covered by the National Health Fund for Insured Persons. Since 2008 four hepatitis B and C treatment projects have been financed by National Health Fund. These provide lamivudine and interferon. Patients who developed resistance to these drugs are given alternative treatment.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include Stowarzyszenie Pomocy Chorym z HCV "Prometeusze", Fundacja "Gwiazda Nadziei".

WHO Assistance

The government of Poland would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising

Qatar

Population (2006):	821,000
Country Classification (2009):	High income
Gross National Income per capita (0):	-
Total health spend as a % of GDP (2006):	4.3%
Per capita total health spend (2006):	$1,426
Per capita govt health spend (2006):	$1,115
Life Expectancy (f/m, 2006):	77 / 77
Healthy Life Expectancy (f/m, 2003):	64 / 67
Median Age (2006):	31

Estimated Mortality (2004)	Total
Acute hepatitis B	6.05
Acute hepatitis C	14.28
Liver cancer	9.59
Cirrhosis	18.61
Infectious diseases	0.11*
Non-communicable diseases	01*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	50
Acute hepatitis C	290
Liver cancer	100
Cirrhosis	440
Infectious diseases	09*
Non-communicable diseases	60*

1-years olds immunised against hepatitis B (2007): 94%

*thousands

The government of Qatar reports as follows:

Policy

The government of Qatar considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Travellers.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Information was not available on whether any government-funded awareness campaigns have taken place in the past five years. Information was not available on whether any action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Information was not available on whether surveillance exists for chronic hepatitis
- Information was not available on whether chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Information was not available on whether prevalence estimates exist.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is compulsory for some groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of Qatar would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Republic of Korea

Estimated Mortality (2004)	Total
Acute hepatitis B	980.47
Acute hepatitis C	-
Liver cancer	13795.77
Cirrhosis	10702.15
Infectious diseases	7.13*
Non-communicable diseases	233*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	14380
Acute hepatitis C	-
Liver cancer	153000
Cirrhosis	179890
Infectious diseases	390*
Non-communicable diseases	5016*

1-years olds immunised against hepatitis B (2007): 91%

*thousands

Population (2006):	48,050,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$22,990
Total health spend as a % of GDP (2006):	6.5%
Per capita total health spend (2006):	$1,487
Per capita govt health spend (2006):	$819
Life Expectancy (f/m, 2006):	82 / 75
Healthy Life Expectancy (f/m, 2003):	71 / 65
Median Age (2006):	36

The government of Republic of Korea reports as follows:

Policy

The government of Republic of Korea considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. WHO Western Pacific region aims to reduce HBsAg seroprevalence to less than 2% among children aged in 5 years or older by 2012. In Korea, the strategy for achieving this has three goals: To reach 95% coverage for the 3rd hepatitis B vaccination; To prevent perinatal transmission to minimize the chronic HBV infection; To monitor and evaluate hepatitis B control program by strengthening the surveillance system.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Persons at high risk (these include family members of hepatitis B carriers, patients who need frequent transfusion, haemodialysis patients, IDUs, public health workers).

Vaccination for high risk groups has been recommended since 1985 and universal infant immunisation introduced in 1995. All antenatal mothers have been screened free of charge since 2000. All HBsAg positive mothers are provided with an educational booklet on preventing hepatitis B transmission which also contains coupons for free vaccination of their child. Used coupons are passed to public health centres for reimbursement and monitoring, and data is passed to the Korean CDC to inform disease surveillance. The take-up rate is estimated at 95%.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. This includes an educational and free infant vaccination booklet for antenatal mothers produced by the Perinatal Transmission Prevention Program on Hepatitis B (as above). Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government. The coupon booklets also contain educational materials about hepatitis B.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance does not exist for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on a monthly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups (not specified).

Compulsory testing: Testing is compulsory for some groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO.

WHO Assistance

The government of Republic of Korea would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Increasing access to treatment
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Republic of Moldova

Population (2006):	3,833,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$2,660
Total health spend as a % of GDP (2006):	7.8%
Per capita total health spend (2006):	$190
Per capita govt health spend (2006):	$107
Life Expectancy (f/m, 2006):	72 / 64
Healthy Life Expectancy (f/m, 2003):	62 / 57
Median Age (2006):	33

Estimated Mortality (2004)	Total
Acute hepatitis B	3.67
Acute hepatitis C	1.65
Liver cancer	422.51
Cirrhosis	3893.69
Infectious diseases	0.89*
Non-communicable diseases	45*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	120
Acute hepatitis C	50
Liver cancer	4120
Cirrhosis	54020
Infectious diseases	85*
Non-communicable diseases	635*

1-years olds immunised against hepatitis B (2007): 95%

*thousands

The government of Republic of Moldova reports as follows:

Policy

The government of Republic of Moldova considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

The National Program for Control of Hepatitis B and C (2007-2011) includes the hepatitis B vaccination strategy, directives on the control of transfusions, communication and education, and treatment. There are individual National Protocols for acute and chronic hepatitis B and C.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: The vaccination of newborn babies (in place since 1995) and groups at risk; The elimination of transmission of viral hepatitis in healthcare settings.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. The Communication Strategy includes the use of TV, radio, and meetings and is particularly focused on targeting risk groups. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are not available. However, unofficial data indicate that in 2008 there were 68,240 patients registered with chronic hepatitis and cirrhosis. The actual total number of people with cirrhosis is believed to be 300,000-500,000, 70% of whom have hepatitis B and/or C. HCC rates are estimated as 7.7 cases per 100,000 population. Total mortality for chronic hepatitis and cirrhosis is estimated at 117 per 100,000 population in 2008.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially. It is accessible only to insured patients in hospitals.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Insurance Agencies fund some treatment for all hospitalised insured patients, but antiviral treatment is only provided to 150-200 patients per year.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO regional and country offices, USAID and UNICEF.

WHO Assistance

The government of Republic of Moldova would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Increasing access to treatment
- Delivery of vaccination
- Surveillance

Romania

Estimated Mortality (2004)	Total
Acute hepatitis B	38.11
Acute hepatitis C	15.18
Liver cancer	2323.51
Cirrhosis	10140.17
Infectious diseases	3.19*
Non-communicable diseases	234*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	870
Acute hepatitis C	200
Liver cancer	20240
Cirrhosis	145620
Infectious diseases	314*
Non-communicable diseases	3139*

1-years olds immunised against hepatitis B (2007): 99%

*thousands

Population (2006):	21,532,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$10,150
Total health spend as a % of GDP (2006):	5.7%
Per capita total health spend (2006):	$610
Per capita govt health spend (2006):	$433
Life Expectancy (f/m, 2006):	76 / 69
Healthy Life Expectancy (f/m, 2003):	65 / 61
Median Age (2006):	37

The government of Romania reports as follows:

Policy

The government of Romania does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: Reduction of the hepatitis B incidence through vaccination of children and risk groups; Provision of treatment free of charge.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Persons at high risk (close contacts of active cases).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Information was not available on whether chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Information was not available on whether prevalence estimates exist.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include all suspected cases and healthcare workers.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place. There is a national infectious diseases hospitals network which manages diagnosis and treatment. Some cases are also treated in gastroenterology clinics. Family doctors act as gatekeepers and can recommend testing and refer the patient to these clinics.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Romania would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions

Russian Federation

Population (2006):	143,221,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$12,740
Total health spend as a % of GDP (2006):	5.3%
Per capita total health spend (2006):	$638
Per capita govt health spend (2006):	$404
Life Expectancy (f/m, 2006):	73 / 60
Healthy Life Expectancy (f/m, 2003):	64 / 53
Median Age (2006):	37

Estimated Mortality (2004)	Total
Acute hepatitis B	793.6
Acute hepatitis C	356.54
Liver cancer	7980.81
Cirrhosis	47167.85
Infectious diseases	58.74*
Non-communicable diseases	1795*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	19180
Acute hepatitis C	8620
Liver cancer	81440
Cirrhosis	941610
Infectious diseases	3412*
Non-communicable diseases	27571*

1-years olds immunised against hepatitis B (2007): 98%

*thousands

The government of Russian Federation reports as follows:

Policy

The government of the Russian Federation considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they work exclusively on the hepatitis strategy.

Activities for prevention, diagnosis and treatment of hepatitis B and C and HIV/AIDS infection are funded through the National Priority Project 'Health' and the HIV Infection and Viral Hepatitis sub-programmes of the Federal programme for the Prevention and Control of Socially Important Diseases.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Travellers; Military personnel; Persons at high risk.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Information was not available on whether prevalence estimates exist.

Disease reporting: Disease reports are published on a weekly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups (unspecified).

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Treatment is part-funded by the government.

Working with civil society

No information was available on whether government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Russian Federation would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment

Samoa

Estimated Mortality (2004)	Total
Acute hepatitis B	0.95
Acute hepatitis C	0.43
Liver cancer	5.07
Cirrhosis	7.01
Infectious diseases	0.18*
Non-communicable diseases	01*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	40
Acute hepatitis C	20
Liver cancer	50
Cirrhosis	140
Infectious diseases	09*
Non-communicable diseases	20*

1-years olds immunised against hepatitis B (2007): 69%

*thousands

Population (2006):	185,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$5,090
Total health spend as a % of GDP (2006):	4.9%
Per capita total health spend (2006):	$232
Per capita govt health spend (2006):	$188
Life Expectancy (f/m, 2006):	70 / 66
Healthy Life Expectancy (f/m, 2003):	60 / 59
Median Age (2006):	20

The government of Samoa reports as follows:

Policy

The government of Samoa considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

The strategy focuses on the prevention of hepatitis B through vaccination and screening.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: To increase coverage for hepatitis B vaccination.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers; Persons at high risk (not specified).

Hepatitis B vaccination is included in the EPI Policy.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has, however, been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are not available.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is compulsory for some groups. These include all pregnant mothers.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place. Patient may access testing through all healthcare facilities. Blood test results are laboratory confirmed and results returned to healthcare facility and patient. Positive cases are reported to Public Health for contact screening and the patient is offered follow-up care and treatment.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO, UNICEF and the Health Sector Community.

WHO Assistance

The government of Samoa would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Seychelles

Population (2006):	86,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$14,360
Total health spend as a % of GDP (2006):	6.8%
Per capita total health spend (2006):	$812
Per capita govt health spend (2006):	$602
Life Expectancy (f/m, 2006):	77 / 68
Healthy Life Expectancy (f/m, 2003):	65 / 57
Median Age ():	-

Estimated Mortality (2004)	Total
Acute hepatitis B	0.00
Acute hepatitis C	0.0
Liver cancer	2.3
Cirrhosis	14.51
Infectious diseases	0.04*
Non-communicable diseases	0*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	0
Acute hepatitis C	0
Liver cancer	30
Cirrhosis	280
Infectious diseases	02*
Non-communicable diseases	10*

1-years olds immunised against hepatitis B (2007): 99%

*thousands

The government of Seychelles reports as follows:

Policy

The government of Seychelles considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

The prevention detection and management of hepatitis and is part of national programmes for screening, immunisation, blood safety, HIV/AIDS and IDUs.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. Part of the National Health Strategic Framework, these include: To improve the health status of all individuals, families and communities living in Seychelles; To maintain and improve the scope and quality of the Expanded Programme of Immunisation; To improve the detection, prevention and treatment of priority communicable disease and outbreak of new diseases.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers; Persons at high risk (people with chronic illnesses such as HIV/AIDS).

Pregnant women, People with HIV/AIDS and IDUs are screened for hepatitis B. All infants, health care workers and people with chronic illnesses are immunised against hepatitis B.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

All donated blood is screened for hepatitis B and C.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are not available. Two cases of hepatitis C were recorded in 2002, both cases of co-infection with HIV. 32 new cases were recorded in 2009 and a further 7 in the first month of 2010, all of which were in intravenous drug users.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include people with HIV/AIDS.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place. All samples taken from the health centres are laboratory screened. Where results are positive a second sample is taken for confirmation. Cases are jointly followed up by the CDC and physician.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Seychelles would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Sierra Leone

Estimated Mortality (2004)	Total
Acute hepatitis B	342.7
Acute hepatitis C	153.97
Liver cancer	700.44
Cirrhosis	318.61
Infectious diseases	48.29*
Non-communicable diseases	27*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	10860
Acute hepatitis C	4880
Liver cancer	9890
Cirrhosis	6200
Infectious diseases	3389*
Non-communicable diseases	734*

1-years olds immunised against hepatitis B (2007): 64%

*thousands

Population (2006):	5,743,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$610
Total health spend as a % of GDP (2006):	3.5%
Per capita total health spend (2006):	$41
Per capita govt health spend (2006):	$20
Life Expectancy (f/m, 2006):	42 / 39
Healthy Life Expectancy (f/m, 2003):	30 / 27
Median Age (2006):	18

The government of Sierra Leone reports as follows:

Policy

The government of Sierra Leone considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

The strategy includes vaccination, blood screening, injection safety and health education.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: To screen 100% of blood for transfusion for hepatitis B; To reduce morbidity and mortality from hepatitis; To administer all injections with disposable materials.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Hepatitis B vaccine is included in the routine EPI. Infants are vaccinated with three dose pentavalent vaccine at 6, 10 and 14 weeks.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening.

Blood is screened for hepatitis B and other diseases before transfusion.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Information was not available on whether liver cancer cases are registered
- Information was not available on whether cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are not available.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place. In most cases patients are diagnosed through screening. Positive cases are educated and managed confidentially. Patients are referred with a case history to a more specialist health facility if the need arises.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. The WHO country office provides technical support and immunisation support from GAVI. This includes a co-funding agreement for vaccines. NGOs are active in health care delivery at various levels and collaborate with the Ministry of Health and Sanitation.

WHO Assistance

The government of Sierra Leone would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance
- Other areas including: blood screening services, the development of policy guidelines and advocacy

Singapore

Population (2006):	4,382,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$43,300
Total health spend as a % of GDP (2006):	3.4%
Per capita total health spend (2006):	$1,228
Per capita govt health spend (2006):	$413
Life Expectancy (f/m, 2006):	83 / 78
Healthy Life Expectancy (f/m, 2003):	71 / 69
Median Age (2006):	38

Estimated Mortality (2004)	Total
Acute hepatitis B	30.25
Acute hepatitis C	0.0
Liver cancer	551.85
Cirrhosis	141.69
Infectious diseases	0.39*
Non-communicable diseases	15*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	470
Acute hepatitis C	0
Liver cancer	4910
Cirrhosis	2100
Infectious diseases	45*
Non-communicable diseases	374*

1-years olds immunised against hepatitis B (2007): 86%

*thousands

The government of Singapore reports as follows:

Policy

The government of Singapore considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

This strategy focuses on hepatitis B vaccination. Other elements of the programme include routine surveillance, routine antenatal screening, screening of voluntary blood donors, healthcare safety measures and public education.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: Achieving control of hepatitis B by 2012 through vaccination (Western Pacific regional goal).

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Military personnel.

Hepatitis B vaccination for infants and young children has been incorporated into the National Childhood Immunisation Programme since 1987. To protect those born before 1987, a 4-year hepatitis B immunisation programme was implemented for adolescents (through educational establishments) in 2001. Full-time national servicemen and non-immune healthcare workers are also offered vaccination.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. These include hepatitis B awareness campaigns conducted by the Health Promotion Board (a statutory board under the Ministry of Health). A leaflet targeted at the general population promotes hepatitis B vaccination, details risk factors and symptoms, provides basic information on hepatitis B and where testing and vaccination can be accessed. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government. This is mainly undertaken by the Health Promotion Board through direct public engagement and through the media.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available. 2008 estimates indicate an incidence of acute hepatitis B of 1.7 per 100,000 population and for acute hepatitis C of 0.2 per 100,000 population.

Disease reporting: Disease reports are published on an annual basis.

Both hepatitis B and hepatitis C are legally notifiable diseases.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is compulsory for some groups. These include all entrants to medical, nursing, dental therapy and dental hygiene schools are tested for hepatitis B (the test is provided free of charge).

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Treatment is part-funded.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO Regional Office for the Western Pacific (WPRO).

WHO Assistance

The government of Singapore would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions

Slovakia

Estimated Mortality (2004)	Total
Acute hepatitis B	9.79
Acute hepatitis C	4.82
Liver cancer	356.58
Cirrhosis	1225.75
Infectious diseases	0.26*
Non-communicable diseases	47*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	130
Acute hepatitis C	60
Liver cancer	3180
Cirrhosis	20820
Infectious diseases	41*
Non-communicable diseases	699*

1-years olds immunised against hepatitis B (2007): 99%

*thousands

Population (2006):	5,388,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$17,060
Total health spend as a % of GDP (2006):	7.0%
Per capita total health spend (2006):	$1,235
Per capita govt health spend (2006):	$913
Life Expectancy (f/m, 2006):	78 / 70
Healthy Life Expectancy (f/m, 2003):	69 / 63
Median Age (2006):	36

The government of Slovakia reports as follows:

Policy

The government of Slovakia does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Persons at high risk.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Information was not available on whether other countries' policies relating to hepatitis B and/or hepatitis C are currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Information was not available on whether chronic hepatitis infections are registered
- Liver cancer cases are not registered
- Information was not available on whether cases of co-infection with HIV are registered

Prevalence estimates: Information was not available on whether prevalence estimates exist.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place. This is included in recommendations and guidelines for the diagnosis and therapy of viral hepatitis A-E.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Treatment for cases of chronic hepatitis B and C are fully covered by the national insurance policy.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of Slovakia would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Other areas (not specified)

Slovenia

Population (2006):	2,001,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$23,970
Total health spend as a % of GDP (2006):	8.4%
Per capita total health spend (2006):	$2,065
Per capita govt health spend (2006):	$1,507
Life Expectancy (f/m, 2006):	82 / 74
Healthy Life Expectancy (f/m, 2003):	72 / 67
Median Age (2006):	41

Estimated Mortality (2004)	Total
Acute hepatitis B	2.21
Acute hepatitis C	0.99
Liver cancer	150.78
Cirrhosis	682.29
Infectious diseases	0.12*
Non-communicable diseases	16*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	40
Acute hepatitis C	20
Liver cancer	1240
Cirrhosis	10220
Infectious diseases	11*
Non-communicable diseases	238*

1-years olds immunised against hepatitis B (2007): -

*thousands

The government of Slovenia reports as follows:

Policy

The government of Slovenia considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Travellers; Military personnel; Persons at high risk (not specified).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

There is national Committee for the Prevention of Hospital Infections , and in every hospital there are specific guidelines on this and a committee to oversee it.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Information was not available on whether cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on a monthly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include for family members and close contacts of people who have hepatitis B, people who have hepatitis C, healthcare workers who have suffered needle-stick injury or similar exposure, IDUs, blood donors.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Drugs are 100% funded through health insurance.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO.

WHO Assistance

The government of Slovenia would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Developing tools to assess the effectiveness of interventions
- Surveillance

Solomon Islands

Estimated Mortality (2004)	Total
Acute hepatitis B	2.28
Acute hepatitis C	1.02
Liver cancer	14.82
Cirrhosis	11.41
Infectious diseases	0.48*
Non-communicable diseases	01*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	90
Acute hepatitis C	40
Liver cancer	250
Cirrhosis	230
Infectious diseases	37*
Non-communicable diseases	46*

1-years olds immunised against hepatitis B (2007): 79%

*thousands

Population (2006):	484,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$1,850
Total health spend as a % of GDP (2006):	4.7%
Per capita total health spend (2006):	$107
Per capita govt health spend (2006):	$99
Life Expectancy (f/m, 2006):	68 / 65
Healthy Life Expectancy (f/m, 2003):	57 / 55
Median Age (2006):	20

The government of Solomon Islands reports as follows:

Policy

The government of Solomon Islands considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

The strategies for hepatitis focus on prevention of hepatitis B through immunisation and blood donor screening.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: 90% DTP-HepB-Hib pentavalent vaccine coverage by 2010; over 90% of infants to receive their first dose of Hepatitis B vaccine within 24 hours of birth; To promote the use of condoms in preventing STIs (including hepatitis B).

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

The EPI Policy (2008) includes the administration of first dose hepatitis B vaccine within 24 hours of birth. It provides delivery guidelines and the vaccination schedule and includes strategies to increase coverage.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

All donated blood is screened for hepatitis B in provincial hospitals and National Referral Hospital. Since 2009 donated blood is also screened for hepatitis C at the National Referral Hospital. This will be introduced to the provinces in 2010.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the GAVI Alliance, which co-financed introduction of hepatitis B vaccine and pentavalent vaccine and the WHO for technical assistance UNICEF for procurement of vaccines and Japan International Cooperation Agency assisted in cold chain.

WHO Assistance

The government of Solomon Islands would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Somalia

Population (2006):	8,445,000
Country Classification (2009):	Low income
Gross National Income per capita (0):	-
Total health spend as a % of GDP (2001):	2.6%
Per capita total health spend (2001):	$18
Per capita govt health spend (2001):	$8
Life Expectancy (f/m, 2006):	56 / 54
Healthy Life Expectancy (f/m, 2003):	38 / 36
Median Age (2006): 1	8

Estimated Mortality (2004)	Total
Acute hepatitis B	480.64
Acute hepatitis C	65.95
Liver cancer	767.57
Cirrhosis	2017.59
Infectious diseases	51.07*
Non-communicable diseases	41*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	14070
Acute hepatitis C	1270
Liver cancer	12040
Cirrhosis	36550
Infectious diseases	3543*
Non-communicable diseases	1180*

1-years olds immunised against hepatitis B (2007): 0%

*thousands

The government of Somalia reports as follows:

Policy

The government of Somalia considers hepatitis B and/or hepatitis C to be an urgent public health issue.

Both hepatitis B and hepatitis C are considered an urgent public health issue in Somalia.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place. The regional target of reduction in the prevalence of chronic hepatitis B virus infection to 1% of children under five years old by 2015 has been endorsed, however.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is not in place.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are not registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available. These indicate a prevalence rate for chronic hepatitis B of up to 10%. Estimates for hepatitis C were not available.

Disease reporting: Disease reports are not currently published.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include blood donors (for whom it is also compulsory).

Compulsory testing: Testing is compulsory for some groups. These include blood donors (for whom it is also free).

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO, the GAVI Alliance and International NGOs.

WHO Assistance

The government of Somalia would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

South Africa

Estimated Mortality (2004)	Total
Acute hepatitis B	234.88
Acute hepatitis C	99.61
Liver cancer	1183.87
Cirrhosis	2125.34
Infectious diseases	369.59*
Non-communicable diseases	242*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	6640
Acute hepatitis C	2780
Liver cancer	15690
Cirrhosis	45130
Infectious diseases	12688*
Non-communicable diseases	5950*

1-years olds immunised against hepatitis B (2007): 97%

*thousands

Population (2006):	48,282,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$8,900
Total health spend as a % of GDP (2006):	8.6%
Per capita total health spend (2006):	$869
Per capita govt health spend (2006):	$364
Life Expectancy (f/m, 2006):	53 / 50
Healthy Life Expectancy (f/m, 2003):	45 / 43
Median Age (2006):	24

The government of South Africa reports as follows:

Policy

The government of South Africa considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Guidelines for the prevention and control of hepatitis B and C were being finalised at the time of study. The draft Guidelines for the Control of Hepatitis B and National Guidelines for the Prevention and Control of Hepatitis C Virus each set out the epidemiological situation, including main transmission routes, in South Africa and the main measures to be used in the prevention and treatment of hepatitis B and C. Areas covered include vaccination, blood and injection safety in healthcare settings and needle exchange facilities for IDUs. Overall treatment approaches including specific guidelines for the treatment of co-infection with HIV/AIDS are also included in both sets of guidelines.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: To reduce the number of new infections through prevention of transmission; To identify cases early in order to minimize the risk of disease progression; To educate all high-risk individuals.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers; Military personnel.

Hepatitis B vaccination is included in the EPI Policy. The military has a separate policy for vaccination of personnel.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

This is addressed in the draft guidelines for the prevention and control of hepatitis B and C (as above) and in national infection control guidelines.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on an annual basis.

Hepatitis B and C are notifiable diseases in South Africa.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. Hepatitis B and C testing is free of charge in the Public Sector.

Compulsory testing: Testing is compulsory for some groups. These include blood donors and healthcare workers.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO County Office.

WHO Assistance

The government of South Africa would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Spain

Population (2006):	43,887,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$28,200
Total health spend as a % of GDP (2006):	8.1%
Per capita total health spend (2006):	$2,388
Per capita govt health spend (2006):	$1,732
Life Expectancy (f/m, 2006):	84 / 78
Healthy Life Expectancy (f/m, 2003):	75 / 70
Median Age (2006):	39

Estimated Mortality (2004)	Total
Acute hepatitis B	164.07
Acute hepatitis C	1002.36
Liver cancer	4611.25
Cirrhosis	5109.25
Infectious diseases	7.78*
Non-communicable diseases	333*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	2110
Acute hepatitis C	9970
Liver cancer	31390
Cirrhosis	63080
Infectious diseases	261*
Non-communicable diseases	4230*

1-years olds immunised against hepatitis B (2007): 96%

*thousands

The government of Spain reports as follows:

Policy

The government of Spain does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

There is a national vaccination strategy for hepatitis B but not a national strategy for hepatitis C, although some autonomous regions have local programmes for this.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Travellers; Military personnel; Persons at high risk (these include those at occupational risk, prison staff, psychiatric inpatients and staff, close contacts of active cases, people who receive routine blood transfusions, people with HIV/AIDS, people with chronic liver disease, IDUs).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. These have been focused hepatitis B prevention. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are not registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Information was not available on whether prevalence estimates exist.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Treatment of hepatitis B and C is covered by the National Health System which has universal coverage and includes 100% of treatment costs for inpatients and retired people and approximately 70% of treatment for outpatients.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Spain would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising

Sri Lanka

Estimated Mortality (2004)	Total
Acute hepatitis B	130.17
Acute hepatitis C	52.65
Liver cancer	180.61
Cirrhosis	4933.04
Infectious diseases	8.56*
Non-communicable diseases	110*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	1610
Acute hepatitis C	660
Liver cancer	2100
Cirrhosis	102510
Infectious diseases	576*
Non-communicable diseases	2377*

1-years olds immunised against hepatitis B (2007): 98%

*thousands

Population (2006):	19,207,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$3,730
Total health spend as a % of GDP (2006):	4.2%
Per capita total health spend (2006):	$213
Per capita govt health spend (2006):	$105
Life Expectancy (f/m, 2006):	76 / 69
Healthy Life Expectancy (f/m, 2003):	64 / 59
Median Age (2006):	30

The government of Sri Lanka reports as follows:

Policy

The government of Sri Lanka does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: Universal infant immunization against hepatitis B; Screening of all blood and blood products for hepatitis B and hepatitis C.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers.

Some military personnel are also vaccinated, particularly where they are involved in work overseas.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Auto-disable syringes are used for all immunisations carried out under the EPI. Safety boxes are used for disposal.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. An island-wide awareness campaign was conducted between 2002 and 2005 as a part of the introduction of hepatitis B vaccine and injection safety into the EPI. This included training programmes, handbooks, posters, and leaflets. Subsequent awareness campaigns have targeted primary healthcare workers (medical and paramedical), healthcare workers in hospital settings (especially nurses through Infection Control Nurses in hospitals) and at the general public (through mass media). Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions do not currently exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available. Epidemiological studies indicate that the incidence of hepatitis B and C is very low in Sri Lanka.

Disease reporting: Disease reports are published on a weekly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups. All healthcare is provided free of charge to all citizens.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. All healthcare is provided free of charge to all citizens.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the GAVI Alliance in the introduction of hepatitis B vaccine and injection safety and the WHO.

WHO Assistance

The government of Sri Lanka would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Sudan

Population (2006):	37,707,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$1,780
Total health spend as a % of GDP (2006):	3.8%
Per capita total health spend (2006):	$61
Per capita govt health spend (2006):	$23
Life Expectancy (f/m, 2006):	61 / 59
Healthy Life Expectancy (f/m, 2003):	50 / 47
Median Age (2006):	20

Estimated Mortality (2004)	Total
Acute hepatitis B	717.54
Acute hepatitis C	256.4
Liver cancer	1444.31
Cirrhosis	8701.36
Infectious diseases	117.86*
Non-communicable diseases	169*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	11930
Acute hepatitis C	2940
Liver cancer	19270
Cirrhosis	120700
Infectious diseases	0*
Non-communicable diseases	3977*

1-years olds immunised against hepatitis B (2007): 78%

*thousands

The government of Sudan reports as follows. This information is applicable to North Sudan only:

Policy

The government of Sudan considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Strategies focus on vaccination, surveillance, blood safety and infection control and on surveillance. The Ministry of Health Guide to Tackling Viral Hepatitis sets out the measures to be taken to combat hepatitis A-E.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers.

The North Sudan EPI Plan 2010 includes components on advocacy, increasing access, service evaluation, multisectoral collaboration and provides delivery guidelines and the immunisation schedule. Under the policy all infants are to be vaccinated with DTP-HepB-Hib pentavalent vaccine at 6, 10 and 14 weeks using Auto-Disable syringes (both introduced in 2008).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on an annual basis.

Acute hepatitis is a notifiable disease in Sudan.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include dialysis patients.

Compulsory testing: Testing is compulsory for some groups. These include foreign nationals applying for citizenship.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO, the GAVI Alliance, and NGOs. These provide support for routine vaccination.

WHO Assistance

The government of Sudan would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance
- Other areas including: Assistance with research into the epidemiology of viral hepatitis in Sudan

In South Sudan there is a vaccination policy and hepatitis B is included as part of routine vaccination. However, the vaccine has not yet been introduced due to a lack of funding for vaccine supply. The programme aims to obtain funding for the introduction of the vaccine into routine vaccination as well as for vaccination of healthcare workers. Donated blood is routinely screened for hepatitis B and HIV in blood banks and hospitals. The additional area proposed, studies on viral hepatitis epidemiology, is also among the priorities for Southern Sudan.

Suriname

Estimated Mortality (2004)	Total
Acute hepatitis B	0.5
Acute hepatitis C	0.0
Liver cancer	31.11
Cirrhosis	58.59
Infectious diseases	0.36*
Non-communicable diseases	02*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	10
Acute hepatitis C	
Liver cancer	300
Cirrhosis	920
Infectious diseases	23*
Non-communicable diseases	59*

1-years olds immunised against hepatitis B (2007): 84%

*thousands

Population (2006):	455,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$7,720
Total health spend as a % of GDP (2006):	7.4%
Per capita total health spend (2006):	$361
Per capita govt health spend (2006):	$151
Life Expectancy (f/m, 2006):	71 / 65
Healthy Life Expectancy (f/m, 2003):	61 / 57
Median Age (2006):	26

The government of Suriname reports as follows:

Policy

The government of Suriname considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

This strategy focuses on prevention of hepatitis B through vaccination. Wider work has not yet been developed.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers; Travellers; Military personnel; Persons at high risk (close contacts of hepatitis B positive people).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Information was not available on whether other countries' policies relating to hepatitis B and/or hepatitis C are currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis*
- Surveillance exists for chronic hepatitis*
- Chronic hepatitis infections are registered*
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

* in hospital settings only.

Prevalence estimates: Information was not available on whether prevalence estimates exist.

Disease reporting: Disease reports are published on a monthly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens. Testing is accessible to those with medical insurance, which covers approximately 85% of the population.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. This is funded through medical insurance. Not all treatment is covered, however.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of Suriname would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Swaziland

Population (2006):	1,134,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$4,700
Total health spend as a % of GDP (2006):	5.9%
Per capita total health spend (2006):	$353
Per capita govt health spend (2006):	$219
Life Expectancy (f/m, 2006):	43 / 41
Healthy Life Expectancy (f/m, 2003):	35 / 33
Median Age (2006):	19

Estimated Mortality (2004)	Total
Acute hepatitis B	6.63
Acute hepatitis C	2.98
Liver cancer	68.73
Cirrhosis	29.88
Infectious diseases	10.75*
Non-communicable diseases	03*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	210
Acute hepatitis C	90
Liver cancer	820
Cirrhosis	670
Infectious diseases	422*
Non-communicable diseases	104*

1-years olds immunised against hepatitis B (2007): 95%

*thousands

The government of Swaziland reports as follows:

Policy

The government of Swaziland considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions do not currently exist
- Information was not available on whether clinical cases require laboratory confirmation prior to reporting
- Information was not available on whether surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are not registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are not available.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is compulsory for some groups. These include blood donors.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of Swaziland would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Switzerland

Estimated Mortality (2004)	Total
Acute hepatitis B	7.0
Acute hepatitis C	13.0
Liver cancer	577.0
Cirrhosis	648.0
Infectious diseases	0.66*
Non-communicable diseases	55*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	100
Acute hepatitis C	200
Liver cancer	4160
Cirrhosis	8830
Infectious diseases	35*
Non-communicable diseases	696*

1-years olds immunised against hepatitis B (2007): -

*thousands

Population (2006):	7,455,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$40,840
Total health spend as a % of GDP (2006):	11.3%
Per capita total health spend (2006):	$4,312
Per capita govt health spend (2006):	$2,598
Life Expectancy (f/m, 2006):	84 / 79
Healthy Life Expectancy (f/m, 2003):	75 / 71
Median Age (2006):	40

The government of Switzerland reports as follows:

Policy

The government of Switzerland does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

At the time of study a new HIV & STI programme was under development which will include viral hepatitis.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Travellers; Persons at high risk (not specified).

There is a universal hepatitis B vaccination programme. Several government directives detail additional target groups for hepatitis B vaccination and the prevention of mother to child transmission. Universal and risk group hepatitis B vaccination is reimbursed by health insurance.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. Hepatitis awareness campaigns have been targeted at IDUs, mainly around hepatitis C. These have been delivered in collaboration with civil society organisations and have included training and educational materials for professionals in the field of drug abuse and for drug users, including a DVD. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available. These indicate approximately 20,000 people are chronically infected with hepatitis B (0.3%) and approximately 70,000 chronically infected with hepatitis C (0.7-1%).

Disease reporting: Disease reports are published on a weekly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO Europe regional office, SEVHEP and Infodrog.

WHO Assistance

No areas for assistance were identified.

Tajikistan

Population (2006):	6,640,000
Country Classification (2009)	Low income
Gross National Income per capita (2006):	$1,560
Total health spend as a % of GDP (2006):	5.0%
Per capita total health spend (2006):	$71
Per capita govt health spend (2006):	$16
Life Expectancy (f/m, 2006):	66 / 63
Healthy Life Expectancy (f/m, 2003):	56 / 53
Median Age (2006):	20

Estimated Mortality (2004)	Total
Acute hepatitis B	314.0
Acute hepatitis C	288.92
Liver cancer	83.46
Cirrhosis	1120.66
Infectious diseases	10.08*
Non-communicable diseases	26*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	10460
Acute hepatitis C	9850
Liver cancer	890
Cirrhosis	17500
Infectious diseases	921*
Non-communicable diseases	616*

1-years olds immunised against hepatitis B (2007): 84%

The government of Tajikistan reports as follows:

Policy

The government of Tajikistan considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

This is led by the National Program on the Prevention of Hepatitis.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has, however, been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include people living with HIV/AIDS.

Compulsory testing: Testing is compulsory for some groups. These include healthcare workers.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the GAVI Alliance and UNICEF for infant hepatitis B immunisation.

WHO Assistance

The government of Tajikistan would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance
- Other areas including: Assistance in ensuring the sustainability of projects and interventions

Thailand

Estimated Mortality (2004)	Total
Acute hepatitis B	867.77
Acute hepatitis C	9.07
Liver cancer	19354.61
Cirrhosis	9465.67
Infectious diseases	111.11*
Non-communicable diseases	307*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	13650
Acute hepatitis C	140
Liver cancer	212090
Cirrhosis	164860
Infectious diseases	3799*
Non-communicable diseases	7472*

1-years olds immunised against hepatitis B (2007): 96%

Population (2006):	63,444,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$7,440
Total health spend as a % of GDP (2006):	3.5%
Per capita total health spend (2006):	$346
Per capita govt health spend (2006):	$223
Life Expectancy (f/m, 2006):	75 / 69
Healthy Life Expectancy (f/m, 2003):	62 / 58
Median Age (2006):	33

The government of Thailand reports as follows:

Policy

The government of Thailand considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include pregnant women and any test requested by a hospital physician.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of Thailand would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Increasing access to treatment

The former Yugoslav Republic of Macedonia

Population (2006):	2,036,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$7,850
Total health spend as a % of GDP (2006):	8.2%
Per capita total health spend (2006):	$623
Per capita govt health spend (2006):	$446
Life Expectancy (f/m, 2006):	76 / 71
Healthy Life Expectancy (f/m, 2003):	65 / 62
Median Age (2006):	35

Estimated Mortality (2004)	Total
Acute hepatitis B	4.05
Acute hepatitis C	3.43
Liver cancer	256.52
Cirrhosis	156.95
Infectious diseases	0.19*
Non-communicable diseases	18*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	120
Acute hepatitis C	110
Liver cancer	2680
Cirrhosis	2530
Infectious diseases	19*
Non-communicable diseases	270*

1-years olds immunised against hepatitis B (2007): 96%

*thousands

The government of The former Yugoslav Republic of Macedonia reports as follows:

Policy

The government of The former Yugoslav Republic of Macedonia considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Related work focuses on the prevention of hepatitis B through vaccination and of hepatitis C through screening and preventative health.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Persons at high risk (haemodialysis patients, close contacts of hepatitis B positive people, people with haemophilia, psychiatric patients).

Vaccination for hepatitis B was introduced into the national vaccination programme in 2004.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. These have targeted parents to encourage uptake of the hepatitis B vaccination through the use of posters, brochures and mass media. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups (not specified).

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO regional office for Europe and NGO Hepta for hepatitis B and C.

WHO Assistance

The government of The former Yugoslav Republic of Macedonia would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions

Timor-Leste

Estimated Mortality (2004)	Total
Acute hepatitis B	26.96
Acute hepatitis C	3.16
Liver cancer	37.33
Cirrhosis	75.17
Infectious diseases	2.73*
Non-communicable diseases	03*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	700
Acute hepatitis C	40
Liver cancer	460
Cirrhosis	1690
Infectious diseases	165*
Non-communicable diseases	95*

1-years olds immunised against hepatitis B (2007): 0%

Population (2006):	1,114,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$5,100
Total health spend as a % of GDP (2006):	16.4%
Per capita total health spend (2006):	$169
Per capita govt health spend (2006):	$150
Life Expectancy (f/m, 2006):	69 / 64
Healthy Life Expectancy (f/m, 2003):	52 / 48
Median Age (2006):	17

The government of Timor-Leste reports as follows:

Policy

The government of Timor-Leste does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Healthcare workers.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Information was not available on whether other countries' policies relating to hepatitis B and/or hepatitis C are currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has, however, been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Timor-Leste would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions

Togo

Population (2006):	6,410,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$770
Total health spend as a % of GDP (2006):	5.5%
Per capita total health spend (2006):	$70
Per capita govt health spend (2006):	$20
Life Expectancy (f/m, 2006):	60 / 55
Healthy Life Expectancy (f/m, 2003):	46 / 44
Median Age (2006):	18

Estimated Mortality (2004)	Total
Acute hepatitis B	24.85
Acute hepatitis C	11.17
Liver cancer	510.27
Cirrhosis	213.67
Infectious diseases	31.05*
Non-communicable diseases	22*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	600
Acute hepatitis C	270
Liver cancer	6530
Cirrhosis	3880
Infectious diseases	1730*
Non-communicable diseases	629*

1-years olds immunised against hepatitis B (2007): -

*thousands

The government of Togo reports as follows:

Policy

The government of Togo considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Information was not available on whether prevalence estimates exist.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of Togo would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Tonga

Estimated Mortality (2004)	Total
Acute hepatitis B	0.27
Acute hepatitis C	0.12
Liver cancer	6.56
Cirrhosis	3.49
Infectious diseases	0.09*
Non-communicable diseases	- *
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	10
Acute hepatitis C	0
Liver cancer	60
Cirrhosis	70
Infectious diseases	04*
Non-communicable diseases	10*

1-years olds immunised against hepatitis B (2007): 99%

*thousands

Population (2006):	100,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$5,470
Total health spend as a % of GDP (2006):	5.4%
Per capita total health spend (2006):	$289
Per capita govt health spend (2006):	$218
Life Expectancy (f/m, 2006):	69 / 73
Healthy Life Expectancy (f/m, 2003):	62 / 62
Median Age (2006):	21

The government of Tonga reports as follows:

Policy

The government of Tonga considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: To maintain high coverage of hepatitis B immunisation (95–99%).

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Travellers; Military personnel; Persons at high risk (not specified).

These are covered as part of the national immunisation policy and the national reproductive health policy.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. These have included mass-media campaigns on radio and television to raise awareness among the general public and workshops to target specific audiences such as seafarers, adolescents and uniformed services personnel (soldiers, police). Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Information was not available on whether clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Information was not available on whether prevalence estimates exist.

Disease reporting: Disease reports are published on a monthly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Treatment in Tonga is still free of charge for all unless accessed through a private doctor.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO and local NGOs.

WHO Assistance

The government of Tonga would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Trinidad and Tobago

Population (2006):	1,328,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$16,800
Total health spend as a % of GDP (2006):	4.2%
Per capita total health spend (2006):	$811
Per capita govt health spend (2006):	$438
Life Expectancy (f/m, 2006):	72 / 66
Healthy Life Expectancy (f/m, 2003):	64 / 60
Median Age (2006):	29

Estimated Mortality (2004)	Total
Acute hepatitis B	4.63
Acute hepatitis C	-
Liver cancer	41.19
Cirrhosis	85.27
Infectious diseases	0.99*
Non-communicable diseases	08*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	50
Acute hepatitis C	-
Liver cancer	400
Cirrhosis	1740
Infectious diseases	48*
Non-communicable diseases	182*

1-years olds immunised against hepatitis B (2007): 89%

*thousands

The government of Trinidad and Tobago reports as follows:

Policy

The government of Trinidad and Tobago considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers; Persons at high risk (not specified).

Hepatitis B vaccination is included in the vaccination schedule in the EPI programme and is one of the compulsory vaccines for school admission.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. These have included EPI health promotion campaigns. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are registered

Prevalence estimates: Prevalence estimates for the country are not available.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. All treatment including for hepatitis is free of charge to all citizens of Trinidad and Tobago.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include PAHO (WHO) in the EPI programme.

WHO Assistance

The government of Trinidad and Tobago would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Turkey

Estimated Mortality (2004)	Total
Acute hepatitis B	1006.0
Acute hepatitis C	-
Liver cancer	1284.0
Cirrhosis	3164.0
Infectious diseases	18.78*
Non-communicable diseases	335*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	20590
Acute hepatitis C	-
Liver cancer	15270
Cirrhosis	51790
Infectious diseases	2135*
Non-communicable diseases	7807*

1-years olds immunised against hepatitis B (2007): 96%

*thousands

Population (2006):	73,922,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$8,410
Total health spend as a % of GDP (2006):	5.6%
Per capita total health spend (2006):	$645
Per capita govt health spend (2006):	$461
Life Expectancy (f/m, 2006):	75 / 71
Healthy Life Expectancy (f/m, 2003):	63 / 61
Median Age (2006):	27

The government of Turkey reports as follows:

Policy

The government of Turkey does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

Hepatitis B and C are not public health urgent issues but are of high public health priorities. Since the introduction of hepatitis B vaccination previous high rates have been reduced.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: To reduce the incidence of hepatitis B to less than 1/100,000 among the population under 5 years of age.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Military personnel; Persons at high risk (not specified).

Hepatitis B vaccine was introduced in 1998 in response to high prevalence rates in the country. Supplementary immunisation activities are now being carried out targeted at risk groups as well as a catch-up programme for adolescents.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. Since 2007 awareness campaigns have been held for risk groups and the general public. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance does not exist for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on an annual basis.

Both hepatitis B and C are notifiable diseases in Turkey.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include blood donors.

Compulsory testing: Testing is compulsory for some groups. These include sex workers, blood donors and pre-operative patients.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Treatments for hepatitis B and C are covered by social insurance. This includes antivirals, immunosupressors, interferon, Intravenous immunoglobulin, monoclonal antibody treatment and organ transplantation.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Turkey would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Developing tools to assess the effectiveness of interventions

Turkmenistan

Population (2006):	4,899,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2005):	$3,990
Total health spend as a % of GDP (2006):	4.8%
Per capita total health spend (2006):	$259
Per capita govt health spend (2006):	$172
Life Expectancy (f/m, 2006):	67 / 60
Healthy Life Expectancy (f/m, 2003):	57 / 52
Median Age (2006):	24

Estimated Mortality (2004)	Total
Acute hepatitis B	122.44
Acute hepatitis C	63.08
Liver cancer	96.63
Cirrhosis	1370.81
Infectious diseases	4.29*
Non-communicable diseases	31*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	3430
Acute hepatitis C	1770
Liver cancer	1170
Cirrhosis	26430
Infectious diseases	480*
Non-communicable diseases	643*

1-years olds immunised against hepatitis B (2007): 98%

*thousands

The government of Turkmenistan reports as follows:

Policy

The government of Turkmenistan considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions do not currently exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published, frequency not specified.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is compulsory for some groups. These include healthcare workers at high risk.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of Turkmenistan would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Tuvalu

Estimated Mortality (2004)	Total
Acute hepatitis B	0.05
Acute hepatitis C	0.02
Liver cancer	1.01
Cirrhosis	0.62
Infectious diseases	0.02*
Non-communicable diseases	- *
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	-
Acute hepatitis C	-
Liver cancer	10
Cirrhosis	10
Infectious diseases	01*
Non-communicable diseases	02*

1-years olds immunised against hepatitis B (2007): 97%

*thousands

Population (2006):	10,000
Country Classification (2009):	n/a
Gross National Income per capita (0):	-
Total health spend as a % of GDP (2006):	11.4%
Per capita total health spend (2006):	$205
Per capita govt health spend (2006):	$189
Life Expectancy (f/m, 2006):	65 / 64
Healthy Life Expectancy (f/m, 2003):	53 / 53
Median Age ():	-

The government of Tuvalu reports as follows:

Policy

The government of Tuvalu considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: To reduce the rates of hepatitis B and hepatitis C by 50%.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers.

Hepatitis B immunisation is carried out as part of the EPI. All infants born to sero positive mothers are vaccinated. Healthcare workers are also vaccinated although this programme requires some strengthening.

Healthcare settings: Information was not available on whether there is a specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has, however, been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Prevalence estimates: Information was not available on whether prevalence estimates exist. However, unofficial data provided indicate a hepatitis B prevalence rate of 13.4% among seafarers and of 9.8% among pregnant mothers.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO and UNICEF in the immunisation programme. It is hoped that further assistance from partners in prevention and control programmes will be agreed in the future.

WHO Assistance

The government of Tuvalu would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Uganda

Population (2006):	29,899,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$880
Total health spend as a % of GDP (2006):	7.2%
Per capita total health spend (2006):	$143
Per capita govt health spend (2006):	$39
Life Expectancy (f/m, 2006):	51 / 49
Healthy Life Expectancy (f/m, 2003):	44 / 42
Median Age (2006):	15

Estimated Mortality (2004)	Total
Acute hepatitis B	231.94
Acute hepatitis C	104.21
Liver cancer	743.78
Cirrhosis	790.49
Infectious diseases	199.6*
Non-communicable diseases	81*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	7560
Acute hepatitis C	3400
Liver cancer	9820
Cirrhosis	18640
Infectious diseases	10210*
Non-communicable diseases	2470*

1-years olds immunised against hepatitis B (2007): 68%

*thousands

The government of Uganda reports as follows:

Policy

The government of Uganda considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; information was not available on whether they work exclusively on the hepatitis strategy.

This strategy is focused on the prevention of hepatitis B through vaccination.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Hepatitis B vaccination is part of the national EPI. Infants are vaccinated with DTP-HepB-Hib pentavalent vaccine. Vaccination of healthcare workers is planned for 2010/2011.

Healthcare settings: Information was not available on whether there is a specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings.

Policy development: Information was not available on whether other countries' policies relating to hepatitis B and/or hepatitis C are currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. These include an intervention targeted at healthcare workers, working with a civil society organisation (AFNET). Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Treatment in public government health facilities is provided free of charge.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO, UNICEF and AFENET.

WHO Assistance

The government of Uganda would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Ukraine

Estimated Mortality (2004)	Total
Acute hepatitis B	532.19
Acute hepatitis C	183.28
Liver cancer	2614.76
Cirrhosis	19187.6
Infectious diseases	23.27*
Non-communicable diseases	660*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	13290
Acute hepatitis C	4600
Liver cancer	25580
Cirrhosis	374540
Infectious diseases	1019*
Non-communicable diseases	8475*

1-years olds immunised against hepatitis B (2007): 96%

*thousands

Population (2006):	46,557,000
Country Classification (2009):	Lower middle income
Gross National Income per capita (2006):	$6,110
Total health spend as a % of GDP (2006):	7.0%
Per capita total health spend (2006):	$542
Per capita govt health spend (2006):	$298
Life Expectancy (f/m, 2006):	73 / 61
Healthy Life Expectancy (f/m, 2003):	64 / 55
Median Age (2006):	39

The government of Ukraine reports as follows:

Policy

The government of Ukraine considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is not in place.

An All-State Program for parenteral hepatitis control has been developed and is awaiting approval by the Cabinet of Ministers.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is not in place.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are not registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available. These indicate that hepatitis C infection ispresent in approximately 3% of the adult population, or 1,132,710 people and 377,570 of these require antiviral therapy. Prevalence estimated for hepatitis B were not available, and it is likely that all estimates have limitations.

Disease reporting: Disease reports are not currently published.

The system for infectious diseases registration (including chronic hepatitis B and C) was substantially revised in June 2009 and improved data are expected to be available from 2010.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially. Anonymous testing is provided by commercial laboratories and must be paid for by the patient.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. Testing is part-funded by the government from local budgets for people living with HIV/AIDS and is also free of charge through screening programmes to blood donors and pregnant women (for whom it is also compulsory). Free testing may be provided to healthcare workers at the discretion of local healthcare administrations.

Compulsory testing: Testing is compulsory for some groups. These include blood donors and pregnant women (for whom it is also free of charge).

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Free treatment for hepatitis C is provided to some citizens through regional hepatitis programmes, which exist in 10 regions. Pegylated interferon and ribavirin became available in 20 regions of Ukraine for HIV/HCV co-infected patients' treatment in 2008-2009.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the WHO, the International HIV/AIDS Alliance, the All-Ukrainian Network of People Living with HIV, Foundation "Renaissance" and local NGOs.

WHO Assistance

The government of Ukraine would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

United Kingdom (England)

(All UK data)	
Population (2006):	60,512,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$33,650
Total health spend as a % of GDP (2006):	8.4%
Per capita total health spend (2006):	$2,784
Per capita govt health spend (2006):	$2,434
Life Expectancy (f/m, 2006):	81 / 77
Healthy Life Expectancy (f/m, 2003):	72 / 69
Median Age (2006):	39

Estimated Mortality (all UK, 2004)	Total
Acute hepatitis B	71.61
Acute hepatitis C	150.2
Liver cancer	2825.83
Cirrhosis	7200.73
Infectious diseases	6.42*
Non-communicable diseases	529*
Estimated Morbidity (all UK, DALYs, 2004)	
Acute hepatitis B	1010
Acute hepatitis C	2400
Liver cancer	20550
Cirrhosis	123920
Infectious diseases	-
Non-communicable diseases	6889*

1-years olds immunised against hepatitis B (2007): -

*thousands

The government of United Kingdom (England) reports as follows:

Policy

The government of England considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

The Hepatitis C Action Plan for England (2004) sets out the main priorities for prevention and control of hepatitis C. Components include access, advocacy and awareness, prevention, testing, surveillance, treatment and multisectoral collaboration. Additional strategies for harm reduction among IDUs and in sexual health policy are in place. A liver disease strategy, currently in development, will also address viral hepatitis.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. For hepatitis C these include: improving surveillance and research; increasing awareness among health professionals, the public and risk groups; promoting accessible testing; providing high-quality, coordinated, accessible services for assessment and treatment; intensifying prevention, reducing transmission in risk populations, particularly IDUs. For hepatitis B: increasing vaccine uptake for MSM accessing GUM clinics.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Healthcare workers; Travellers; Persons at high risk (including close contacts of active cases, IDUs, prisoners, MSM, people with HIV).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Several strategies for prevention of communicable disease infections in healthcare settings exist. Specific directives exist on management of actual and potential occupational exposure and on safe working practices for healthcare workers with hepatitis B and C.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government. These include a national hepatitis C information campaign for healthcare professionals, the public, former IDUs and South Asian populations. This has provided information to family doctors, online resources for the public, and a free and confidential phone line. Mass media (press, radio, TV) have been used. Laboratory diagnoses increased by approximately 50% from 2003 to 2008.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are not registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered*

*Sentinel surveillance of acute hepatitis C in HIV positive MSM is carried out.

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on a weekly basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially. Testing is free and confidential, as is all healthcare for all UK residents.

Cost: Testing is available free of charge to all citizens. Anonymous testing is available in GUM clinics.

Compulsory testing: Testing is compulsory for some groups. Screening is recommended for healthcare workers and some students; those who are not willing to be tested cannot perform exposure-prone procedures.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place. These are developed locally with national guidance.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. The Government funds 100% of drug costs for hepatitis B and C for UK residents.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include a range of patient and civil society organisations, medical bodies and government departments and advisory bodies.

WHO Assistance

No areas for WHO assistance were identified

United Kingdom (Northern Ireland)

Estimated Mortality (all UK, 2004)	Total
Acute hepatitis B	71.61
Acute hepatitis C	150.2
Liver cancer	2825.83
Cirrhosis	7200.73
Infectious diseases	6.42*
Non-communicable diseases	529*
Estimated Morbidity (all UK, DALYs, 2004)	
Acute hepatitis B	1010
Acute hepatitis C	2400
Liver cancer	20550
Cirrhosis	123920
Infectious diseases	-
Non-communicable diseases	6889*

1-years olds immunised against hepatitis B (2007): -

*thousands

(All UK data)	
Population (2006):	60,512,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$33,650
Total health spend as a % of GDP (2006):	8.4%
Per capita total health spend (2006):	$2,784
Per capita govt health spend (2006):	$2,434
Life Expectancy (f/m, 2006):	81 / 77
Healthy Life Expectancy (f/m, 2003):	72 / 69
Median Age (2006):	39

The government of Northern Ireland reports as follows:

Policy

The government of Northern Ireland does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally.

The Action Plan for the Management and Control of Hepatitis C in Northern Ireland (2007) focuses on prevention of infection and on successful treatment of those already infected. Components include advocacy and awareness, prevention, increasing access, screening, testing, surveillance, service evaluation, treatment and multisectoral collaboration.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. The Action Plan includes a number of actions listed across 14 areas for focus, and specific targets are contained within each of these.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Healthcare workers; Persons at high risk (these include people at occupational risk, babies born to infected mothers).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Details of the groups covered by this strategy were not available to this study.

Guidance materials on Health clearance for Tuberculosis (TB), Hepatitis B, Hepatitis C and HIV for healthcare workers with direct clinical contact with patients have been developed. Draft guidance for management of Hepatitis C infected healthcare workers was under development at the time of study.

Policy development: Information was not available on whether other countries' policies relating to hepatitis B and/or hepatitis C are currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. No information was available on the central features of the national monitoring system as it relates to viral hepatitis.

Prevalence estimates: Information was not available on whether prevalence estimates exist.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is not compulsory for any groups.

Hepatitis B in a notifiable disease in Northern Ireland.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of Northern Ireland would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions

United Kingdom (Scotland)

(All UK data)	
Population (2006):	60,512,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$33,650
Total health spend as a % of GDP (2006):	8.4%
Per capita total health spend (2006):	$2,784
Per capita govt health spend (2006):	$2,434
Life Expectancy (f/m, 2006):	81 / 77
Healthy Life Expectancy (f/m, 2003):	72 / 69
Median Age (2006):	39

Estimated Mortality (all UK, 2004)	Total
Acute hepatitis B	71.61
Acute hepatitis C	150.2
Liver cancer	2825.83
Cirrhosis	7200.73
Infectious diseases	6.42*
Non-communicable diseases	529*
Estimated Morbidity (all UK, DALYs, 2004)	
Acute hepatitis B	1010
Acute hepatitis C	2400
Liver cancer	20550
Cirrhosis	123920
Infectious diseases	-
Non-communicable diseases	6889*

1-years olds immunised against hepatitis B (2007): -

*thousands

The government of Scotland reports as follows:

Policy

The government of Scotland considers hepatitis B and/or hepatitis C to be an urgent public health issue.

Hepatitis C, in particular, is considered an urgent public health issue. Current Hepatitis B prevalence is low, however, there is awareness that epidemiology may change and more evidence will be gathered on this in future.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

The government has so far published two phases of its hepatitis C Action Plan. The first focused on raising awareness and generating data. The Action Plan Phase 2 (2008-2011), developed from the findings of the first, is supported by over £40m funding. Components include advocacy and awareness, prevention, increasing access, screening, testing, surveillance, service evaluation, treatment and multisectoral collaboration. There is a particular focus on engaging the prison population and current and former IDUs, identified as the highest risk groups.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. A number of goals and specific targets are included in the Action Plan under four themes: Testing, treatment, care and support; Prevention; Information generating; and Coordination activities. These include specific targets, for example for the number of people receiving treatment. The aim is to increase treatment sufficiently to flatten the mortality curve.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Healthcare workers; Persons at high risk (including close contacts of active cases, IDUs, prisoners, MSM, people with HIV).

The Hepatitis B vaccination programme in Scotland is similar to that in operation in the rest of the UK.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Vaccination of healthcare workers. Information was not available on safe injecting or blood screening policies.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have taken place in the past five years. Specific actions on awareness raising have been included in both Phase 1 and Phase 2 Action Plans. These targeted healthcare workers during the first phase of the action plan, while the second phase covers both public and professional activity and will utilise posters, leaflets, PR activity, online activity and direct marketing (to professionals). Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has also been taken by the government. The action plan and communications around it recognise that stigma is an issue, and that stigmatisation should be addressed. The plan seeks to put in place infrastructure to 'normalise' hepatitis C as far as possible in line with other chronic conditions.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. No information was available on the central features of the national monitoring system as it relates to viral hepatitis.

Prevalence estimates: Information was not available on whether prevalence estimates exist.

Disease reporting: No information on the existence or frequency of disease reporting was available to this study.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is compulsory for some groups. These include some healthcare workers, depending on the nature of their work.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place. These exist for hepatitis C and are developed locally.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. All medical treatment is free to all residents.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include a range of voluntary sector organisations, including the Hepatitis C Trust, Mainliners, and the Scottish Drugs Forum.

WHO Assistance

No areas for assistance were identified.

United Kingdom (Wales)

Estimated Mortality (all UK, 2004)	Total
Acute hepatitis B	71.61
Acute hepatitis C	150.2
Liver cancer	2825.83
Cirrhosis	7200.73
Infectious diseases	6.42*
Non-communicable diseases	529*
Estimated Morbidity (all UK, DALYs, 2004)	
Acute hepatitis B	1010
Acute hepatitis C	2400
Liver cancer	20550
Cirrhosis	123920
Infectious diseases	-
Non-communicable diseases	6889*

1-years olds immunised against hepatitis B (2007): -

*thousands

(All UK data)	
Population (2006):	60,512,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$33,650
Total health spend as a % of GDP (2006):	8.4%
Per capita total health spend (2006):	$2,784
Per capita govt health spend (2006):	$2,434
Life Expectancy (f/m, 2006):	81 / 77
Healthy Life Expectancy (f/m, 2003):	72 / 69
Median Age (2006):	39

The government of Wales reports as follows:

Policy

The government of Wales considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

The Minister for Health and Social Services has approved the Blood Borne Viral Hepatitis Action Plan for Wales 2010 -2014 and resources have been allocated for its implementation.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These are defined in the Action Plan and in the Wales Harm Reduction Strategy.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Healthcare workers; Persons at high risk (including close contacts of active cases, IDUs, prisoners, MSM, people with HIV).

The Hepatitis B vaccination programme in Wales is that in operation in the rest of the UK (see England).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is available free of charge to all citizens.

Compulsory testing: Testing is compulsory for some groups. These include some healthcare workers.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Treatment is free at the point of access for all.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the National Liver Trust, Hepatitis C trust.

WHO Assistance

The government of Wales would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Developing tools to assess the effectiveness of interventions

United Republic of Tanzania

Population (2006):	39,459,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$980
Total health spend as a % of GDP (2006):	5.5%
Per capita total health spend (2006):	$45
Per capita govt health spend (2006):	$27
Life Expectancy (f/m, 2006):	51 / 50
Healthy Life Expectancy (f/m, 2003):	41 / 40
Median Age (2006):	18

Estimated Mortality (2004)	Total
Acute hepatitis B	550.86
Acute hepatitis C	247.49
Liver cancer	1046.33
Cirrhosis	1354.35
Infectious diseases	247.46*
Non-communicable diseases	136*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	15750
Acute hepatitis C	7080
Liver cancer	13600
Cirrhosis	29580
Infectious diseases	12907*
Non-communicable diseases	3854*

1-years olds immunised against hepatitis B (2007): 83%

*thousands

The government of the United Republic of Tanzania reports as follows:

Policy

The government of the United Republic of Tanzania considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place.

The strategy focuses on prevention of hepatitis B through vaccination and blood screening. No clear strategies for hepatitis C have yet been formulated.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These include: To vaccinate over 90% of infants with the third dose of hepatitis B vaccine; to reduce infection through blood transfusion.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

This is carried out under the infant immunisation policy which is part of the national health policy.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions do not currently exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are not registered
- Information was not available on whether liver cancer cases are registered
- Information was not available on whether cases of co-infection with HIV are registered

Prevalence estimates: Information was not available on whether prevalence estimates exist.

Disease reporting: Disease reports are not currently published.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially. Testing is accessible in urban areas but rarely in rural parts of the country.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. National policy provides free health services to children under five years old, pregnant women and the elderly. Other patients are subsidized through a cost sharing regime, and in an advanced stage of infection (for example if chronically ill or diagnosed with hepatocellular carcinoma) patients are treated free of charge.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the GAVI Alliance and the WHO, both in infant vaccination.

WHO Assistance

The government of the United Republic of Tanzania would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Delivery of vaccination
- Developing tools to assess the effectiveness of interventions
- Surveillance

United States of America

Estimated Mortality (2004)	Total
Acute hepatitis B	753.31
Acute hepatitis C	4651.16
Liver cancer	15804.97
Cirrhosis	27509.1
Infectious diseases	68.13*
Non-communicable diseases	2144*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	11550
Acute hepatitis C	72900
Liver cancer	137810
Cirrhosis	423770
Infectious diseases	2527*
Non-communicable diseases	34650*

1-years olds immunised against hepatitis B (2007): 92%

*thousands

Population (2006):	302,841,000
Country Classification (2009):	High income
Gross National Income per capita (2006):	$44,070
Total health spend as a % of GDP (2006):	15.3%
Per capita total health spend (2006):	$6,714
Per capita govt health spend (2006):	$3,074
Life Expectancy (f/m, 2006):	80 / 75
Healthy Life Expectancy (f/m, 2003):	71 / 67
Median Age (2006):	36

The government of United States of America reports as follows:

Policy

The government of United States of America considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they work exclusively on the hepatitis strategy.

The Recommendations for Prevention and Control of Hepatitis C Virus Infection and Related Chronic Disease (1998) includes guidelines for preventing transmission; identifying, counselling, and testing those at risk; and evaluating and managing cases. Components include advocacy and awareness, prevention, increasing access, screening, testing, surveillance, service evaluation, treatment and multisectoral collaboration.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These focus on reducing incidence and prevalence and include specific targets.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Travellers; Persons at high risk (these include MSM, IDUs, close contacts of active cases, people with chronic liver disease or HIV infection).

The Immunization Strategy to Eliminate Transmission of Hepatitis B Virus Infection (2008) recommends vaccination for adults considered at risk and those who request vaccination. Additional policies exist for adult and for child vaccination.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Specific publications detail the management of occupational exposures; haemodialysis settings; healthcare worker vaccination; and universal precautions.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Information was not available on whether chronic hepatitis infections are registered
- Information was not available on whether liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is easily accessible to more than 50% of the population. It can be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. These include blood, organ and tissue donors (for whom it is also compulsory). For others cost is dependent on insurance status.

Compulsory testing: Testing is compulsory for some groups. These include blood, organ and tissue donors (for whom it is also free).

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government. Treatment is free of charge for people co-infected with HIV, military personnel, government employees and their dependents, and those eligible for federally-sponsored healthcare. The treatments available vary across programmes.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of United States of America would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions
- Surveillance

Uzbekistan

Population (2006):	26,981,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$2,190
Total health spend as a % of GDP (2006):	4.7%
Per capita total health spend (2006):	$177
Per capita govt health spend (2006):	$89
Life Expectancy (f/m, 2006):	70 / 65
Healthy Life Expectancy (f/m, 2003):	61 / 58
Median Age (2006):	23

Estimated Mortality (2004)	Total
Acute hepatitis B	870.93
Acute hepatitis C	211.94
Liver cancer	364.67
Cirrhosis	6210.7
Infectious diseases	17.94*
Non-communicable diseases	131*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	26380
Acute hepatitis C	7170
Liver cancer	4460
Cirrhosis	125000
Infectious diseases	1872*
Non-communicable diseases	2804*

1-years olds immunised against hepatitis B (2007): 98%

*thousands

The government of Uzbekistan reports as follows:

Policy

The government of Uzbekistan considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is a designated individual to lead this strategy nationally; they do not work exclusively on the hepatitis strategy.

This work is directed by Measures Directed at Decreasing Morbidity Resulting from Viral Hepatitis in Uzbekistan, an order issued by the Ministry of Health in 2000. Alongside two other Ministry orders this provides a framework for prevention, diagnosis, treatment, surveillance and reporting.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Persons at high risk (close contacts of people who have hepatitis B, laboratory specialists and healthcare workers who have contact with biological materials).

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are currently examined for examples of good practice. The availability of further examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions do not currently exist
- Clinical cases require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are not registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on an annual basis.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to all citizens. It is, however, provided free of charge to some groups. Testing is free and compulsory for blood donors, healthcare workers, patients on hospitals and wards with high risk of infection, pregnant women, children in orphanages.

Compulsory testing: Testing is compulsory for some groups. Testing is free and compulsory for blood donors, healthcare workers, patients on hospitals and wards with high risk of infection, pregnant women, children in orphanages.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include the GAVI Alliance.

WHO Assistance

The government of Uzbekistan would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Delivery of vaccination
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Surveillance

Venezuela

Estimated Mortality (2004)	Total
Acute hepatitis B	132.53
Acute hepatitis C	52.18
Liver cancer	744.01
Cirrhosis	1857.26
Infectious diseases	6.38*
Non-communicable diseases	77*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	2290
Acute hepatitis C	590
Liver cancer	7650
Cirrhosis	29060
Infectious diseases	-*
Non-communicable diseases	2565*

1-years olds immunised against hepatitis B (2007): 71%

*thousands

Population (2006):	27,191,000
Country Classification (2009):	Upper middle income
Gross National Income per capita (2006):	$10,970
Total health spend as a % of GDP (2006):	5.1%
Per capita total health spend (2006):	$396
Per capita govt health spend (2006):	$196
Life Expectancy (f/m, 2006):	78 / 71
Healthy Life Expectancy (f/m, 2003):	67 / 62
Median Age (2006):	25

The government of Venezuela reports as follows:

Policy

The government of Venezuela does not consider hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

The strategy focuses on the prevention of hepatitis B through vaccination.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are not in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Adolescents; Healthcare workers; Military personnel; Persons at high risk (not specified).

Hepatitis B vaccination was introduced in 2008. The policy includes infant vaccination within 24 hours of birth.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is not in place.

Policy development: Information was not available on whether other countries' policies relating to hepatitis B and/or hepatitis C are currently examined for examples of good practice.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: The treatment of hepatitis B and/or hepatitis C is not funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are not developed and implemented in collaboration with patient groups, international organisations and/or other partners.

WHO Assistance

The government of Venezuela would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Delivery of vaccinatio

Viet Nam

Population (2006):	86,206,000
Country Classification (2009):	Low income
Gross National Income per capita (2006):	$2,310
Total health spend as a % of GDP (2006):	6.6%
Per capita total health spend (2006):	$264
Per capita govt health spend (2006):	$86
Life Expectancy (f/m, 2006):	75 / 69
Healthy Life Expectancy (f/m, 2003):	63 / 60
Median Age (2006):	25

Estimated Mortality (2004)	Total
Acute hepatitis B	2115.02
Acute hepatitis C	970.85
Liver cancer	8703.87
Cirrhosis	7224.44
Infectious diseases	67.58*
Non-communicable diseases	353*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	38040
Acute hepatitis C	17720
Liver cancer	90620
Cirrhosis	125160
Infectious diseases	3855*
Non-communicable diseases	7542*

1-years olds immunised against hepatitis B (2007): 67%

*thousands

The government of Viet Nam reports as follows:

Policy

The government of Viet Nam considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is not in place.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is not in place.

Funding: treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. Specific details of these were not available to this study.

WHO Assistance

The government of Viet Nam would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Increasing access to treatment
- Delivery of vaccination
- Developing tools to assess the effectiveness of interventions
- Surveillance

Zimbabwe

Estimated Mortality (2004)	Total
Acute hepatitis B	63.25
Acute hepatitis C	28.42
Liver cancer	1157.19
Cirrhosis	474.95
Infectious diseases	213.95*
Non-communicable diseases	50*
Estimated Morbidity (DALYs, 2004)	
Acute hepatitis B	1660
Acute hepatitis C	750
Liver cancer	12550
Cirrhosis	10240
Infectious diseases	6899*
Non-communicable diseases	1335*

1-years olds immunised against hepatitis B (2007): 62%

*thousands

Population (2006):	13,228,000
Country Classification (2009):	Low income
Gross National Income per capita (0):	-
Total health spend as a % of GDP (2006):	8.4%
Per capita total health spend (2006):	$147
Per capita govt health spend (2006):	$77
Life Expectancy (f/m, 2006):	43 / 44
Healthy Life Expectancy (f/m, 2003):	33 / 34
Median Age (2006):	19

The government of Zimbabwe reports as follows:

Policy

The government of Zimbabwe considers hepatitis B and/or hepatitis C to be an urgent public health issue.

National strategy: A specific strategy for the prevention and control of hepatitis B and/or hepatitis C is in place. There is not a designated individual to lead this strategy nationally.

Goals: Goals for the prevention and control of hepatitis B and/or hepatitis C are in place. These are part of national control guidelines for infectious diseases.

Hepatitis B vaccination policy: A national hepatitis B vaccination policy is in place. Groups covered by this policy include: Infants; Healthcare workers.

Infants are vaccinated with pentavalent vaccine under the EPI.

Healthcare settings: A specific strategy to prevent infection with hepatitis B and/or hepatitis C in healthcare settings is in place. Areas covered by this strategy include: Safe injections; Blood screening; Vaccination of healthcare workers.

Universal precautions are observed for all invasive procedures including vein-punctures. Blood for transfusion is centrally screened for HIV/AIDS and hepatitis at the National Blood Transfusion Services.

Policy development: Policies from other countries that relate to hepatitis B and/or hepatitis C are not currently examined for examples of good practice. The availability of such examples would be considered useful to the government in improving awareness, prevention, care and support and access to treatment in future.

Public awareness and education

Government-funded public awareness campaigns for hepatitis B and/or hepatitis C have not taken place in the past five years. Action to reduce stigma experienced by, and discrimination against, people who have hepatitis B and/or hepatitis C has not been taken by the government.

Surveillance

National routine disease surveillance for hepatitis B and/or hepatitis C is in place. Central features of the national monitoring system as it relates to viral hepatitis include:

- Standard case definitions exist
- Clinical cases do not require laboratory confirmation prior to reporting
- Surveillance exists for acute hepatitis
- Surveillance exists for chronic hepatitis
- Chronic hepatitis infections are registered
- Liver cancer cases are registered
- Cases of co-infection with HIV are not registered

Prevalence estimates: Prevalence estimates for the country are available.

Disease reporting: Disease reports are published on a weekly basis.

Hepatitis B is a notifiable disease in Zimbabwe.

Testing

Access: Testing for hepatitis B and/or hepatitis C is not easily accessible to more than 50% of the population. It cannot be accessed anonymously or confidentially. The clinical skills and laboratory capacity needed for case detection are not readily available across the country.

Cost: Testing is not available free of charge to any citizens.

Compulsory testing: Testing is not compulsory for any groups.

Treatment and care

Pathway: A clear patient pathway for the screening, diagnosis, referral and treatment of hepatitis B and/or hepatitis C is in place.

Funding: The treatment of hepatitis B and/or hepatitis C is funded or part-funded by the government.

Working with civil society

Government programmes for the prevention and control of hepatitis B and/or hepatitis C are developed and implemented in collaboration with patient groups, international organisations and/or other partners. These include technical and material support from the WHO in setting up surveillance, equipping laboratories and training staff. Others including the GAVI Alliance and UNICEF input into the national EPI.

WHO Assistance

The government of Zimbabwe would welcome assistance from the WHO in the prevention and control of hepatitis B and/or hepatitis C in the following areas:

- Awareness raising
- Increasing access to treatment
- Developing goals for the prevention and control of hepatitis B and hepatitis C
- Developing tools to assess the effectiveness of interventions

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Appendix 1

Definitions

National Strategy: A formulated, official national plan that sets out the work required to address hepatitis B and/or hepatitis C. It details what is to be done, by whom, during what time frame and using what resources.

Vaccination Policy: A specifically written document of the government or Ministry of Health which sets out the goals for addressing vaccination in the country, the priorities among these goals and the main directives of how these will be achieved.

Surveillance: The monitoring of the incidence and prevalence of hepatitis B and/or hepatitis C at the national level, for example by an individual or department within the Ministry of Health.

Registered: Essential data, for example relating to the number and location of cases that occur each year, are reported to and recorded by national government at regular intervals.

Accessible testing: Significant geographical or financial barriers do not prevent more than 50% of the population from accessing testing for hepatitis B or C.

Patient Pathway: A planned and documented process that sets out each step for a patient from diagnosis (including how testing is accessed, e.g. through screening programmes) to completing treatment and/or being able to manage their condition long-term.

Appendix 2

Contact Information

First Name_____

Last Name_____

Position_____

Company Name_____

Street Address_____

City_____

Postal Code / Zip Code_____

Country_____

Phone Number_____

Email Address_____

Where appropriate, please provide names and contact details of colleagues providing supporting information.

Question 1

Does your Government consider hepatitis B and/or hepatitis C an urgent public health issue?

( ) Yes ( ) No

Please provide details to demonstrate this, and/or email us relevant information when you send us this document

Question 2

Does your Government have a specific strategy for the prevention and control of hepatitis B and/or hepatitis C?

( ) Yes ( ) No

Please give details of the strategy or strategies, and if possible, please email us copies of your strategies when you send us this document

Question 3

Is there a designated individual to lead the strategy nationally?

( ) Yes ( ) No

If yes, does that individual work exclusively on the hepatitis strategy?

( ) Yes ( ) No

Question 4

Does your Government have goals for the prevention and control of hepatitis B and/or hepatitis C?

( ) Yes ( ) No

***Please detail current goals or email us relevant documentation when you send this document

Question 5

Does your Government have a hepatitis B vaccination policy?

( ) Yes ( ) No

Does a policy exist for:

(choose all that apply)

( ) Infants ( ) Adolescents ( ) Healthcare Workers
( ) Military personnel ( ) Travellers ( ) Persons at high risk
(please detail groups considered high risk below)

Please provide further details or email policy documentation when you send us this survey

Question 6

Does your Government have a specific strategy to prevent infection with hepatitis B and hepatitis C in healthcare settings?

( ) Yes ( ) No

Does the strategy cover:

( ) Safe injections ( ) Blood screening

( ) Vaccination of healthcare workers

Please provide further detail, and/or email us further information when you send us this document

Question 7

Has your Government funded any public hepatitis B and/or hepatitis C awareness campaigns in the last 5 years?

( ) Yes ( ) No

Please provide details of the campaigns including method of delivery, target audience, objectives and results, and/or email us further information when you send us this document

Question 8

Has your Government taken any action to reduce the stigma of, and discrimination against, people infected with hepatitis B and/or hepatitis C?

( ) Yes ( ) No

Please provide further detail, and/or email us further information when you send us this document

Question 9

Does your Government carry out routine disease surveillance for hepatitis B and/or hepatitis C?

( ) Yes ( ) No

Appendix 2

With the Government/s surveillance for hepatitis B and/or hepatitis C:

Do standard case definitions exist?
( ) Yes ( ) No ( ) Do not know

Do clinical cases require laboratory confirmation prior to reporting?
( ) Yes ( ) No ( ) Do not know

Does surveillance exist for acute hepatitis?
( ) Yes ( ) No ( ) Do not know

Does surveillance exist for chronic hepatitis?
( ) Yes ( ) No ( ) Do not know

Are chronic infections registered?
( ) Yes ( ) No ( ) Do not know

Are liver cancer cases registered?
( ) Yes ( ) No ( ) Do not know

Are cases of co-infection with HIV registered?
( ) Yes ( ) No ( ) Do not know

Are hepatitis B and/or C prevalence estimates for the country available?
( ) Yes ( ) No ( ) Do not know

How often are disease reports published?
( ) Weekly ( ) Monthly ( ) Annually
( ) No reports published ( ) Other (please specify)

Where available , please provide latest prevalence estimates, disease reports, or other relevant information here and/or email us further information when you send us this document

Question 10

In terms of testing for hepatitis B and hepatitis C in your country, is it:

( ) Easily accessible to more than 50% of the population?
( ) Anonymous/confidential?
( ) Free of charge for all?
( ) Free of charge for any group/s? (please detail below)
( ) Compulsory for any group/s? (please detail below)
( ) None of the above

Please provide further details:

Question 11

Is there a clear patient pathway for screening, diagnosis, referral and treatment for hepatitis B and/or hepatitis C?

( ) Yes ( ) No

If yes, please provide details, and/or email us further information when you send us this document

Question 12

Does your Government fund or part-fund the treatment of hepatitis B and/or hepatitis C?

( ) Yes ( ) No

If yes, please supply details of all drugs funded for hepatitis B and hepatitis C, the criteria for their provision and percentage of cost funded. Where possible please provide supporting documentation

Question 13

In developing and implementing programmes for the prevention and control of hepatitis B and/or hepatitis C, does your government work with patient organisations or other partners (e.g. WHO regional or country offices; global bodies such as the GAVI Alliance; local, national or international NGOs)?

( ) Yes ( ) No

If yes, please supply details, including the names of partner organisations.

Question 14

The World Hepatitis Alliance intends to use the information collected here to produce a comprehensive report on national policies relating to viral hepatitis which highlights examples of the most progressive work. Would you find this report useful in examining best practice in improving awareness, prevention, care, support and access to treatment?

( ) Yes ( ) No

Do you currently examine cases of best practice in these policies from other countries?

( ) Yes ( ) No

Question 15

Working with governments to strengthen health systems and foster health security are some of the WHO's highest priorities. Please identify in which areas, if any, you would appreciate assistance from WHO for the control and prevention of hepatitis B and/or hepatitis C:

( ) Surveillance
( ) Delivery of vaccination
( ) Developing goals for hepatitis B and hepatitis C prevention and control
( ) Developing tools to assess the effectiveness of interventions
( ) Increasing access to treatment
( ) Awareness raising
( ) Other (please specify)