South-East Asia Region
This chapter presents South-East Asia region findings from the World Hepatitis Alliance’s 2014 civil society survey in two sections.

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

8.1. Respondents

Nine organisations from six countries in the South-East Asia region responded to the World Hepatitis Alliance’s 2014 civil society survey. The governments of all of those countries provided information for the 2013 WHO global policy report, and thus all respondents were able to comment on the accuracy of their governments’ responses. Additional information about respondents is presented in Table 8.1.

Table 8.1. South-East Asia region respondents to the World Hepatitis Alliance’s 2014 civil society survey (N=9)

<table>
<thead>
<tr>
<th>Country</th>
<th>Civil society survey respondents (#)</th>
<th>NGO – hepatitis patient group</th>
<th>NGO – direct service provider</th>
<th>NGO – other</th>
<th>Medical society</th>
<th>Private foundation</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>India</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Indonesia</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Myanmar</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Nepal</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Thailand</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>
South-East Asia Region continued

One respondent (11%) identified itself as a nongovernmental direct service provider (Figure 8.1). Two (22%) identified themselves as medical societies, and two (22%) identified themselves as private foundations.

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

Two respondents (22%) were based in upper-middle-income countries, three (33%) in lower-middle-income countries, and four (44%) in low-income countries (Figure 8.2).

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

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

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

The following survey items were most commonly identified as points on which civil society respondents in the South-East Asia region agreed with their governments’ responses: item 2.1, regarding World Hepatitis Day activities and viral hepatitis awareness campaigns; item 3.5, regarding a national viral hepatitis research agenda and viral hepatitis serosurveys; item 4.1, regarding the existence of a national hepatitis A vaccination policy; item 4.2, regarding the goal of eliminating hepatitis B; item 4.6, regarding injection safety in health care settings; and item 4.8, regarding infection control for blood products. Further details are presented in Table 8.2.

The following survey items were most commonly identified as points on which civil society respondents in the South-East Asia region disagreed with their governments’ responses: item 1.3, regarding whether the government has a viral hepatitis prevention and control programme that includes activities targeting specific populations, and item 5.5, regarding the inclusion of hepatitis B drugs and hepatitis C drugs on national essential medicines lists and in government-subsidised programmes. Further details are presented in Table 8.3.
### Table 8.2. Survey items eliciting the highest levels of agreement from civil society respondents, South-East Asia region (N=9)

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Question(s) addressed by governments for 2013 WHO global policy report</th>
<th># (%) of respondents who indicated agreement with their governments’ response(s) by selecting “to our knowledge, this information is accurate”</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Did your government hold events for World Hepatitis Day 2012?</td>
<td>9 (100%)</td>
</tr>
<tr>
<td></td>
<td>Has your government funded any public viral hepatitis awareness campaigns since January 2011, other than World Hepatitis Day?</td>
<td></td>
</tr>
<tr>
<td>3.5</td>
<td>Is there a national public health research agenda for viral hepatitis?</td>
<td>8 (88.9%)</td>
</tr>
<tr>
<td></td>
<td>Are viral hepatitis serosurveys conducted regularly?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If yes, how often? When was the last one carried out?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Please specify the target populations.</td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td>Is there a national hepatitis A vaccination policy? If yes, what groups does the policy address?</td>
<td>8 (88.9%)</td>
</tr>
<tr>
<td>4.2</td>
<td>Has your government established the goal of eliminating hepatitis B? If yes, in what timeframe?</td>
<td>8 (88.9%)</td>
</tr>
<tr>
<td>4.6</td>
<td>Is there a national policy on injection safety in health care settings?</td>
<td>8 (88.9%)</td>
</tr>
<tr>
<td></td>
<td>If yes, what type of syringes does the policy recommend for therapeutic injections?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are single-use or auto-disable syringes, needles and cannulas always available in all health care facilities?</td>
<td></td>
</tr>
<tr>
<td>4.8</td>
<td>Is there a national infection control policy for blood banks?</td>
<td>8 (88.9%)</td>
</tr>
<tr>
<td></td>
<td>Are all donated blood units (including family donations) and blood products nationwide screened for hepatitis B?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are all donated blood units (including family donations) and blood products nationwide screened for hepatitis C?</td>
<td></td>
</tr>
</tbody>
</table>

### Table 8.3. Survey items eliciting the highest levels of disagreement from civil society respondents, South-East Asia region (N=9)

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Question(s) addressed by governments for 2013 WHO global policy report</th>
<th># (%) of respondents who indicated disagreement with their governments’ response(s) by selecting “to our knowledge, this information is not accurate”</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3</td>
<td>Does your government have a viral hepatitis prevention and control programme that includes activities targeting specific populations? If yes, please indicate which populations.</td>
<td>5 (55.6%)</td>
</tr>
<tr>
<td>5.5</td>
<td>Which hepatitis B drugs and hepatitis C drugs are included on the national essential medicines list or are subsidised by the government?</td>
<td>3 (33.3%)</td>
</tr>
</tbody>
</table>
## Bangladesh

**Liver Foundation of Bangladesh**

NGO – liver disease prevention, treatment, education and research

Dhaka, Bangladesh

www.liver.org.bd

### SURVEY HIGHLIGHTS

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

- **The government information was thought to be accurate for 80.0% of items.**
- **Survey points marked “accurate”: 1.1, 1.2, 2.1, 2.2, 3.1, 3.2, 3.3, 3.4, 3.5, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.9, 5.2, 5.3 and 5.5.**

- **The government information was thought to not be accurate for 16.0% of items.**
- **Survey points marked “not accurate”: 1.3, 4.8, 4.10 and 5.1.**

- **The respondent took no position on the government information for 4.0% of items.**
- **Survey points marked “take no position”: 5.4.**

**Survey comments from the Liver Foundation of Bangladesh:**

<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2 The government collaborates with the following in-country civil society group to develop and implement its viral hepatitis prevention and control programme: Liver Foundation of Bangladesh.</td>
<td>In different issues regarding prevention and control of viral hepatitis, some government officials regularly communicate with the Liver Foundation of Bangladesh.</td>
</tr>
<tr>
<td>3.1 There is no routine surveillance for viral hepatitis.</td>
<td>On the national level there is no routine surveillance system for viral hepatitis. Recently the government started surveillance of foodborne infectious diseases in one of its surveillance programmes where hepatitis A and hepatitis E are included and being conducted regularly. Similarly, hepatitis B and hepatitis C are monitored regularly in another programme (safe blood programme).</td>
</tr>
<tr>
<td>3.5 There is no national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are not conducted regularly.</td>
<td>Recently the government has planned to start a serosurvey programme nationwide for several diseases including viral hepatitis.</td>
</tr>
<tr>
<td>4.3 Information was not provided on the percentage of newborn infants nationally in a given recent year who received the first dose of hepatitis B vaccine within 24 hours of birth or the percentage of one-year-olds nationally (ages 12–23 months) in a given recent year who received three doses of hepatitis B vaccine.</td>
<td>First dose of Hepatitis B vaccine is given at 6th week of age along with DPT Vaccine in EPI programme.</td>
</tr>
<tr>
<td>4.6 There is no national policy on injection safety in health-care settings. Single-use or auto-disable syringes, needles and cannulas are always available in all health-care facilities.</td>
<td>Draft injection safety policy is waiting for approval of government.</td>
</tr>
<tr>
<td>Information reported by government (2012–2013)</td>
<td>Civil society respondent comments (2014)</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>5.4</strong> Publicly funded treatment is not available for hepatitis B or hepatitis C.</td>
<td>A very small percentage of people benefit from the public funding of treatment.</td>
</tr>
<tr>
<td>To our knowledge, this information is accurate.</td>
<td></td>
</tr>
<tr>
<td><strong>5.5</strong> The following drugs for treating hepatitis B drugs are on the national essential medicines list: interferon alpha, pegylated interferon, lamivudine, adefovir dipivoxil, entecavir, telbivudine and tenofovir. The following drugs for treating hepatitis C are on the national essential medicines list: interferon alpha, pegylated interferon, ribavirin, boceprevir and telaprevir.</td>
<td>Only lamivudine and tenofovir are present to the essential drug list.</td>
</tr>
<tr>
<td>To our knowledge, this information is not accurate.</td>
<td></td>
</tr>
<tr>
<td><strong>1.3</strong> The government does not have a viral hepatitis prevention and control programme that includes activities targeting specific populations.</td>
<td>There are prevention and control activities in the national EPI programme targeting children under the age of one.</td>
</tr>
<tr>
<td></td>
<td>Though there is a law of “Safe Blood Transfusion Act 2002” which was approved by parliament, a national blood policy is still required to guide and bring blood use in a uniform way to be followed by all blood transfusion centres across the country.</td>
</tr>
<tr>
<td><strong>4.8</strong> There is a national infection control policy for blood banks. Not all donated blood units and blood products nationwide are screened for hepatitis B. It is not known whether all donated blood units (including family donations) and blood products nationwide are screened for hepatitis C.</td>
<td>There is a foodborne infection surveillance programme started by the Institute of Epidemiology, Disease Control and Research, Bangladesh from 2013.</td>
</tr>
<tr>
<td></td>
<td>The health system as a whole may be developed with introducing health insurance scheme for health services in the country.</td>
</tr>
<tr>
<td><strong>4.10</strong> The government does not have guidelines that address how hepatitis A and hepatitis E can be prevented through food and water safety.</td>
<td>A person may be designated as a viral hepatitis focal point holding responsibility to oversee viral hepatitis activities in the country.</td>
</tr>
<tr>
<td>We take no position regarding this statement.</td>
<td>The designated institute/person should establish liaison/links with national and international stakeholders, development partners like the United Nations Development Programme, UNICEF, the World Health Organization and the World Bank for implementing programmes at micro levels for awareness-raising, human resource development and capacity-building for diagnosis and management. Local pharmaceutical companies may contribute through production of vaccines, reagents and essential drugs for diagnosis, prevention and management of hepatitis at a subsidised rate.</td>
</tr>
</tbody>
</table>

**Statement from the Liver Foundation of Bangladesh regarding key hepatitis policy issues in Bangladesh:**

As viral hepatitis and its consequences are multi-faceted, prevention and control measures and management procedures differ from one another. The diseases also traverse both communicable and noncommunicable phases. So the disease burden in acute and chronic stage including cirrhosis and liver cancer and great complications in pregnancy contribute at a great extent to disease burden of the country.

In view of the facts above, we must have changes in the country’s health system. Considering viral hepatitis a major public health issue, the systemic changes proposed in health services are as follows:

> To establish a viral hepatitis disease unit, similar to other major departments in health services like mycobacterial disease control, malaria and parasitic disease control, and National AIDS and Sexually Transmitted Disease Control Programme under director general of health services.

> A separate institute may be established and designated as national viral hepatitis institute which may function as a centre of excellence in this field and all types of investigation, surveillance of outbreaks, case management, monitoring and follow-up of chronic patients and conduct of all hepatitis-related research activities and to establish network with other international organisations.

> A person may be designated as a viral hepatitis focal point holding responsibility to oversee viral hepatitis activities in the country.
SURVEY HIGHLIGHTS

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

- The government information was thought to be accurate for 52.0% of items.
  Survey points marked “accurate”: 1.1, 1.2, 1.3, 2.1, 3.1, 3.2, 3.3, 3.4, 3.5, 4.1, 4.6, 4.8, 4.10 and 5.3.

- The government information was thought to not be accurate for 24.0% of items.
  Survey points marked “not accurate”: 1.3, 4.3, 4.4, 5.1, 5.4 and 5.5.

- The respondent took no position on the government information for 24.0% of items.
  Survey points marked “take no position”: 2.2, 4.2, 4.5, 4.7, 4.9 and 5.2.

The Viral Hepatitis Foundation Bangladesh did not provide any comments about survey items. The respondent also did not provide a statement regarding key hepatitis policy issues in Bangladesh.
3.1 There is no routine surveillance for viral hepatitis. Even the existing antiretroviral centres do not maintain the data for coinfection.

3.2 There are standard case definitions for hepatitis. Hepatitis deaths are not reported to a central registry. The percentage of hepatitis cases reported as "undifferentiated" or "unclassified" hepatitis is not known.

4.2 The government has not established the goal of eliminating hepatitis B. Even patients on antiretroviral therapy with hepatitis B coinfection are not encouraged with tenofovir.

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

5.2 The government does not have national policies relating to screening and referral to care for hepatitis B or hepatitis C.
## Information reported by government (2012–2013)

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

1.2 There is a designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities. It has four staff members. It is not known how many people work full-time on hepatitis-related activities in all government agencies/bodies.

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

3.3 Liver cancer cases and cases with HIV/hepatitis co infection are registered nationally. The government does not publish hepatitis disease reports.

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

5.3 People testing for both hepatitis B and hepatitis C register by name; the names are kept confidential within the system. Hepatitis B and hepatitis C tests are free of charge for all individuals and are compulsory for blood donors.

## Civil society respondent comments (2014)

At least the government has started taking the initiative for hepatitis B vaccination for newborn babies.

We have been doing advocacy on improving access to hepatitis C treatment since 2012 with the Government Health Department. However, we do not know of the existence of such teams or units at the state level solely for hepatitis C.

Based on our experience, most health care providers are still lacking adequate information on viral hepatitis.

Cases are not registered nationally and as such the disease report is not applicable.

Hepatitis outbreaks are neither reported to the government nor does the government have any adequate laboratory to support investigations.

We have no such system as of now. Hepatitis B and hepatitis C are among the mandatory tests for antiretroviral initiation. People are paying Rs 300 to the government hospital whereas the fee is Rs 750 at private diagnostic centres.

Our network mainly focuses on hepatitis B and hepatitis C. We have no information on hepatitis A.
Statement from the Community Network for Empowerment regarding key hepatitis policy issues in India:

India does not have a surveillance system for hepatitis C and the burden of the disease is unknown. However, the graveness of the situation is documented through data and information from independent studies. Recent studies conducted by the World Health Organization have reported that among people who inject drugs the national prevalence rate of HIV/hepatitis C coinfection is 92% while individual sites have also reported a prevalence range of 26% to 93%. In the context of Manipur, the prevalence of the coinfection has been reported as 92% and 90.2% in Churachandpur district.

In spite of having such rich data for more than a decade now, and in spite of India being a signatory to the World Health Assembly’s 2010 viral hepatitis resolution, nothing substantial has been done to improve services, prevention measures or provide treatment as a government response.

Considering the seriousness of the hepatitis issue in India, particularly hepatitis C, the government should develop a national strategy to respond to this public health issue including resource allocation at the earliest. An exclusive programme for prevention of hepatitis should be implemented in collaboration with different key stakeholders.

Civil society should be provided a greater role in curbing viral hepatitis in terms of planning, implementation and monitoring. Community-based groups and networks of hepatitis C-infected and -affected people should be involved in all decision-making, planning and implementation of hepatitis programming.


2. Ibid p/16.


India

Liver Foundation, West Bengal*

NGO – direct service provider
Kolkata, India
www.liverfoundation.in

SURVEY HIGHLIGHTS

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

- The government information was thought to be accurate for 80.0% of items.
  - Survey points marked “accurate”: 1.3, 2.1, 2.2, 3.1, 3.2, 3.3, 3.4, 3.5, 4.1, 4.2, 4.3, 4.5, 4.6, 4.7, 4.8, 4.9, 5.1, 5.2, 5.4 and 5.5.

- The government information was thought to not be accurate for 4.0% of items.
  - Survey points marked “not accurate”: 1.1.

- The respondent took no position on the government information for 16.0% of items.
  - Survey points marked “take no position”: 1.2, 4.4, 4.10 and 5.3.

The Liver Foundation, West Bengal did not provide any comments about survey items.

Statement from the Liver Foundation, West Bengal regarding key hepatitis policy issues in India:

Chronic hepatitis, as a term, is exclusionary for insurance coverage by most insurance providers.

No national hepatitis control programme exists that can provide support to infected and diseased people for their health care expenditures through government funding.

No guidelines or standard protocol for the management of hepatitis exist. This lays bare the situation even further and creates a freestyle situation in patient care strategies. In the absence of any system for monitoring of clinical and hospital practice, this often turns out to be an absolutely “zero protection” scenario for patient interest. Indiscriminate and unnecessary hospitalisations, unnecessary drug use and unnecessary therapeutic procedures are some of the examples of imperfect practice of relevance in hepatitis care that are in vogue.

There is a perception even in government circles that hepatitis B and hepatitis C are not priorities in India which is besieged with so many other conditions. Lack of data on the disease burden and economic impact of hepatitis are the primary reasons for this.

National coordination for necessary regulations for supporting patient’s interest including health care-related travel subsidies, treatment subsidies, other social security benefits that are available to people with chronic diseases such as HIV and cancer should be initiated. There are multiple stakeholders with different roles that can be knit together to create a proactive hepatitis supportive ambience.

Liver Foundation, West Bengal, is a voluntary organisation focused on different health issues. Initiated by a handful of professionals and socially committed scientists having an interest and focus on liver disease awareness as well as public health issues facing the country. So this view is based on our own experience as well as different reports and statistics.

* World Hepatitis Alliance member.
Survey comments from the Association of Viral Hepatitis Controllers in Indonesia:

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

As far as we have observed, the Indonesian government, especially the Ministry of Health has been striving to increase the awareness of hepatitis virus (in particular Hepatitis B) starting from boosting the theme of hepatitis in the World Health Assembly, then supporting the World Hepatitis Day campaign every July 28 since the year 2010. The prevention programme towards hepatitis B has been implemented since the year of 1986, which was the pilot project in Lombok; and then integrated to the programme of basic immunization in 1997 and in 2003, a vaccination to the newborn babies, afterwards in 2004 HB was integrated with the combination of DPT/HB and in 2014, it was integrated with vaccine HIB (Haemophilus influenzae B).

Hepatitis surveillance has been executed but it was still clinically based (not in a laboratory way) so it has not been broken up into its kind (A, B, or C). Prevention for drug abuse has been done together with the prevention programme for HIV. The pilot project for screening the pregnant women are being done currently, and it has been planned that HBIG will be given to babies. Regarding the treatment, it has been sought to give the lamivudine with low cost, and it has been proposed to be put into BPJS (social security programme).
1.3 The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific population: health-care workers, including health-care waste handlers.

For prevention and control, the prevention activity is performed by immunisation at the earliest age possible by giving HB-O immediately after the baby born and after given vitamin K. Immunisation can only be given to the babies born at the hospital/maternity clinic or other health facilities. As it is known there is still quite a big number of babies who were born outside the health facilities so that it was still tolerable if immunisation was given to the babies whose age were less than seven days for the areas which were difficult to reach. For health-workers, the immunisation are carried out independently by some hospitals, whilst in general for health-care and waste handlers it was done by the Environmental Health Directorate in PHBS programme (Clean and healthy behaviour programme).

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

For the event of World Hepatitis Day 2012, the government prepared fund to increase public awareness, and this campaign has started since January 2011. Because this is the new activity then it requires a bureaucratic time.

<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2 There is no designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities. There are 12 full-time equivalent staff members who work on hepatitis-related activities in all government agencies/bodies.</td>
<td>Based on our observations, it is true that at this time in the Department of Health there is no specific department for hepatitis but it is combined with diarrhoea, gastrointestinal infection and hepatitis. Also in October 2010 recently, actually at least 20 personnel are needed to prevention and treatment programmes. Details on this case are being prepared. We cooperate with professional organisations (The Indonesian Association for the study of the Liver) and Working Group of Viral Hepatitis in the Department of Health to help preparing the guideline of hepatitis B treatment and guideline for screening the pregnant mother.</td>
</tr>
<tr>
<td>1.3 The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific population: health-care workers, including health-care waste handlers.</td>
<td>For prevention and control, the prevention activity is performed by immunisation at the earliest age possible by giving HB-O immediately after the baby born and after given vitamin K. Immunisation can only be given to the babies born at the hospital/maternity clinic or other health facilities. As it is known there is still quite a big number of babies who were born outside the health facilities so that it was still tolerable if immunisation was given to the babies whose age were less than seven days for the areas which were difficult to reach. For health-workers, the immunisation are carried out independently by some hospitals, whilst in general for health-care and waste handlers it was done by the Environmental Health Directorate in PHBS programme (Clean and healthy behaviour programme).</td>
</tr>
</tbody>
</table>

**To our knowledge, this information is accurate.**
3.2 There are standard case definitions for hepatitis. Deaths, including from hepatitis, are reported to a central registry. Information was not provided on the percentage of hepatitis cases reported as “undifferentiated” or “unknown” hepatitis.

3.3 Liver cancer cases are registered nationally, but it is not known whether cases with HIV/hepatitis coinfection are. The government publishes hepatitis disease reports monthly and annually.

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

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

3.1 There is no routine surveillance for viral hepatitis.

To our knowledge, this information is accurate.

The government collaborates with the professional organisations such as PPHI-The Indonesian Association for the Study of the Liver, IDAI-Indonesian Pediatric Association, IDI-Indonesian Doctors Association, IBI-The Indonesian Midwives bonds, PPNI-Indonesian national nurses union and also with several other organisations among others the Working Group of Viral Hepatitis in the Department of Health/ Pokja Hepatitis, Indonesian AIDS Society, PKNI (Perkumpulan Korban NAFZA Indonesia), Ikatan Perempuan Positif HIV – woman bond positive HIV, Perhimpunan Obstetri dan Ginekologi Indonesia- Indonesian Society of Obstetrics and Gynecology, Perhimpunan Patologi Klinik-society of clinical pathology.

Hepatitis surveillance has been done since a long time ago but it is still in the shape of clinical hepatitis reports; especially in the Health Centre community, the reagent is not available for hepatitis type checking. Need to be Improved.

Indonesia has had a guideline prepared by the government and experts using the reference of World Health Organization guidelines. The report in the main office is received by the sub-directorate of surveillance disease control and environmental health, but it has not been socialised properly and not yet fully understood the definition of establishing the diagnosis and the treatment procedure. Need to be improved.

Liver cancer has been reported nationally for the coinfection with HIV but it is still in the shape of sporadic reports based on the study result.

There is always an investigation for the outbreak condition. Blood sample is taken and then sent to Badan Lit Bang Kes (Agency for Healthcare Research and Development) to identify the hepatitis type. The readiness of this Agency is sufficient in the term of reagent supply and the examination elisa/PCR.
4.2 The government has not established the goal of eliminating hepatitis B.

Government has not established the goal of eliminating hepatitis B because they still have to arrange several matters for example, to reach the high level and evenly coverage of hepatitis B immunisation; to enhance the surveillance system that can cover the entire health care facility; to be able to have a network for the examination of the type of hepatitis; to increase the awareness towards the hepatitis disease; to improve the knowledge of the health-workers to understand/recognise the hepatitis disease; to refer the patient that should be referred; and free treatment for hepatitis disease.

The constraint that we have is we need to establish the correct magnitude of the problem. The accurate data is not yet known.

4.3 Information was not provided on the percentage of newborn infants nationally in a given recent year who received the first dose of hepatitis B vaccine within 24 hours of birth. Nationally, 94% of one-year-olds (ages 12–23 months) in a given recent year received three doses of hepatitis B vaccine.

Regarding the result of the coverage yearly, it could be seen from JRF/Join Report Form which was assessed by WHO and UNICEF, it was separated between the coverage of babies born in the health-facility and in the field who were assisted by midwives. For Booster purposes, Pentavalent was given in the age of 18 months (this is the new policy). There are still differences in the data between Western and Eastern Indonesia.

3.5 There is a national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are not conducted regularly.

To our knowledge, this information is accurate.

National research agenda for viral hepatitis has been carried out by Badan Lit Bang Kes (Agency for Healthcare Research and Development) in the form of Basic Health Research. This research is performed in every 3 years. In 2014, surveys will be carried out integratedly with HIV.

There is no national policy for the prevention of hepatitis A but the vaccine in the private sector is available at their own expense. The government policy is to improve the environmental cleanliness and individual sanitation hygiene.

There is no national policy on hepatitis A vaccination.
### Information reported by government (2012–2013)

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

To our knowledge, this information is accurate.

#### 4.5 There is no specific national strategy and/or policy for preventing hepatitis B and hepatitis C infection in health-care settings. Health-care workers are not vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood.

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

### Civil society respondent comments (2014)

#### Blood screening is currently being done in Jakarta towards the pregnant mothers. It is as an early initiation and approximately targeted about 5,000 pregnant women; and the next step is for those who are indicated “positive” to be followed by the examination of HBV-DNA, and their baby will be given HIG (at this time it is still in trial process).

*In 2013 a screening had been carried out throughout Jakarta. In 2014 in Jakarta plus 12 new provinces, there will be an examination for 126,000 pregnant mothers and health workers. The collection of blood will be done approximately in August this year.*

#### Up to now, there is not any government policy yet to undertake the screening and immunisation to the health-care workers, but there are several private hospitals that delivered immunisation to their employees. In the National General Hospital Cipto Mangunkusumo, it had ever been given the immunisation of hepatitis B assisted by Askes (national insurance for civil servants/government employee).

*For the prevention of hepatitis C, the education to the Health-care workers who will do the medical treatment or who are in contact with blood, such as transfusion, then the injection is given in order to follow the existing Standard Operating Procedure (SOP).*

#### National policy for safety injection especially for conducting the immunisation, it has been used auto-disable syringe in order to prevent to be used again. The need for a syringe is sufficiently available.
To our knowledge, this information is accurate.

5.1 Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools of health professionals (pre-service education) and on-the-job training. There are no national clinical guidelines for the management of viral hepatitis.

Recently, the Sub-directorate of diarrhoea, hepatitis Disease Control along with the professional organisations have prepared guidelines for treatment of Hepatitis B and Hepatitis C. As stated earlier since October 2010 the programme of Hepatitis viruses have been included in the Sub-Directorate Disease Control in the Directorate General of Disease Control and Environmental Health, and started to perform several programmes related to hepatitis viruses, especially hepatitis B and hepatitis C. It is initiated with the examination of lab workers within the MOH and studies of pregnant woman. If they are positive then a further treatment is carried out in Jakarta. They will perform the same action next year in the other 12 provinces throughout Indonesia.

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

There is not a national policy yet for screening against hepatitis B or C, it is still in the level of Pilot Project to the pregnant mothers in Jakarta.

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

Policy from Government to screen the blood donor for hepatitis B, hepatitis C, HIV and syphilis exists. Their names are kept confidential and screening in Red Cross Lab is free of charge. The cost will be borne by the blood users including the blood bags.

The patient with the lab result “positive” will be given a letter and afterwards, they get treatment. It is not compulsory to do a screening for those who are not a blood donor.

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

There is national infection control policy for blood banks. All donors are screened for hepatitis B, C, HIV and syphilis. It was initiated in 1992 and has since then been implemented.

4.10 The government has guidelines addressing how hepatitis A and hepatitis E can be prevented through food and water safety.

There has been a guideline in the sub-directorate of water supply and sanitation. It explains the transmission of hepatitis A and E through food and drinks. The rapid test is needed.

5.4 Government employees are eligible for publicly funded treatment for hepatitis B and hepatitis C. Information was not provided on the amount spent by the government on such treatment.

The government employee who suffers from hepatitis B and C after diagnosis by the expert will get treatment. There is not any report yet as to how many people have been treated by the government subsidy (in Askes -the government employee insurance/ names of medicines used has been listed).
Statement from the Association of Viral Hepatitis Controllers in Indonesia regarding key hepatitis policy issues in Indonesia:

To raise the awareness and to promote partnership is a huge challenge. Lack of knowledge and awareness among the general public, health professionals and policy-makers constitute a huge barrier. It is very essential for those people to have sufficient knowledge about viral hepatitis. One of the causes of the slow response from policy makers, health professionals and the general public is the wrong opinion that viral hepatitis is not a crisis disease within a short time.

A person who is affected by chronic hepatitis will experience complaints and severe symptoms after 15 to 25 years. Whereas a person with chronic hepatitis when it is symptomatic, it means it was already too late and the healing will be difficult or even impossible; except if the patient is still able to have a surgery or transplantation in which the cost becomes very expensive and only very few people in Indonesia have access. Explaining and altering people’s perception above is one of our urgencies in order to change the paradigm about the awareness of viral hepatitis disease. They should know that with early detection and vaccinations, then the chronic liver disease and liver cancer could be prevented so that the cost of the treatment and care of patients with cirrhosis could be significantly reduced. Therefore, the advanced cases which are very expensive (tertiary treatment) will be shifted to the vaccination (primary prevention) and the earlier treatment (secondary prevention).

In fact, the efforts to provide information about viral hepatitis has been widely carried out either by the Ministry of Health and professional organisations, especially professional organisations which are involved in the problem of hepatitis and also other professional organisations or civil organisations which are very concerned with liver disease, especially hepatitis. Unfortunately, these efforts run alone and have not been coordinated. They do it with their moderate way and with a very small amount of frequency; so that the above efforts do not show the real results. Hepatitis has become the attention of the government following the World Health Organization resolution in May 2010. Hepatitis has become the government programme since October 2010, and therefore this section is incorporated in the Sub-directorate of Diarrhea and Gastrointestinal infections. Nevertheless we really expect that hepatitis has its own sub-directorate in the future.

A stronger commitment from the Ministry of Health towards the hepatitis problem in Indonesia is expected starting from all levels of high-ranking officials as well as its lower rank. To manage the problem of viral hepatitis, it should be coordinated by a team of special handling which is carried out by a number of staff in which the leader should continually focus specifically on viral hepatitis, because in fact, the “Hepatitis Problem itself” which is very huge. However, now there has been an attention towards the matters above and the good news is “Hepatitis Program” will be included in the “National Five Year Development Plan 2015–2019.

The group above should continuously provide more intensive information to the policy makers, health professionals and to the wider community. Undoubtedly the people in the Ministry of Health will be supported by various stakeholders who are very concerned with the problem of hepatitis because during this time the problem of hepatitis has become the huge public health problem which has been neglected. It is expected that the prevention and control of viral hepatitis will be running much better.

In 1997, government had launched a mass vaccination for hepatitis B in all provinces in Indonesia, but the results are not yet as expected by all parties which is the decrease in the prevalence. One of the factors which may cause is the first HB vaccination coverage that might not hit the target. And also the catch-up vaccination has not yet been programmed as well as the vaccination for high-risk groups. Another issue is the difficulty to access to the diagnostics for people living with hepatitis as well as the access to the further treatment. As we have known these costs are very high.

The majority of people in Indonesia do not have the access to treatment for Hepatitis B, let alone for Hepatitis C. Is local production for these hepatitis medicines possible?
2.1 The government did not hold events for World Hepatitis Day 2012, but has funded other viral hepatitis public awareness campaigns since January 2011 (Annex A).

Liver Unit (Yangon General Hospital) has held “World Hepatitis Day” events since 2009 while Liver Foundation (Myanmar) and GI and Liver Society (Myanmar Medical Association) carried out the events in 2013.

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

There are some drawbacks as screening tests are not molecular assays

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

It is included in notifiable diseases on paper but public is not aware and it is not carried out systematically.

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

This is just on paper and not accurate.
<table>
<thead>
<tr>
<th>Information reported by government (2012–2013)</th>
<th>Civil society respondent comments (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.5</strong> There is a national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are conducted regularly; the most recent one was in 2010.</td>
<td>Funds are required for national serosurveys and has not been available for many years.</td>
</tr>
<tr>
<td><strong>4.5</strong> There is a specific national strategy and/or policy/guidelines for preventing hepatitis B and hepatitis C infection in health-care settings. Health-care workers are vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood.</td>
<td>Few departments have this kind of facility.</td>
</tr>
<tr>
<td><strong>5.3</strong> People testing for both hepatitis B and hepatitis C register by name; the names are kept confidential within the system. Hepatitis B and hepatitis C tests are not free of charge for everyone, but they are free for pregnant women and blood donors. Hepatitis B and hepatitis C tests are compulsory for pregnant women, blood donors and people applying for employment.</td>
<td>True for blood donors and for some antenatal care centres.</td>
</tr>
<tr>
<td><strong>1.1</strong> There is a written national strategy or plan that focuses primarily on the prevention and control of viral hepatitis, and also integrates other diseases. It includes components for raising awareness, surveillance, vaccination, prevention in general, prevention of transmission via injecting drug use, prevention of transmission in health-care settings, and treatment and care.</td>
<td>We have no information about this existing.</td>
</tr>
<tr>
<td><strong>4.3</strong> Nationally, 10% of newborn infants in a given recent year received the first dose of hepatitis B vaccine within 24 hours of birth and 38% of one-year-olds (ages 12–23 months) in a given recent year received three doses of hepatitis B vaccine.</td>
<td>Birth dose may be true in cities but difficult in rural areas.</td>
</tr>
<tr>
<td><strong>4.9</strong> There is a national policy relating to the prevention of viral hepatitis among people who inject drugs.</td>
<td>Bylaws may be required for legal use of syringes for people who inject drugs.</td>
</tr>
<tr>
<td><strong>5.5</strong> The following drugs for treating hepatitis B are on the national essential medicines list: interferon alpha, pegylated interferon, lamivudine, adefovir dipivoxil, entecavir, telbivudine and tenofovir. The following drugs for treating hepatitis C are on the national essential medicines list: interferon alpha, pegylated interferon and ribavirin.</td>
<td>These drugs are too expensive for routine use.</td>
</tr>
</tbody>
</table>
Statement from the Liver Foundation regarding key hepatitis policy issues in Myanmar:

Of the five types of viral hepatitis, Hepatitis A, B, C, and E are endemic in Myanmar. Hepatitis B and C are blood borne infections and can cause chronic infections leading to complications. Hepatitis A and E are water-borne infections. All four infections can be prevented and it is very important for the general population to be aware of these facts and the duty of the government to carry out awareness-raising activities to educate the public.

Currently there is weakness in the awareness-raising activities both for blood-borne infections (hepatitis B and C) and waterborne infections (hepatitis A and E) by the government. There should be increase in the distribution of educational posters, pamphlets, advertisements on TV and radio broadcasting to reach the community. Simple advice such as not sharing razors, toothbrushes, nail cutters, using only disposable syringes, compulsory screening of blood donors, personal hygiene, sanitation and vaccination are all of great importance to prevent transmission.

In Myanmar, according to research findings, the main mode of transmission for hepatitis B is from mother to child during birth. Thus birth dose of hepatitis B vaccine is of great importance to prevent chronic infection in the child. However although hepatitis B vaccine has been introduced into the EPI over 10 years ago, the schedule is 2.5, 3.5 and 4.5 months with the pentavalent vaccine currently. The Government is trying to obtain monovalent HB vaccine for birth dose but not carried out as yet.

In Myanmar, prior permission from the government or local authority is required for local NGOs or international NGOs to carry out activities in the community such as health education talks, blood screening, and vaccination programmes. Thus these groups should all work together in harmony to obtain successful results. The government should take the initiative, make health plans and projects and also work in collaboration and coordination with local NGOs and international NGOs to use their participation, to give them official recognition and also use their resources and funding as available.
SURVEY HIGHLIGHTS

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

The government information was thought to be accurate for 80.0% of items.

Survey points marked "accurate": 1.1, 1.2, 2.1, 2.2, 3.1, 3.3, 3.5, 4.1, 4.2, 4.3, 4.4, 4.5, 4.7, 4.8, 4.9, 4.10, 5.1, 5.2, 5.3 and 5.4.

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

Survey points marked "not accurate": 1.3, 3.4, 4.6 and 5.5.

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

Survey points marked "take no position": 3.2.

Union C did not provide any comments about survey items.

Statement from Union C regarding key hepatitis policy issues in Nepal:

National coordination. The government of Nepal should acknowledge the need and express a greater level of commitment to hepatitis screening, diagnosis, treatment, care and support. For that, it should immediately identify the national coordination body which can work in close coordination with national centre for AIDS and STD control.

Viral hepatitis among people who use drugs must be appropriately included in national HIV programmes and drug strategies and programmes, as well as in the Universal Access framework, Global Fund, Pooled Fund programmes and other national platforms.

Increase access to affordable, high quality, effective and safe diagnostic and testing services. Except for a few tests such as antibody and LFT, other diagnostics are carried out by sending blood samples to the Indian laboratories. HIV testing should always be offered to clients with hepatitis, and hepatitis B and hepatitis C testing should likewise be offered to people living with HIV.

Awareness-raising, partnerships and resource mobilisation. Work with community to increase the awareness on viral hepatitis including media.

Evidence-based policy and data for action. People who use drugs and people living with hepatitis B or hepatitis C or HIV coinfection must be involved in the formulation, implementation, monitoring, and evaluation of all strategies and policies that affect their lives.

The United Nations, donors and foreign development agencies supporting HIV prevention and other services targeting people who use drugs must include a hepatitis component in their programme.

Harm reduction programmes must not only be sustained, but urgently scaled up and expanded to provide adequate coverage and a wide range of services including (but not limited to) needle and syringe programmes.

Prevention of transmission. A rapid regimen of hepatitis B vaccination should be made widely available for people who inject drugs as recommended by WHO.

Screening, care and treatment. Currently, no pharmaceutical companies exist in the country. Patients need to go to the Indian cities to bring in even pegylated interferon.

Facilitate to make available the medication for hepatitis B and hepatitis C including pegylated interferon and new generation direct-acting antiviral agents. Government should start a dialogue with pharmaceutical companies to reduce the price of medication.
1.2 There is no designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities. There are no people working full-time on hepatitis-related activities in any government agency/body.

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

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

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

* World Hepatitis Alliance member.

SURVEY HIGHLIGHTS

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

The government information was thought to be accurate for 96.0% of items.

Survey points marked “accurate”: 11, 1.2, 1.3, 21, 2.2, 31, 3.2, 3.3, 3.5, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, 4.10, 5.1, 5.2, 5.3, 5.4 and 5.5.

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

Survey points marked “take no position”: 3.4.

Survey comments from the Liver Care Foundation:

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<tr>
<td>There is no written national strategy or plan that focuses exclusively or primarily on the prevention and control of viral hepatitis.</td>
<td>We have had universal vaccine since 1994 in newborn but we lack evaluation.</td>
</tr>
<tr>
<td>There is no designated governmental unit/department responsible solely for coordinating and/or carrying out viral hepatitis-related activities. There are no people working full-time on hepatitis-related activities in any government agency/body.</td>
<td>Last year the infectious control department had a committee about this but up to now there is no progression. There is no action.</td>
</tr>
<tr>
<td>The government has a viral hepatitis prevention and control programme that includes activities targeting the following specific population: health-care workers, including health-care waste handlers.</td>
<td>This policy was individual for each hospital with regards to health care workers. Further, the vaccine costs could not be reimbursed.</td>
</tr>
<tr>
<td>The government did not hold events for World Hepatitis Day 2012 and has not funded other viral hepatitis public awareness campaigns since January 2011.</td>
<td>They have not any campaign and no budget for this event.</td>
</tr>
<tr>
<td>The government does not collaborate with in-country civil society groups to develop and implement its viral hepatitis prevention and control programme.</td>
<td>They are only planning.</td>
</tr>
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<tr>
<td>3.2 There are standard case definitions for hepatitis. Deaths, including from hepatitis, are reported to a central registry. Of hepatitis cases, 25% are reported as “undifferentiated” or “unclassified” hepatitis.</td>
<td>We do not have a standard form for reported deaths from hepatitis. In Thailand not only hepatitis A, B and C infection we have toxic hepatitis from herbal medicine so when the patient died from hepatitis we couldn’t differentiate the definite course of hepatitis.</td>
</tr>
<tr>
<td>3.5 There is no national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are not conducted regularly. The most recent serosurvey, which targeted the general population, was carried out in 2004.</td>
<td>Up to now they did not.</td>
</tr>
<tr>
<td>4.1 There is no national policy on hepatitis A vaccination.</td>
<td>They have no policy and vaccine is not reimbursed.</td>
</tr>
<tr>
<td>4.2 The government has not established the goal of eliminating hepatitis B.</td>
<td>They have universal vaccination for newborns since 1994 but we lack the education for preventing transmission to a hepatitis B-infected person’s contacts.</td>
</tr>
<tr>
<td>4.3 Nationally, 99% of newborn infants in a given recent year received the first dose of hepatitis B vaccine within 24 hours of birth and 98% of one-year-olds (ages 12–23 months) in a given recent year received three doses of hepatitis B vaccine.</td>
<td>In theory it should be 99% but in real life it is not, it depends on each area such as university hospital and local hospital. Universal coverage plan for all newborns but we lack the knowledge of natural history of HBV for medical personnel and the people so the percentage was low in some areas. In the Northeast of Thailand, the prevalence of the people around 20 years old is more than 3% (Liver Care Foundation 2010).</td>
</tr>
<tr>
<td>4.4 There is a national policy that specifically targets mother-to-child transmission of hepatitis B (Annex B).</td>
<td>We have no national policy, only vaccination after birth, HBIG is not universally used, depends on the knowledge of medical personnel and budget of the mother.</td>
</tr>
<tr>
<td>4.5 There is a specific national strategy and/or policy for preventing hepatitis B and hepatitis C infection in health-care settings, but it addresses only vaccination for healthcare workers. Healthcare workers are not vaccinated against hepatitis B prior to starting work that might put them at risk of exposure to blood.</td>
<td>The prevention was done by each hospital and commonly was done after starting work so put them to contaminate before vaccination.</td>
</tr>
<tr>
<td>Information reported by government (2012–2013)</td>
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<tr>
<td>4.6 There is a national policy on injection safety in health-care settings, which recommends single-use syringes for therapeutic injections. Single-use or auto-disable syringes, needles and cannulas are always available in all health-care facilities.</td>
<td>Up to now we used disposable syringe and needle. The cannula is reused.</td>
</tr>
<tr>
<td>4.8 There is a national infection control policy for blood banks. All donated blood units (including family donations) and blood products nationwide are screened for hepatitis B and hepatitis C.</td>
<td>We have had a national policy for screening for more than 20 years.</td>
</tr>
<tr>
<td>5.1 Health professionals obtain the skills and competencies required to effectively care for people with viral hepatitis through schools for health professionals (pre-service education), on-the-job training and technical seminars. There are national clinical guidelines for the management of viral hepatitis, which include recommendations for cases with HIV coinfection.</td>
<td>They did not obtain the skills or knowledge. We have only guidelines from liver society of Thailand.</td>
</tr>
<tr>
<td>5.2 The government has national policies relating to screening and referral to care for hepatitis B, but not for hepatitis C.</td>
<td>They do not have this policy.</td>
</tr>
<tr>
<td>5.3 People testing for both hepatitis B and hepatitis C register by name; the names are kept confidential within the system. Hepatitis B and hepatitis C tests are not free of charge for all individuals, but they are for pregnant women, blood donors and civil servants. Hepatitis C tests are free of charge for blood donors. Hepatitis B and hepatitis C tests are compulsory for blood donors.</td>
<td>The government does not have the data for these patients and the screening was free of charge for few persons and hepatitis B and hepatitis C are screened free for blood donors.</td>
</tr>
<tr>
<td>5.4 Publicly funded treatment is available for hepatitis B and hepatitis C. Patients under the universal coverage scheme are eligible. However, only lamivudine and tenofovir are included in the universal coverage package for hepatitis B, and major drugs for treating hepatitis C are not included. The amount spent by the government on publicly funded treatment for hepatitis B and hepatitis C is not known.</td>
<td>Up to now lamivudine and tenofovir are the only essential drugs for chronic hepatitis B treatment and chronic hepatitis C treatment was immediately available in all genotypes and HIV coinfection HCV. The criteria are active HCV infection with significant fibrosis.</td>
</tr>
</tbody>
</table>
Statement from the Liver Care Foundation regarding key hepatitis policy issues in Thailand:

According to our work about five years ago we gave the education for awareness of chronic hepatitis infection in each province of Northeast Thailand we found that they have high prevalence rate of hepatitis B and hepatitis C infection. The average HBV was 8% and HCV was 4% so we are faced with high rates of complications such as cirrhosis and liver cancer average 1-2:500 in each event of tour. Our plan in next year will be screen, give the education, find the new case, prevention in the family and assess the treatment in this area that cover the people more than 22.5 million. Our problem was we lack the funds and implement from the government. So our plan will do as much as our fund we can.

Information reported by government (2012–2013)

5.5 The following drugs for treating hepatitis B are on the national essential medicines list: lamivudine and tenofovir. No drug for treating hepatitis C is on the national essential medicines list.

Civil society respondent comments (2014)

Drugs for HCV treatment in all genotypes and coinfection HIV&HCV is immediately available in soon.

We have not both of medical personnel and laboratory test for evaluation especially if we have severe outbreak.
Statement from the Thai Association for the Study of the Liver regarding key hepatitis policy issues in Thailand:

In Thailand, we are currently funding treatment of chronic hepatitis C genotypes 2 and 3. However, only 900 patients are treated in the first year as compared to our estimation of 2,000. This emphasises the need for an awareness campaign. In 2015 the treatment will extend to all genotypes and HIV/hepatitis C co-infection as well. We really do need a good awareness programme throughout the next few years to reach patients who need the treatment. For chronic hepatitis B, there is no good policy yet, and it may come out rather late. So we need both awareness and the establishment of a national policy.

Survey comments from the Thai Association for the Study of the Liver:

- To our knowledge, this information is accurate:
  - 3.3 Liver cancer cases and cases with HIV/hepatitis coinfection are registered nationally. The government publishes hepatitis disease reports weekly and annually.
  - 3.5 There is no national public health research agenda for viral hepatitis. Viral hepatitis serosurveys are not conducted regularly. The most recent serosurvey, which targeted the general population, was carried out in 2004.

- To our knowledge, this information is not accurate:
  - 3.1 There is routine surveillance for viral hepatitis. There is a national surveillance system for the following types of acute hepatitis: A, B, C, D and E, but not for any type of chronic hepatitis.

- The government information was thought to be accurate for 84.0% of items.
  - Survey points marked “accurate”: 1.1, 1.2, 1.3, 2.1, 2.2, 3.3, 3.4, 3.5, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, 4.10, 5.1, 5.2 and 5.3.

- The government information was thought to not be accurate for 12.0% of items.
  - Survey points marked “not accurate”: 3.1, 5.2 and 5.5.

- The respondent took no position on the government information for 4.0% of items.
  - Survey points marked “take no position”: 3.2.