Canadian Coalition of Organizations Responding to Hepatitis B and C

About the ASKS Report Card Project - 2011 Hepatitis Strategy Report Card (July 27, 2011)

Introduction:

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

1. Promotes prevention of hepatitis B and C through expanded education, immunization and harm reduction programs all across Canada.

2. Improves access to comprehensive care and treatment programs in all areas of the country.

3. Increases knowledge and innovation through interdisciplinary research and surveillance to reduce the burden of hepatitis B and C on Canadians.

4. Creates awareness about risk factors, stigma and the need for testing among the general population and at-risk groups.

5. Builds capacity through training and recruitment of qualified health professionals.

6. Supports communities and community-based groups in developing, delivering and evaluating peer-driven and focused initiatives.

As a way to obtain a snapshot of the state of the nation with respect to these 6 ASKS, the Coalition has prepared a report card which identifies what is being successfully achieved as well as gaps that must be addressed and uses this information to develop a grade reflecting the current performance of the Canadian federal, provincial and territorial governments.

Definitions:

Expectation: What do we want? What would be an ideal (but realistic and achievable) situation?

Measurement: Examples of the sort of data and measurements needed to grade compliance with an Expectation.

Current Practice (specific to provincial, territorial and federal activities): What is the current practice or situation in this province/territory and federally, if any?

Comments**:** Comments, recommendations or items to note about an issue. Comments address the difference between an expectation and the current practices.

Grading: Grades take into account expectations and current practices across the country. The following grading scale is used:

A = Excellent performance; no criticism
B = Very good performance; room for improvement
C = Room for considerable improvement
D = Not very good performance
F = Serious issues exist

ASK 1: Prevention of hepatitis B and C through expanded education, immunization and harm reduction programs					Current Practice							Current Practice						Current Practice
Issue	**Expectation**	**Measurement**	**Comment**	**Grade**	**Alberta**	**British Columbia**	**Manitoba**	**NFLD**	**New Brunswick**	**NWT**	**Nova Scotia**	**Nunavut**	**Ontario**	**PEI**	**Quebec**	**Sask**	**Yukon**	**Federal**
1a) Universal neonatal HBV vaccination	Every infant born in Canada is offered free vaccination against HAV and HBV.	Are HAV and HBV vaccines offered? What percentage of infants born are vaccinated?	HBV vaccines programs are supposed to be publicly funded across Canada which is not the case in all provinces as some Canadians must pay and others do not have to. Greater consistency is needed both in terms of availability for all children and public coverage.	C-	No universal neonatal HBV vaccination program. Universal vaccination for adolescents or preadolescents.	HBV vaccine is given for free as part of routine immunizations to infants and to children who are in Grade 6 who have not been given the vaccine before. In 2008, 82.7% of children in BC were up-to-date for age (2 years old).	No universal neonatal HBV vaccination program. Universal vaccination for adolescents or preadolescents.	No universal neonatal HBV vaccination program. Universal vaccination for adolescents or pre-adolescents.	Yes: > 90% of newborns receive the HBV vaccine.	No information readily available.	HAV and HBV vaccinations offered to children in Grade 7.	No information readily available.	Hepatitis B is a publicly-funded immunization for children in Grade 7 and for people who meet the high risk eligibility criteria.	No information readily available.	Hepatitis A and B vaccines are offered to children in Grade 4. This includes youth in Aboriginal communities.	Hepatitis B vaccine is a publicly-funded immunization for children in Grade 6.	Information not available.	Publicly-funded HBV vaccination programs are available in all provinces and territories. The age at which vaccinations are offered varies from region to region.
	All pregnant women are offered screening for HBV and HCV and counseled on the benefits of prenatal detection, especially for HBV.	Are pregnant women routinely sreened for HBV and HCV? Are pregnant women counseled of the benefits of prenatal detection?	It is good news that women can be screened/are offered screening about anywhere in Canada. Screening should be offered in a proactive fashion and better counselling services should be offered for those in need.	B+	Yes, for HBV.	Yes, for HBV.	Yes, for HBV.	Information not available.	Yes, for HBV.	No information readily available.	Yes, for HBV.	No information readily available.	Yes, for HBV.	No information readily available.	Women can request screening / screening is done if the mother is at risk.	Yes, for HBV.	Information not available.	PHAC recommends that all pregnant women be routinely screened for HBV. Nothing noted about counseling. PHAC does not recommend pregnant women be routinely screened for HCV.
	Provinces/territories have in place a process for offering and encouraging babies born to HBV+ mothers to receive medical interventions to prevent vertical transmission.	What percentage of babies were born HBV-positive last year? Are infants born to HBV+ women immunized at birth?	In general, the standard to prevent HBV vertical transmission is good across Canada.	B	Infants born to HBV+ women are immunized at birth.	Infants born to HBV+ women are immunized at birth.	Infants born to HBV+ women are immunized at birth.	Information not available.	Infants born to HBV+ women are immunized at birth.	No information readily available.	Infants born to HBV+ women are immunized at birth.	No information readily available.	Infants born to HBV+ women are immunized at birth.	No information readily available.	Infants born to HBV+ women are immunized at birth.	Infants born to HBV+ women are immunized at birth. Hepatitis B is at low prevalence in SK and there are only sporadic births to Hep B positive mothers.	Information not available.	PHAC recommends infants born to HBV positive mothers receive the appropriate dose of HBV vaccine within 12 hours of birth and one at one month of age. The third needle is given at six months of age. Immune globulin is also given at birth.
1b) Catch-up vaccination programs	Program is in place which identifies, notifies, and offers vaccinations to individuals not previously vaccinated.	Are catch up vaccination programs in place for: (a) school aged children; (b) people who use drugs; (c) newcomers to Canada; (d) Aboriginal communities; and (e) correctional institutions?	Lack of consistency nationally. HAV and HBV catch-up vaccinations should be offered to all populations at no cost.	C-	Information not available.	In general these services are available.	High risk individuals are eligible for the HBV vaccine at no cost.	Information not available.	a) Grade 4 catch-up program; b) No; c) Yes, publicly funded for children born after 1986; d) Same as (c); e) Same as (c).	No information readily available.	HCV-positive people received HAV & HBV vaccine for free. Corrections and Immigrant both offer the vaccines.	No information readily available.	HBV vaccine is a publicly funded immunization for people who meet the high risk eligibility criteria.	No information readily available.	Catch-up programs available for children in Grade 4 and for free at local community service centers.	HBV vaccine is offered to individuals at increased risk through targeted immunization programs. This includes: Children in a grade lower than Grade 6 whose families have immigrated to Canada from regions of intermediate and high HBV prevalence, people who inject drugs and their contacts, and transplant recipients.	Information not available.	PHAC recommends universal vaccination for HBV; schedule varies from region to region. PHAC recommends HBV specifically for those at risk (e.g. health care workers, people who use drugs, newcomers to Canada). PHAC recommends pre-exposure prophylaxis for individuals at risk of HAV infection or at risk of greater severity of HAV infection. The combined HAV/HBV vaccine is recommended to children scheduled for HBV vaccine who have an indication for HAV and for groups at risk of either hepatitis.

ASK 1: Prevention of hepatitis B and C through expanded education, immunization and harm reduction programs					Current Practice							Current Practice						Current Practice
Issue	**Expectation**	**Measurement**	**Comment**	**Grade**	**Alberta**	**British Columbia**	**Manitoba**	**NFLD**	**New Brunswick**	**NWT**	**Nova Scotia**	**Nunavut**	**Ontario**	**PEI**	**Quebec**	**Sask**	**Yukon**	**Federal**
1c) Prevention of HCV and HBV infections among at-risk populations	Accessible and population-appropriate harm reduction programs are in place in all correctional institutions.	Do all correctional institutions have needle exchange programs? Describe harm reduction services.	This is an opportunity to treat, prevent and educate a very high-risk population in relation to viral hepatitis and other infectious diseases, as well as drug-treatment strategies including methadone. No consistency from one institution to another either federally or provincially. No needle exchanges in prisons. Condoms, bleach and other harm measures not always readily available as they should be. It can be difficult for inmates to access a doctor or a nurse. Consequently, HIV, HCV and HBV infection rates remain quite high in the prison system despite being preventable infections.	F	Alberta is increasing access to harm reduction in prisons including methadone maintenance, condoms and bleach.	Condoms and bleach provided but availability varies depending on the type of prison.	Primary/secondary/tertiary prevention efforts (including testing) are an integral part of the overall STBBI prevention program targeted at many key populations including corrections. STI Nurses in Corrections provide education on sexually transmitted and blood-borne infections (STBBI). There are STI public health nurses in corrections in 8 of the 9 provincial institutions.	Information not available.	Continuance of methadone maintenance therapy (inmates can not start methadone therapy in prison). Some prisons have addiction and mental health services. Condoms and bleach available.	No information readily available.	No needle exchange programs provided.	No information readily available.	Methadone maintenance is continued for those who initiate outside of a correctional institution but it is difficult to begin treatment in a correctional institution. Condoms and bleach are available.	No information readily available.	No needle exchanges in prisons. HBV vaccine and continuation of methadone maintenance therapy initiated prior to prison are available.	Methadone, condoms (on request), dental dams and addiction and mental health services available in all prisons. Regina Correction Centre has an in-house 28 day addiction treatment unit located within the facility. Youth facilities have sessions on reducing risk. Healthcare orientation sessions have commenced at Pine Grove Correctional Center as part of the HIV strategy and these will be phased into other centres.	Condoms available at Whitehorse Correctional Centre.	No prison-based needle exchange programs exist in federal prisons. There are prevention programs around STIs, blood borne pathogens and substance use and materials distributed include bleach, condoms and prevention kits. However, there is no consistency from one institution to the next. Federal facilities also have a special mental health detention unit. Awareness and education programs are in place.
	Up-to-date infection control policies are in place and enforced in all healthcare provider settings, body art and beauty industry facilities, and at all correctional facilities.	Do all healthcare settings, correctional facilities and Personal Services Settings (PSS) or Establishments (PSE) such as body art and beauty facilities have up-to-date and enforced infection control policies?	Health care settings and correctional facilities have up-to-date and enforced infection control policies. Personal Services Settings (body art, beauty, acupuncturist facilities) need to be regulated across the nation and control / enforcement measures put into place. In a few locations the PSS industry is creating training and testing for practitioners and some cities are working to develop more stringent control / enforcement measures as well as public education.	B-	Health care settings: "Guidelines for Standard Practice & Isolation Precautions in Community Based Health Services"(2005) and "Acute Care Infection Prevention & Control (IP&C) Manual" (2005) to promote a standard of infection control across the continuum of care in Alberta. Body art facilities: From 2002.	All have policies. Basic PSS regulations are part of BC's (1983) Public Health Act. PSS guidelinles available are: PSEs (2000), Ear and Body Piercing (1999), and Tattooing (1999). The degree to which PSS policies are updated, used and enforced is inconsistent and varies widely among municipalities and between urban and rural settings. Cosmetology industry has voluntarily developed an online course (www.ciabc.net) to update practitioners on best practices.	Body art facilities: Winnipeg has a comprehensive 'Body Modification' bylaw specific to tattooing and body piercing services.	Information not available.	Body art facilities: Body art facilities are not regulated so it is left to each facility owner/artists to self-regulate.	No information readily available.	Health care settings: Infection control policy – CDHA. Body art facilities: No infection control through government – each place has own control practices (not a regulated industry). Correctional facilities: Polices are in place in prisons.	No information readily available.	Health care settings: "Routine Practices and Additional Precautions for all Health Care Settings" 2010. Personal Service Settings: Provincial regulations via "Infection Prevention and Control Best Practices for Personal Service Settings" 2009. Health boards are mandated to inspect at least once/year (more if there are complaints).	No information readily available.	Health care settings: Have up-to-date and enforced infection control policies. Body art facilities: There is no standard infection control policy. Correctional facilities: Same as health care settings.	Personal Service Settings: Health Hazard Regulations require personal service facilities to operate in a sanitary manner and in a manner that will not facilitate the transmission of communicable disease. Correctional facilities: Responsible for providing inmates with information about awareness and prevention of communicable diseases and have policies outlining these.	Body art and beauty facilities lack up-to-date infection control policies.	Health care settings: Universal precautions as a minimum standard of practice in all health care settings. Recommendations also outline steps to take when / if a health care professional is infected or becomes infected. Body art facilities: 1999 document from Health Canada outlines infection control practices for body art (piercing and tattooing); nothing specific to hepatitis C. Beauty industry facilities: No information found. Correctional facilities: Provide household bleach but not clean needles.

ASK 2: Improve access to treatment, care and prevention programs					Current Practice						Current Practice				Current Practice				
Issue	**Expectation**	**Measurement**	**Comment**	**Grade**	**Alberta**	**British Columbia**	**Manitoba**	**NFLD**	**New Brunswick**	**NWT**	**Nova Scotia**	**Nunavut**	**Ontario**	**PEI**	**Quebec**	**Sask**	**Yukon**	**Federal**
2a) Access to healthcare	All HBV+ and HCV+ individuals are given equal access to treatments, specialty care and liver transplants.	Is HCV and HBV treatment available in all communities including correctional facilities?	HCV and HBV treatment generally available but not uniformly in all Canadian regions or in all correctional settings. More specialists are needed and waiting time needs to be reduced. Individuals perceived as at risk of re-infection need to be treated along with supports and services that help ensure preventing re-infection. Cost for treatment disparities need to be reduced or eliminated.	C	Alberta Health & Wellness runs Hepatitis Clinics and Hepatitis Support Clinics. HCV treatment is available through comprehensive clinics in Calgary, Red Deer, Alberta and Grand Prairie. Generally not available in provincial correctional facilities. HBV treatment is more easily accessible in communities including in correctional facilities.	Treatment not available in all communities. In provincial correctional facilities, treatment is only available for those who are on treatment when they enter.	Information not available.	Information not available.	Treatment is not available in all communities, only where there is a specialist. No treatment access in the provincial correctional settings.	No information readily available.	Treatment is not available in all communities. It is mainly available in Halifax and Sydney. Treatment is offered in correctional facilities.	No information readily available.	Treatment is available in many but not all communities. The Ontario Hepatitis Nursing Program trains and hires nurses and other members of multidisciplinary team to provide support to people across Ontario in following treatment plans.	No information readily available.	Treatment is available in provincial correctional institutions. It is difficult for prisoners to continue treatment when they leave prison.	Regina Correctional Centre has implemented an HCV screening and treatment program that has seen over 30 offenders during incarceration over the past year and followed up with them upon release through an HCV community clinic nurse. This experience will be used to develop policy and clinical practice guidelines for all adult facilities.	Continuation of HCV treatment is available at Whitehorse Correctional Centre but not starting of treatment	CSC reports HBV and HCV treatment is available in correctional institutions but it is based on internal screening. 123 individuals were treated for HCV in 2001, up from 91 in 2000.
		How many people were treated for hepatitis C/B last year?	Information is not effectively monitored in many communities across the country. Still, too many people are undiagnosed and need to be identified and treated to help address the epidemic. Screening based on age in addition to risk needs to be enforced. Too few patients are treated, hampering prevention and causing undue suffering, acute and chronic care and transplant costs.	C-	Information not available.	Less than 1,000 treated for HCV last year (less than 2%). Information not available HBV.	Information not available.	Information not available.	Information not available.	No information readily available.	About 20% of people with HCV are treated. People with HBV who meet the criteria are treated.	No information readily available.	Information not available.	No information readily available.	Information not available.	Information not available.	Information not available.	Information not available.
		Are liver transplants available to individuals coinfected with HIV?	While liver transplants should be available in theory, numbers of transplants are too low in practice. This is particularly true for HIV and HCV co-infected persons. Poor availability of livers is a barrier to more transplants and needs to be addressed.	C	Information not available.	Liver transplants are available but numbers are small. Guidelines are emerging.	Information not available.	Information not available.	Information not available.	No information readily available.	Generally yes if people meet cardiovascular and respiratory health requirements.	No information readily available.	Yes, but only recently. A model for donation and transplant services is being explored.	No information readily available.	Yes, but only recently.	Information not available.	Yukoners access transplant-related services outside of Yukon.	Transplants are a provincial/ territorial responsibilty.
		What is the average wait time to see a specialist	Wait time varies too much from region to region. More consistently shorter wait times are needed regardless of where one lives in Canada.	C	Varies. Wait time is 10 days in Calgary Health Region.	In Victoria the average wait is 4-6 months if referred by family doctor. In Kelowna the wait time to get in to the HCV Clinic is about 1 year. Priority cases get preference.	Information not available.	Information not available.	6 months - 1 year.	No information readily available.	3-5 months.	No information readily available.	Wait times not tracked for this specialty.	No information readily available.	Wait times vary between regions. In Montreal, it is between 2 weeks and a year. In other regions it is longer.	Wait times not tracked for this specialty.	Wait times unknown. Specialist comes to Yukon every 10 weeks.	In 2008, Health Canada reported that Canadians wait on average 4.3 weeks to see a specialist for a new illness or condition.
	HBV and HCV management guidelines are reviewed regularly to ensure they conform to medical standards, best practices and advances.	How often are HBV and HCV management guidelines reviewed? What is the date of the latest publication?	Management guidelines generally up-to-date. More coherent national guidelines are needed. There are inconsistencies from province to province, including regarding support for complex health needs.	C	Management guidelines updated in January 2011 for HBV and HCV.	Last clinical guideline review in 2003. Last diagnostic guideline review in 2011.	Last guidelines dated 2008 (HBV) and 2009 (HCV).	Information not available.	Changes to the questionnaire in 2010.	No information readily available.	Updated annually at a conference attended by hepatologists, nurses and healthcare stakeholders.	No information readily available.	2007 Canadian Consensus Guidelines.	No information readily available.	5 regions of Quebec have management guidelines for people living with HCV or HBV. Most recent: 2009.	Information not available.	Information not available.	2007 Canada Consensus Guidelines (HBV and HCV). 2002 Canadian Nurses Association's *Hep C: A Nursing Guide* .
2b) Drug coverage	HBV and HCV treatment including anemia drugs and recognized alternative therapies, are covered under provincial drug plans or programs.	Are HBV and HCV treatments (including anemia drugs and recognized alternative treatments) covered under provincial drugs plans? What treatments are covered?	Drug coverage is available everywhere but policies are inconsistent across the nation. A more uniform and universal drug coverage program is needed. Some policies are outdated, such as not re-treating patients who previously were unsuccessful with HCV treatment.	C	HBV drugs, peg-interferon, ribavirin and epoetin are included in the Drug Benefit List meaning they can be covered under Alberta Blue Cross. People who receive Income Support automatically receive health benefits and coverage for prescription drugs.	HBV drugs are covered in a limited fashion. Only HCV drugs peg-interferon and ribavirin are covered. Anemia drugs are not covered.	Pharmacare coverage with income-adjusted deductibles. Hepatitis drugs are eligible for coverage under the Exception Drug Status Program (EDS).	HBV and HCV drugs are covered under the Newfoundland and Labrador Prescription Drug Program.	HBV and HCV drugs are covered under the New Brunswick Prescription Drug Program.	No information readily available.	HBV and HCV drugs are covered under provincial Pharmacare. Colony stimulating factors and erythropoietin are only available through third party payers.	No information readily available.	HBV and HCV drugs as well as epoeitin are covered under the Exceptional Access Program.	No information readily available.	HBV and HCV drugs are covered under RAMQ.	HBV and HCV drugs are covered under Saskatchewan Drug Plan programs.	HBV and HCV are covered under territorial Pharmacare or Chronic Disease Program.	HBV and HCV treatments may be covered under the following federal programs: First Nations and Inuit Health, Interim Federal Health Program, Correctional Services of Canada (Federal inmates), and Canadian Forces Health Services.
		What are the criteria for access/coverage?	See above.	C	Require special authorization. Information must include the patient's pre-treatment anti-HCV and serum HCV RNA (by PCR) status. Information is also required regarding whether liver enzymes (ALT/AST) are elevated, or the results of liver biopsy.	Require special authorization. ALT 1.5x higher on two consecutive occasions. Pharmacare doesn't cover treatment if liver is decompensated, or if there is active alcohol abuse, illicit IV drug &/or intranasal cocaine use.	Require approval by EDS Program. Biopsy and ALT scores and viral load required.	Require special authorization.	Require special authorization.	No information readily available.	Require special authorization.	No information readily available.	Require special authorization. Criteria can include biopsy scores, viral load and/or ALT scores (depending on the treatment).	No information readily available.	Require special authorization .	Require special authorization.	Require special authorization .	Requrie special authorization.

ASK 2: Improve access to treatment, care and prevention programs					Current Practice													
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2c) Organ Donation	Increase the number of available organs from cadaveric and live donors	Is the number of available organs for transplantation increasing, decreasing or staying the same?	Poor availability of livers is a barrier to more transplants and needs to be addressed. Infected livers should be considered as a life saving measure for recipients who are willing to receive such livers. Live liver transplant should be more widely promoted.	C	Staying the same over the past 10 years.	Marginal increases.	Staying the same over the past few years.	Information not available.	Very low organ donation numbers.	No information readily available.	Staying the same.	No information readily available.	Increasing over the past 10 years.	No information readily available.	Information not available.	Staying the same.	Yukoners access transplant-related services outside of Yukon.	426 liver transplants in 2010.
		Describe any campaigns undertaken to promote organ donation in the past 2-3 years	Generally, two campaigns a year but federal government needs to take greater leadership in this area.	B	Human Organ Procurement and Exchange coordinates ongoing donations, allocation, recovery, education and promotion campaigns.	Information not available.	Ministry funds a Living Organ Donor Reimbursement Program. Online registry and public awareness campaign in development.	Information not available.	Service NB does some promotion on Medicare cards. There is an organ donor week/day.	No information readily available.	Active and ongoing organ donor awareness campaigns.	No information readily available.	Trillium Gift of Life Network is very active in promoting donations. The 2011 campaign is called Life 1500 and there are many community events including religious and cultural perspectives.	No information readily available.	There are at least two campaigns every year to promote organ donation.	In 2011, April was declared organ and tissue donation awareness month. A public awareness campaign was also launched (www.isanorgandonor.com). Ministry funds a Living Organ Donor Expense Reimbursement Program to reduce potential barrier to making a living organ donation.	Information not available.	Canadian Blood Services is currently engaged in creating a national organ donation procurement program. In 2001 and 2002, Health Canada implemented public awareness campaigns but there have been none since.
2d) Drug research and approvals	Government approval processes for clinical trials take into account different groups of populations affected by HCV and HBV	How many clinical trials were conducted last year? How many people were enrolled?	Wider circulation of information and how to access clinical trials needed and encouragement and supports of university and industry research in this area from governments. Clinical trials in rural centres are needed.	C	Information not available.	Privately-run clinics regularly offer research trials in Victoria (Percuro) and Vancouver (Liver and Intestinal Research - LAIR Centre). These trials are offered to populations of varied ages and lifestyles.	Information not available.	Information not available.	Information not available.	No information readily available.	3 trials, no candidates to date.	No information readily available.	Information not available.	No information readily available.	Of those infected, some are involved in research trials.	Information not available.	Information not available.	Information not available.
	Drug approval process is timely, efficient and safe.	Are drugs approved in coordination with other provinces, the federal government and /or other countries?	Drug approval process is good but more consistency in coverage and accesss among provinces would be desirable. Sometimes drugs can receive a fast track review by Health Canada. In general, once approved by Health Canada provinces can be very slow to review them and approve them for their own formulary. Each province makes its own decisions, leading to inequities across Canada. One national drug plan would be desirable.	B	Follows Common Drug Review recommendations.	Drug review process takes federal CDR into account, but additional BC considerations include existing coverage of similar drugs in BC, provincial budget, and input from BC citizens. Of DBC's 12 members, 3 are from the public. DBC process includes input from patients, caregivers, and patient groups (since October, 2010).	Follows Common Drug Review recommendations.	Follows Common Drug Review recommendations.	Follows Common Drug Review recommendations.	No information readily available.	Follows Common Drug Review recommendations.	No information readily available.	Drug review process takes federal CDR into account, but additional Ontario considerations include provincial budget and input from its citizens. Two of CED's members are Patient Representatives. CED process includes input from registered patient groups (since April, 2010).	No information readily available.	Quebec has its own drug review process.	Follows Common Drug Review recommendations.	Follows Common Drug Review recommendations.	Drug coverage protocols are reviewed/updated through the drug review process as information becomes available (e.g. new protocols for treatment, or new drugs become available that may change the listing of current drugs). Health Canada assesses safety of new drugs, and issues a Notice of Compliance (NOC). Then, the Common Drug Review (CDR) process takes into consideration both clinical- and cost-effectivenes of the new non-cancer drugs to issue evidence-based recommendations. CDR process includes input from patient groups (since May, 2010).

ASK 3: Increase knowledge and innovation through interdisciplinary research and surveillance to reduce the burden of HBV and HCV on Canadian population and services					Current Practice													Current Practice	Current Practice
Issue	**Expectation**	**Measurement**	**Comment**	**Grade**	**Alberta**	**British Columbia**	**Manitoba**	**NFLD**	**New Brunswick**	**NWT**	**Nova Scotia**	**Nunavut**	**Ontario**	**PEI**	**Quebec**	**Sask**	**Yukon**	**Federal**
3a) Surveillance	Surveillance data and updates are published in a timely and accessible manner.	Is surveillance data available to the public? How or in what ways? Last date published?	Some surveillance data is accessible online however some of it is not very recent (2-3 years old).	B	Surveillance data is available online through reporting. Last date: July 2008.	Annual update available online at BCCDC website. Last report: 2009.	The Monthly Communicable Disease Report (posted on Mb Health website) includes Hepatitis B & C case counts. Last posted: April 2011.	Information not available.	Depending on the issue, "Disease Watch" will give out stats on certain diseases in NB, including viral hepatitis.	No information readily available.	Available online. Last published " 2009	No information readily available.	Surveillance data is available online. Last published: 2008	No information readily available.	Surveillance data is accessible online however it's not very recent (2-3 years old).	Aggregate data is available to the public upon request but has not been formally published for public.	Surveillance data published from Yukon CDC. Accessible upon request.	Surveillance data available on the PHAC website; last surveillance report published March 2011.
	HBV and HCV-related hepatocellular carcinoma (HCC) morbidity and mortality data are monitored on an ongoing basis.	Are HCC morbidity and mortality data monitored? How often?	A coordinated central registry would be desirable. If a person had HBV or HCV, this should be recorded, available and searchable, regardless of cause of death.	A-	Alberta Cancer Registry	Yes, annually.	Cancer Registry	Information not available.	Cancer Registry	No information readily available.	NS Cancer Registry	No information readily available.	Ontario Cancer Registry	No information readily available.	Cancer registry	Monitoring is annual. HBV and HCV-related HCC is monitored by the Saskatchewan Cancer Agency.	Cancer Registry	1,850 new cases of HCC in 2010, 750 deaths in 2010. Monitored by PHAC annually. All cancers are monitored by provincial/territorial cancer registries and contributed to the Canadian Cancer Statisics.
	Incidence of HBV and HCV is monitored through routine surveillance, enhanced surveillance and population-based surveys.	How is the incidence of HBV and HCV monitored?	HBV should be a reportable disease as is HCV and reported to Health Canada. Reporting parameters should be expanded; the details required are currently limited so important indicators such as genotype and access to treatment are not consistently monitored. There should be systematic HIV/HBV/HCV testing at annual check-ups particularly for those at risk either because of lifestyle or age group (baby boomers) who may have been infected and do not know.	C	Through Notifiable Disease Reporting System.	Clinical and confirmed case reports are collected from the health regions in British Columbia through the integrated Public Health Information System (iPHIS). Starting in 2005, only confirmed cases are described in the main report, in keeping with BC reporting to the Public Health Agency of Canada.	Routine surveillance based on lab-reported cases and follow-up case investigation form completion with ethnicity & risk info reported.	Information not available.	By law, HBV and HCV are reported diseases to Public Health. Follow-up is done on all newly identified cases.	No information readily available.	Through Public Health	No information readily available.	Cases are collected through reporting.	No information readily available.	Based on reporting from physicians.	Passive surveillance system based on cases reported under the Public Health Act.	Information not available.	Health Canada's National Notifiable Disease Reporting System regularly reports on diseases under national surveillance; in 1998 an enhanced sentinel site surveillance system for acute hepatitis B and C.
	Compulsory reporting is required from all health authorities.	Is HCV reporting required from all health authorities?	HBV should be subject to compulsory reporting as is HCV.	B	Yes	Yes	Yes	Yes	Yes	No information readily available.	Yes	No information readily available.	Yes	No information readily available.	Yes	Yes	Yes	Routine case-by-case notification of confirmed HCV is required to the federal level by the *Public Health Act* . HBV is not required to be reported by all provinces, but it is recommended that confirmed and suspected cases of HBV be reported to the federal level.
	Surveillance data describes HBV and HCV in terms of a case definition which reflects acute, chronic and resolved infections.	Is there a case definition? Is the case definition used in surveillance data?	National acute and chronic definitions are used, but a case definition for resolved infection is required.	B-	National acute and chronic definitions are used.	National acute and chronic definitions are used.	National acute and chronic definitions are used.	National acute and chronic definitions are used.	National acute and chronic definitions are used.	No information readily available.	National acute and chronic definitions are used.	No information readily available.	National acute and chronic definitions are used.	No information readily available.	National acute and chronic definitions are used.	National acute and chronic definitions are used.	National acute and chronic definitions are used.	HCV Confirmed: Detection of anti-hepatitis C antibodies (anti-HCV) and should be confirmed by a second manufacturer's EIA, immunoblot or nucleic acid (e.g., PCR) for HCV-RNA. OR Detection of hepatitis C virus RNA (HCV-RNA). HBV Confirmed Chronic Carrier: Laboratory confirmation of infection: Persistence of confirmed Hepatitis B surface antigen (HBsAg) positivity for more than 6 months in the context of a compatible clinical history of probable exposure OR HBsAg positive and immunoglobulin M antibody to hepatitis B core antigen (anti-HBc IgM) negative or total antibody to Hepatitis B core antigen (anti-HBc total) positive and HBV-DNA positive AND HBsAg negative and antibody to Hepatitis B Surface Antigen (anti-HBs) negative. HBV Probable Chronic Carrier: Laboratory confirmation of infection: HBsAg positive in the context of compatible clinical history and/or appropriate epidemiologic exposure, e.g., self reported past history of Hepatitis B, born in Hepatitis B endemic country .
3b) Research funding	Increase funding for HBV and HCV research.	Is there funding available for HBV and HCV research? How much? Has available funding changed?	Insufficient funding both federally and provincially/territorially (for non-pharmaceutical research topics and areas). Greater overall coordination needed nationally. Lack of transparency as to how federal funds are used. More psycho-social focused research funding needed, including community based research.	C	No provincial funding for research, however, the government has been very supportive of innovation in hepatitis care delivery models.	Yes there is funding but amount varies. Limited increase in funding over the last few decades.	Information not available.	Information not available.	Information not available.	No information readily available.	AIRN (Atlantic Interdisciplinary Research Network) and Capital District Health Authority both have limited research funds.	No information readily available.	MOHLTC (ON) funds some research via the Ontario HIV Treatment Network (OHTN), but there is no similar research funding body for hepatitis.	No information readily available.	The Ministry of Health Program was renewed for another five years. They fund organizations to do Hep C work.	No targeted research funding identified by the Ministry of Health at this time.	No research funding available.	Hepatitis C Prevention, Support and Research Program (PHAC): Initiated in 1999 for 5 years, renewed for three more years in 2004, renewed for annual funding in 2008 ($10.65 million annually). CIHR funds the National Canadian Research Training Program in Hepatitis C and also supports hepatitis-related research through grants.
	Enhance knowledge exchange and dissemination of HBV and HCV research.	Are there knowledge exchange and dissemination funds available for HBV and HCV research? How are they used?	Need for a coordinated national knowledge dissemination and sharing mechanism with sufficient and reliable financial support from provincial, territorial and federal governments.	C	No provincial funding for research dissemination.	Some funds from multiple sources.	Information not available.	Information not available.	Information not available.	No information readily available.	AIRN (Atlantic Interdisciplinary Research Network) and Capital District Health Authority both have limited funds.	No information readily available.	Provincial funding for CATIE to act as a central information dissemination and sharing mechanism for Hep C.	No information readily available.	There are round tables held.	Information not available.	No knowledge exchange and dissemination funding available.	Funding through the Hepatitis C Prevention, Support and Research program requires a dissemination strategy. A 2009 report on the Hepatitis C program included a focus on knowledge synthesis and exchange. Some financial support for other organizations (such as CATIE) to disseminate and share research, however funding is not stable.

ASK 4: Create awareness about risk factors, stigma and the need for testing and treatment among the general population and at-risk populations					Current Practice						Current Practice				Current Practice			
Issue	**Expectation**	**Measurement**	**Comment**	**Grade**	**Alberta**	**British Columbia**	**Manitoba**	**NFLD**	**New Brunswick**	**NWT**	**Nova Scotia**	**Nunavut**	**Ontario**	**PEI**	**Quebec**	**Sask**	**Yukon**	**Federal**
(4a) Awareness around HBV and HCV diagnosis, stigma and risk.	Establish testing programs aimed at high-risk populations.	Are there testing programs targeted for: (a) people who use drugs; (b) Aboriginal communities; (c) youth; and (d) people in prison? What are they? Are there evaluations?	Testing is routinely offered in some settings (prisons, treatment centres) otherwise it is only on demand. Testing programs should include anonymous testing as for HIV and be offered through existing programs such as STI clinics. Reports on testing should inform a national prevention and treatment strategy.	C	Range of activities included in STI *and BBP Strategy and Action Plan 2011-2016* to reach high risk and under-reached populations.	In 2005, CSC introduced enhanced screening for bloodborne and sexually transmitted infections.	Information not available.	Information not available.	Testing is available at some needle exchange programs, methadone clinics and in correctional facilities.	No information readily available.	Routine testing in addiction services, correctional facilities, community-based programs and immigration services.	No information readily available.	The Ontario Hepatitis Nursing Program is mandated to work to increase testing among vulnerable and at-risk populations.	No information readily available.	There are testing programs in correctional facilities and drug treatment centres. Testing is free in aboriginal health centres.	Information not available.	Organizations like Blood Ties receive territorial and federal funding specifically to address HCV in at-risk populations. They promote education, prevention and decreasing stigma. Blood Ties works in all Yukon communities.	Hepatitis testing and counseling is available in federal prisons and testing increased by 4% from 2000 to 2001. No information on evaluation of testing programs.
	Create ongoing education campaigns aimed at the general public, medical community, and patients to de-stigmatize both diseases.	Are there education campaigns for raising awareness and decreasing stigma? What are they? Are there evaluations?	No concerted effort to do so nationally in a coordinated fashion. There are individual programs and organizations doing great work but with limited evaluations, often in isolation and with funding that is generally insufficient to support various initiatives. Campaigns need to be separated from HIV campaigns. Funding from federal government is inconsistent.	C	Range of activities included in *STI and BBP Strategy and Action Plan 2011-2016.*	Series of stigma publications on the BC CDC website. Non-profits, university and city govt. co-sponsored several public anti-stigma presentations in Victoria in 2010/2011. Vancouver, Victoria, Surrey, and several Interior towns hold regular WHD Liver/Health fairs and memorials for those who have died.	Information not available.	Information not available.	Some campaigns in the past through SIDA/AIDS Moncton and John Howard Society as well as provincial addictions and mental health services.	No information readily available.	Communities in Nova Scotia celebrate World Hepatitis Day, Liver Care Month, Hepatitis Awareness Month. Liver Care Month evaluations show positive responses.	No information readily available.	In 2007 the Ministry launched a province-wide public awareness campaign encouraging individuals at risk to talk to their doctors and get tested for hepatitis C. Included TV spots, posters, website, and self-assessment tools. Ministry also publishes a series of promotional campaign materials that includes the HBV vaccine. MOHLTC provides funding to other organizations to engage in Hep C work.	No information readily available.	Through organizations like Hépatites Ressources that provide information to this effect in schools, conferences for healthcare providers and through support programs for people living with HBV/HCV.	Information not available.	See above.	Information not available.
	Awareness programs about HBV and HCV risk factors aimed at youth and at-risk populations are developed and promoted.	Are there awareness programs about risk factors aimed at youth and at-risk populations? What are they? Were they evaluated? What were the results of the evaluations?	There are individual programs and organizations doing great work but with limited evaluations, often in isolation and with funding that is generally insufficient to support various initiatives.	C	Range of activities included in STI *and BBP Strategy and Action Plan 2011-2016.*	There are many ongoing awareness activities by CLF, HIV/AIDS and co-infection focused, and hepatitis-focused organizations. Limited evaluation has been done.	Information not available.	Information not available.	See above.	No information readily available.	Through organizations like Public Health and Phoenix Youth.	No information readily available.	See above.	No information readily available.	Through organizations like Hépatites Ressources that go into schools, treatment centers, prisons and work with street-outreach workers.	Information not available.	See above.	Information not available.
	Outreach programs and campaigns encouraging monitoring and treatment are regularly undertaken to reach HBV+/HCV+ diagnosed individuals who are asymptomatic, untreated or non-responders, including those in correctional facilities.	Are there outreach programs and campaigns that promote HBV and HCV as health priorities? What are they? Are there evaluations?	No concerted effort to do so nationally in a coordinated fashion. There are individual programs and organizations doing great work but with limited evaluations, often in isolation and with funding that is generally insufficient to support various initiatives.	C	Range of activities included in STI *and BBP Strategy and Action Plan 2011-2016.*	There are outreach activities, but limited evaluation is available.	Information not available.	Information not available.	See above.	No information readily available.	Through organizations like HepNS and the Canadian Liver Foundation.	No information readily available.	See above.	No information readily available.	Awareness is growing among physicians and their patients but support for these programs is limited.	Information not available.	See above.	Information not available.

ASK 5: Build capacity through training and recruitment of qualified healthcare professionals					Current Practice													
Issue	**Expectation**	**Measurement**	**Comment**	**Grade**	**Alberta**	**British Columbia**	**Manitoba**	**NFLD**	**New Brunswick**	**NWT**	**Nova Scotia**	**Nunavut**	**Ontario**	**PEI**	**Quebec**	**Sask**	**Yukon**	**Federal**
5a) Education and training for healthcare providers	Curriculum in HBV and HCV healthcare provider training is established and related continuing education programs are provided.	Are there HBV and HCV training and continuing education opportunities available for healthcare providers?	HBV and HCV training and continuing education are available to various levels of healthcare providers in a variety of formats. Training needs to be mandatory for emergency room staff and nurses. More efforts required to improve enrollment and uptake of knowledge.	B	Included in the *STI and BBP Strategy and Action Plan 2011-2016* .	Yes, in a variety of formats.	Yes, central focus or component of several programs run through the Continuing Medical Education (CME) Office at the University of Manitoba.	Inform-ation not avail-able.	Some opportunities for continuing education available.	No inform-ation readily avail-able.	Range of opportunities available through nursing programs.	No information readily available.	Yes, in a variety of formats. In 2007-2008 the Ontario Hepatitis Nursing Program developed training and recruitment components of a publicly-funded hepatitis nursing program.	No inform-ation readily avail-able.	Yes.	Yes, FNIHB provides training and continuing education once a year to health careproviders (nurses with the Saskatchewan Registered Nurses Association and nurses working in First Nations communities).	Blood Ties offers yearly HIV/HCV training to Aboriginal community health representatives with funding from PHAC.	N/A
5b) Recruitment and retention of skilled healthcare providers	Provide incentives to encourage doctors, nurses and allied healthcare professionals to specialize in areas related to HBV and HCV.	Are there any incentives provided to specialize in hepatology? If so, what kind?	National and provincial incentives seriously lacking for hepatologists.	D	No province-wide incentive specifically for hepatologists.	No province-wide incentive specifically for hepatologists.	No province-wide incentive specifically for hepatologists.	Inform-ation not avail-able.	Information not available.	No inform-ation readily avail-able.	No province-wide incentive specifically for hepatologists.	No information readily available.	No province-wide incentive specifically for hepatologists.	No inform-ation readily avail-able.	An incentive structure is in place in certain regions.	No province-wide incentive specifically for hepatologists.	No province-wide incentive specifically for hepatologists.	N/A
		Are the numbers of health care providers specializing in hepatology, gastroenterology and infectious diseases increasing, decreasing or staying the same?	Stable situation in general however need to plan ahead and do succession planning as large number of health professionals are poised to retire.	B	Numbers have increased over the past decade.	Numbers have increased over the past decade.	Numbers have remained stable.	Inform-ation not avail-able.	Information not available.	No inform-ation readily avail-able.	Information not available.	No information readily available.	Numbers have increased.	No inform-ation readily avail-able.	Information not available.	Number of ID specialists has stayed the same. Number of GI specialists has increased from an average of 9 (2005-2009) to 11 (2010).	N/A - specialists visit Yukon.	N/A
		How many specialists currently serve the population?	Current number of specialists meet the basic needs but as more patients surface, a larger number of specialists will be needed. Need to be proactive rather than reactive. Use specialists more specifically and train family physicians and nurses to manage most HBV and HCV care.	B	Varies. 7 hepatologists in Calgary, 8 in Edmonton.	Few hepatologists, so generally gastroenterologists and hepatology nurses are the specialists for HBV/HCV patients. In remote areas some GPs are becoming experts in treatment.	3 hepatologists, 10 gastroenterologists and 9 infectious disease specialists.	Inform-ation not avail-able.	Approximately 6-8 per area.	No inform-ation readily avail-able.	2 hepatologists and 3 nurse practitioners.	No information readily available.	Information not available.	No inform-ation readily avail-able.	Information not available.	11 gastroenerologists and 8 infectious disease specialists.	Specialist comes to Yukon every 10 weeks.	N/A

ASK 6: Support communities and community-based groups in developing, delivering and evaluating peer-driven and focused initiatives					Current Practice													
Issue	**Expectation**	**Measurement**	**Comment**	**Grade**	**Alberta**	**British Columbia**	**Manitoba**	**NFLD**	**New Brunswick**	**NWT**	**Nova Scotia**	**Nunavut**	**Ontario**	**PEI**	**Quebec**	**Sask**	**Yukon**	**Federal**
6a) Prevention and Education Programs	Stable funding ensures outreach programs (harm reduction and education) are accessible to at-risk communities through local frontline organizations.	Is there stable funding available for outreach programs? How much? What types of outreach programs are accessible to at risk populations?	Provincial funding has been relatively stable and supportive in some instances, but in others has been inadequate or non-existent. Federal funding has been inconsistent and delays in renewing funding agreements has been an ongoing problem putting at risk the very existence of many organizations. PHAC has not lived up to its ongoing funding promise made by the Minister of Health in 2008. Resources are still scarce and difficult to access. Strong resistance at the federal level to the concept of harm reduction.	F	Prevention and education funding opportunities are included in the *STI and BBP Strategy and Action Plan 2011-2016*; funding is not stable and funding structures have been undergoing change in recent years.	Funding is not consistent. Types of programs includes: testing, referrals and education for high risk populations. Funding is slightly more reliable for groups also targeting people who inject drugs and/or people co-infected with HIV/AIDS.	Funding to organizations such as the Manitoba Harm Reduction Network/595 Prevention Team, Nine Circles.	Inform-ation not avail-able.	2011 STI campaign in NB will encourage prevention and education programs through Public Health and with other community partners.	No inform-ation readily avail-able.	Annual funding made available through Ministry of Health and Wellness for a range of programs. No increase in funding within past 6 years.	No inform-ation readily available.	Funding is available from the MOHLTC Hepatitis C Secretariat for a range of programs and organizations.	No inform-ation readily avail-able.	Governmentt has renewed a 5- year funding program that provides funds to external organizations to engage in Hep C work.	Ongoing annualized provincial funding is provided to regional health authorities (RHAs) and community -based organizations specific to outreach for individuals with HIV/AIDS. There will also be new funding available to CBOs through an RFP process. Outreach programming is available in Regina, Saskatoon and Prince Albert and additional FTEs will be expanded to more communities.	Funding for needle exchange programs is stable. Funding for prevention /awareness programs for HCV is stable from the territorial government. Federal Hep C Strategy funding has been steadily decreasing over the past 5 years.	PHAC Hepatitis C program provides funding for developing, evaluation and capacity building of community-based programs, organizations and initiatives that serve people living with hepatitis C. $10.65 million annually for whole HCV program since 1998.
6b) Care and Support Programs	Organizations that provide care and support to individuals infected with and affected by hepatitis B and C are provided stable funding.	Is there stable funding available for support/care programs? How much? What process is involved to access funding? What types of support programs are accessible to at risk populations?	Same as above.	F	Alberta Health & Wellness runs Hepatitis Clinics, Hepatitis Support Clinics and Hepatitis Support Programs. Provincially-funded opportunities for organizations are also outlined in the *STI and BBP Strategy and Action Plan 2011-2016* .	Medical services are publicly reimbursed. There is a trend to integrated HCV, harm reduction and HIV prevention initiatives. There are also programs related to housing, health care, mental health in larger centers, fewer in outlying areas. Support for elderly, non-ambulatory, housebound, and rural patients is seldom available.	Information not avail-able.	Inform-ation not avail-able.	There are no specific support or care programs targeting people living with HBV/HCV. The EMH program offers services to anyone that is referred to them by a family doctor or specialist.	No inform-ation readily avail-able.	Funding is not consistent.	No inform-ation readily available.	Funding is available from the MOHLTC Hepatitis C Secretariat for a range of programs and organizations. The Hepatitis C Secretariat forms and supports Hepatitis C Treatment and Support Teams across the province--multidisciplinary teams including a nurse, a psycho-social support worker, an outreach worker and a case manager.	No inform-ation readily avail-able.	Organization s struggle to have the funds necessary to meet the growing support needs of people infected and affected.	Ongoing annual funding is provided to Regional Health Authorities and community-based organizations specific to care and support for individuals with HIV/AIDS. Included in this is the provision of care for clients with Hep B and C. There will also be new funding available to community-based organizations through a Request for Proposal process.	Funding for providing care and support services to HCV positive people is stable from territorial government. Federal Hep C Strategy funding has been steadily decreasing over the past 5 years.	PHAC Hepatitis C program has a care and treatment support component, which focused on building the capacity of organizations to provide better care, treatment and support for those living with hepatitis C. $10.65 million annually for whole HCV program since 1998.