National Hepatitis Elimination Profiles
Indicator Definitions
Last Updated 16 August 2022- to be updated by November 30, 2022

Country goals and targets	Definition	Format
National commitment		
HBV Elimination goal	The country has committed to HBV elimination and set forth a specific year/date it aims to achieve elimination of HBV	Yes/No
HCV Elimination goal	The country has committed to HCV elimination and set forth a specific year/date it aims to achieve elimination of HCV	Yes/No
Year of HBV Elimination goal	Year of HBV national elimination goal defined in National Action Plan or other government document	Year
Year of HCV Elimination goal	Year of HCV national elimination goal defined in National Action Plan or other government document	Year
Elimination of HBV Mother to Child Transmission Elimination Goal	The country has committed to elimination of HBV mother to child transmission and set forth a specific year/date to achieve elimination	Yes/No
HBV Action Plan	Whether the country has a written document that includes goals, objectives, targets, or activities for prevention, testing, and/or treatment of hepatitis B, either in combination with hepatitis C or independently. The Action Plan may be integrated with other infectious diseases.	Yes/No
HCV Action Plan	Whether the country has a written document that includes goals, objectives, targets, or activities for prevention, testing, and/or treatment of hepatitis C, either in combination with hepatitis B or independently. The Action Plan may be integrated with other infectious diseases.	Yes/No
Epidemiologic situation		
HBV		
Prevalence of HBsAg	**The national prevalence of HBsAg in the general population (all ages, both sexes unless otherwise noted) for the most recent year available**. If an estimate from a serosurvey is available from the last 5 years, this estimate was used exclusively. If survey estimates from sub-populations were available (i.e. blood donors), then this data was used part of a range with modelled estimates. In the absence of strong national survey data, modelled estimates based on mathematical modelling or pooled data were used. Estimates from before 2010 are excluded. In some cases, local partners suggested a range of estimate best represented the local situation or alternative estimates are widely accepted by the Ministry of Health. In these cases, the source of the data is shown.	Percentage (%) of Absolute Number depending on national data available
Prevalence of HBsAg, Children < 5 yrs, Survey/surveillance	The national prevalence of HBsAg in children less than 5 years of age for the most recent year available based on either a nationally representative survey, surveillance data, or other government report. Estimates from before 2010 are excluded.	Percentage (%)

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Prevalence of HBsAg, Children < 5 yrs (%), Modelled	The national prevalence of HBsAg in children less than 5 years of age for the most recent year available based on a mathematical model or pooled estimate. For the majority of countries, estimates from the Institute of Health Metrics and Evaluation's Global Burden of Disease Study are used for the year 2019. Estimates from before 2010 are excluded.	Percentage (%)
Estimated number of new cases, Survey/surveillance	The estimated number of incident HCV cases based on national surveillance or other nationally represented survey approach. The estimated number of new cases for 2015 and the most recent year available are presented (when available).	Number
Percent change in new cases	The percent change in new cases is calculated based on change in new cases in 2015 compared to the latest year available. This indicator is presented to track progress towards the WHO interim 2020 target of a percent change in incidence of 30% between 2015 and 2020.	Percentage (%)
Mortality rate (per 100,000)	Estimated HCV-related death rate per 100,000 population for all ages. When available, estimates from the Ministry of Health or national vital statistics or sentinel surveillance system are presented. When not available, 2019 modelled estimates are presented from the Global Burden of Disease Study from the Institute of Health Metrics and Evaluation. HCV-related deaths include deaths due to acute HCV, cirrhosis and other chronic liver diseases attributable to HCV, and liver cancer attributable to HCV.	Number per 100,000
Number of HBV-related deaths	The number of HBV-related deaths for all-ages, all sexes the most recent year available. When available, estimates from the Ministry of Health or national vital statistics or sentinel surveillance system are presented. When not available, 2019 modelled estimates are presented from the Global Burden of Disease Study from the Institute of Health Metrics and Evaluation. HBV-related deaths include deaths due to acute HBV, cirrhosis and other chronic liver diseases attributable to HBV, and liver cancer attributable to HBV.	Number
Percent change in deaths	The percent change in number of deaths is calculated based on change in deaths in 2015 compared to the latest year available. This indicator is presented to track progress towards the WHO interim 2020 target of a percent change in mortality of 10% between 2015 and 2020.	Percentage (%)
HCV		
Prevalence of anti-HCV	The national prevalence of anti-HCV in the general population (all ages, both sexes unless otherwise noted) for the most recent year available based on either a nationally representative survey, surveillance data, or other government report. If an estimate from a serosurvey is available from the last 5 years, this estimate was used exclusively. If survey estimates from sub-populations were available (i.e. blood donors), then this data was used as part of a range with modelled estimates. In the absence of strong national survey data, modelled estimates based on mathematical modelling or pooled data were used. Estimates from before 2010 are excluded. In some cases, local partners suggested a range of estimates best represented the local situation or alternative estimates are widely accepted by the Ministry of Health. In these cases, the source of the data is shown.	Percentage (%) of Absolute Number depending on national data available

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Prevalence of chronic HCV, Survey/surveillance	The national prevalence of chronic HCV, or HCV viremia, in the general population (all ages, both sexes unless otherwise noted) for the most recent year available. If an estimate from a serosurvey is available from the last 5 years, this estimate was used exclusively. If survey estimates from sub-populations were available (i.e. blood donors), then this data was used as part of a range with modelled estimates. In the absence of strong national survey data, modelled estimates based on mathematical modelling or pooled data were used. Estimates from before 2010 are excluded. In some cases, local partners suggested a range of estimates best represented the local situation or alternative estimates are widely accepted by the Ministry of Health. In these cases, the source of the data is shown.	Percentage (%)
Estimated number of new cases	The estimated number of incident HCV cases based on national surveillance or other nationally represented survey approach. The estimated number of new cases for 2015 and the most recent year available are presented (when available). For many countries, this data is not available.	Number
Percent change in new cases	The percent change in new cases is calculated based on change in new cases in 2015 compared to the latest year available. This indicator is presented to track progress towards the WHO interim 2020 target of a percent change in incidence of 30% between 2015 and 2020.	Percentage (%)
Mortality rate (per 100,000)	Estimated HCV-related death rate per 100,000 population for all ages. When available, estimates from the Ministry of Health or national vital statistics or sentinel surveillance system are presented. When not available, 2019 modelled estimates are presented from the Global Burden of Disease Study from the Institute of Health Metrics and Evaluation. HCV-related deaths include deaths due to acute HCV, cirrhosis and other chronic liver diseases attributable to HCV, and liver cancer attributable to HCV.	Number per 100,000
Number of HCV-related deaths	The number of HCV-related deaths for all-ages, all sexes the most recent year available. When available, estimates from the Ministry of Health or national vital statistics or sentinel surveillance system are presented. When not available, 2019 modelled estimates are presented from the Global Burden of Disease Study from the Institute of Health Metrics and Evaluation. HCV-related deaths include deaths due to acute HCV, cirrhosis and other chronic liver diseases attributable to HCV, and liver cancer attributable to HCV.	Number
Percent change in deaths	The percent change in number of deaths is calculated based on change in deaths in 2015 compared to the latest year available. This indicator is presented to track progress towards the WHO interim 2020 target of a percent change in mortality of 10% between 2015 and 2020.	Percentage (%)
Status of program planning and service delivery		
Coverage of Infant HepB 3 dose vaccination (%)	Coverage of 3 dose hepatitis B vaccine for infants (<1-year-old) for the most recent year available. For the majority of countries, data was extracted from the WHO Vaccine-Preventable Diseases Monitoring System Database. This data was derived from official reports and in the majority of cases was reported as part of the WHO/UNICEF joint reporting process. In some cases, government reports are cited when more recent data is available or other citation is preferred by government stakeholders. The 2020 WHO interim target is 90% coverage.	Percentage (%)

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Coverage of HepB vaccine for newborns (%)	Coverage of hepatitis B vaccine given within 24 hours of birth for the most recent year available. For the majority of countries, data was extracted from the WHO Vaccine-Preventable Diseases Monitoring System Database. This data was derived from official reports and in the majority of cases was reported as part of the WHO/UNICEF joint reporting process. In some cases, government reports are cited when more recent data is available or other citation is preferred by government stakeholders The 2020 WHO interim target is 50%.		Percentage (%)
Proportion of people living with HBV aware of their status (%)	The proportion of all people living with hepatitis B who are aware of their status (received notification of their diagnosis). The WHO interim target is 30%.		Percentage (%)
Number of persons screened for HBsAg	The number of persons screened for HBsAg annually for most recent years available.		Number
Number of persons on HBV treatment	The number of eligible persons on HBV treatment annually for most recent years available.		Number
Proportion of eligible persons diagnosed with HBV on treatment (%)	An estimate of the proportion of persons living with HBV who are on treatment out of all persons living with HBV who are diagnosed and eligible for treatment. WHO only has a global goal for absolute number of persons on treatment, but no country-specific goals.		Percentage (%)
Number of needles-syringes per year per person who injects drug	Estimated number of needles/syringes per person who injects drugs (PWID) per year. This indicator is a performance measure for WHO HBV/HCV elimination targets. The WHO target is 200 syringes/needles per PWID per year by 2020. The main reference for this indicator was Larney et al, 2017: Larney S, Peacock A, Leung J, et al. Global, regional, and country-level coverage of interventions to prevent and manage HIV and hepatitis C among people who inject drugs: a systematic review. Lancet Glob Health. 2017;5(12):e1208-e1220. doi:10.1016/S2214-109X(17)30373-X. Accessible at: https://pubmed.ncbi.nlm.nih.gov/29074410/		Number
Proportion of people living with HCV diagnosed (%)	The proportion of all people living with chronic hepatitis C who are aware of their status (received notification of their diagnosis). The WHO interim target is 30%.		Percentage (%)
Number of persons screened for anti-HCV	The number of persons screened for anti-HCV annually for most recent years available.		Number
Number of persons initiated on HCV treatment	The number of persons initiated on HCV treatment annually for most recent years available		Number
Proportion of people diagnosed who have been cured (%)	An estimate of the proportion of persons living with HBV who are on treatment out of all persons living with HBV who are diagnosed and eligible for treatment. WHO only has a global goal for absolute number of persons on treatment, but no country-specific goals.		Percentage (%)
Policy environment			
Strategic information	Adopted	Partially Adopted	Not Adopted

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Routine official reports to monitor HBV and HCV mortality	The Ministry of Health, national public health agency, or other government department collects estimates of HBV- and HCV-related mortality through a standardized system, releasing estimates publicly annually or another regular schedule.	Reports are for only HBV or HCV, if system is under development, if the system exists but there is no routine reporting, or if system has limitations where case reporting is not complete.	There is no national system from the Ministry of Health, national public health agency, or other government department to collect and report HBV- and HCV-related mortality.
Routine official reports to monitor HBV and HCV incidence	The Ministry of Health, national public health agency, or other government department collects estimates of new cases of acute HBV and HCV, through a standardized system, releasing estimates publicly annually or another regular schedule.	Reports are for only HBV or HCV, if system is under development, if the system exists but there is no routine reporting, or if system has limitations where case reporting is not complete (i.e. only chronic cases are reported).	There is no national system from the Ministry of Health, national public health agency, or other government department to collect and report HBV ad HCV-related incidence.
Routine official reports to monitor HBV and HCV prevalence	The Ministry of Health, national public health agency, or other government department releases routine reports on estimates for the national prevalence of HBsAg and anti-HCV or chronic HCV, up to every 5 years. The last survey was conducted within the last 5 years.	Estimates are for only HBV or HCV, if the last estimate for either HBV or HCV is older than 5 years, or if regional but not nationally representative estimates are available.	A nationally representative sero-survey has never been conducted to estimate HBV or HCV prevalence (either anti-HCV or chronic HCV).
Estimates of HBV and HCV economic burden	Estimates on either the costs of elimination, cost-effectiveness of elimination or testing or treatment, or return on investment (disease management costs) have been produced for HBV and HCV.	Estimates are available for only HBV or HCV or if estimates for either HBV or HCV are in development.	No economic estimates for either HBV or HCV are available.
Monitoring HBV and HCV testing and treatment	National patient registry is in place for HBV and HCV testing and treatment monitoring. The Ministry of Health, national public health agency, or other government department releases annual updates on number of persons tested and treated for both HBV and HCV.	A a system is in place for only for either HBV or HCV or if the system is in development.	No system is in place to track the number of persons diagnosed and treated for HBV or HCV.
Registration of medicines and tests	Adopted	Partially Adopted	Not Adopted
Registration of originator HCV medicines	At least one HCV direct acting antiviral from an originator company is registered in the country. In some countries, this indicator is further specified for pan-genotypic originator medicines.	Registration of originator HCV direct acting antivirals is in progress.	No originator HCV direct acting antivirals are registered.
Eligible for HCV medicines	Eligible: The country is eligible for HCV generic medications as a result of being included in one of the following licensing agreements. Note that it is possible that the country may not be eligible for the full set of existing license agreements described. The country lists for each agreement are provided below. 1) Sofosbuvir (SOF) and SOF-based regimens: Bilateral, non-exclusive licenses were granted by Gilead to generic manufacturers on SOF, SOF/ledipasvir (LDV), SOF/velpatasvir (VEL), SOF/VEL/voxilaprevir (VOX) compounds. These select generic manufacturers can then sell these products in 105 countries and territories.		Not Eligible: The country is not eligible for HCV generic medications.

	Full country eligibility list is available at: https://www.medspal.org/?product_standardized_name%5B%5D=Sofosbuvir+400+mg&page=1 2) Daclatasvir (DAC) and SOF/DAC: A MPP license agreement with Bristol-Myers Squibb was signed in 2015 for Daclatasvir (DAC). This agreement grants generic manufacturers permission to sell generic DAC and DAC/SOF combinations in 112 countries and in other countries where there is no patent infringement. Full country eligibility list is available at: https://medicinespatentpool.org/licence-post/daclatasvir-dcv/. For more information on the MPP-BMS agreement, please visit: https://medicinespatentpool.org/licence-post/daclatasvir-dcv/. 3) Glecaprevir/pibrentasvir (G/P): In 2018, the MPP signed a royalty-free license agreement with AbbVie for G/P, a pangenotypic combination drug to cure HCV. The license enables quality-assured manufacturers to develop and sell generic medicines containing G/P in 96 low- and middle-income countries (LMICs) at affordable prices, enabling access to and treatment scale-up with the most effective pan-genotypic regimens. For more information on the MPP-AbbVie agreement, please visit: https://medicinespatentpool.org/licence-post/glecaprevirpibrentasvir-gp/. For more information on registration and approval of medications by WHO, please visit: https://medicinespatentpool.org/what-we-do/global-licence-overview/update-on-progress-of-mpp-sublicensees/.		
Registration of generic HCV medicines	At least 1 generic HCV direct acting antiviral is registered in the country	Generic directing acting antivirals are in the process of being registered.	No generic direct acting antiviral is registered in the country
Licensed point-of-care PCR testing to detect HBV and HCV	At least point-of-care PCR platform and test kit is registered in country, i.e. GeneXpert for both HBV DNA and HCV RNA and/or cAg.	Point-of-care PCR platform and test kits are registered for either HBV or HCV, or registration is in progress.	No point-of-care testing is available for HCV RNA or cAg or HBV DNA.
HepB Birth Dose and PMTCT	*Adopted*	*Partially Adopted*	*Not Adopted*
HepB vaccine birth dose policy	National policy /recommendation in place for universal hepatitis B vaccine for newborns within 24 hours.	If this type of policy comes from the state/province level, a partial score is given if the policy does not exist in every state/province. If the country has a selective policy for infants born to HBsAg+ mothers, then a partial score is given.	No HepB birth dose policy is in place.
Routine maternal HBsAg screening policy	National policy /recommendation in place for routine HBsAg screening of pregnant women.	If the maternal HBsAg screening policy comes from the state/province level, a partial score is given if the policy does not exist in every state/province.	No maternal HBsAg screening policy is in place.
Routine maternal HCV screening policy	National policy /recommendation in place for routine anti-HCV or HCV PCR testing of pregnant women	If the maternal HCV policy comes from the state/province level, a partial score is given if the policy does not exist in every state/province.	No maternal HCV screening policy is in place.

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Screening to diagnose HBV and HCV infection			
HBV testing recommendations: Risk-based	The country has national recommendations for HBsAg screening of populations known to be at higher risk, i.e. people who inject drugs, men who have sex with men, migrants, etc.	A national recommendation for HBsAg screening of populations known to be at higher risk is in place but not fully adopted or risk-based HBsAg screening policy is only adopted by a limited number of states or provinces.	No national risk-based HBsAg screening policy exists.
HCV testing recommendations: Risk-based	The country has national recommendations for anti-HCV screening of populations known to be at higher risk, i.e. people who inject drugs, men who have sex with men, migrants, etc.	A national recommendation for anti-HCV or HCV PCR or cAg screening of populations known to be at higher risk is in place but not fully adopted or risk-based HBsAg screening policy is only adopted by a limited number of states or provinces.	No national risk-based HCV screening policy exists.
HBV screening recommendations: Age cohort/Universal/Other special group	All countries are assessed if they have HBV risk-based screening recommendations in place. If additional policies are in place, either age-cohort, special population, or universal, then these recommendations are also acknowledged.	An expanded HBV screening policy has been developed but has not implemented yet (awaiting funding, healthcare worker training, etc).	There is no other HBV screening recommendation beyond risk-based screening.
HCV screening recommendations: Age cohort/Universal/Other special group	All countries are assessed if they have HCV risk-based screening recommendations in place. If additional policies are in place, either age-cohort, special population, or universal, then these recommendations are also acknowledged	An expanded HCV screening policy has been developed but has not implemented yet (awaiting funding, healthcare worker training, etc).	There is no other HCV screening recommendation beyond risk-based screening.
No patient co-pays for HBsAg and anti-HCV testing	The costs of HBsAg and anti-HCV testing is fully covered by public sector insurance scheme so there is no cost to patients.	Only HBsAg or anti-HCV testing is covered by the public sector insurance scheme or there is variation in co-pay policies across states/provinces.	Patients must pay for anti-HCV and HBsAg testing out-of-pocket.
Access to HBV and HCV Treatment	Adopted	Partially Adopted	Not Adopted
HBV			
National treatment guidelines exist	National guidelines for HBV treatment are available from the Ministry of Health or national professional society of hepatology/study of liver disease.	HBV clinical treatment guidelines are not fully rolled out and implemented and/or if guidelines are under development.	No HBV clinical treatment guidelines have been developed.
Simplified care: Simplified treatment and monitoring algorithm for primary care providers	National guidelines for HBV treatment include simplified algorithms and recommendations for primary care providers to management non-complicated, stable patients without referral to specialty care	Guidance on HBV treatment for primary care providers is in development, has been developed but not implemented, or guidance is limited or not comprehensive.	No guidance on HBV treatment for primary care providers has been adopted.

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Simplified care: No patient co-pays	When there is a public insurance scheme, the costs of HBV treatment are fully covered so there is no cost to patients.	There is variation in co-pay policies across states/provinces.	Patients must pay for HBV treatment out-of-pocket. In the absence of a public insurance scheme, this policy would not be adopted.
HCV			
National treatment guidelines exist	National clinical guidelines for HCV treatment are available from the Ministry of Health or national professional society of hepatology/study of liver disease, and are based on use of direct acting antivirals. Partially	Guidelines for HCV treatment are not fully rolled out and implemented and/or if guidelines are under development.	No guidelines for HCV treatment have been developed.
Simplified care algorithm: Less than 2 clinic visits during treatment	National clinical guidelines for HCV treatment recommend less than 2 visits over the course of treatment monitoring, including SVR testing at 12 weeks post treatment. This indicator does not include diagnostic visits or pre-treatment evaluation visits, which can be a barrier in other countries.	Guidelines for HCV treatment are in the process of being updated to be simplified and remove monthly monitoring requirements.	Guidelines for HCV treatment require monthly monitoring during HCV treatment.
Simplified care algorithm: Non-specialists can prescribe treatment	National guidelines and reimbursement criteria for the public sector insurance scheme allow non-specialists, i.e. general practitioners, primary care doctors, to prescribe HCV DAAs and monitor treatment.	Guidelines for HCV treatment and/or reimbursement criteria only permit non-specialists to prescribe HCV DAAs under certain circumstances or there is variation across states/provinces.	Only specialists can prescribe HCV treatment.
Simplified care algorithm: No patient treatment co-pays	The When there is a public insurance scheme, the costs of HCV treatment are fully covered so there is no cost to patients. In the absence of a public insurance scheme, this policy would not be adopted. This policy is partially adopted when there is variation in co-pay policies across states/provinces.	There is variation in co-pay policies across states/provinces.	Patients must pay for HCV treatment out-of-pocket. In the absence of a public insurance scheme, this policy would not be adopted.
No fibrosis restrictions	No restrictions on reimbursement for HCV treatment based on fibrosis stage, preferably based on public insurance reimbursement criteria. When public reimbursement criteria were not available, clinical guidelines may be referenced. The source referenced is cited appropriately.	There is variation in fibrosis restrictions across states/provinces.	Fibrosis restrictions for HCV treatment remain in place nationally.
No sobriety restrictions	No restrictions on reimbursement for HCV treatment based on sobriety, preferably based on public insurance reimbursement criteria. When public reimbursement criteria were not available, clinical guidelines may be referenced. The source referenced is cited appropriately. Partially adopted is acknowledged	There is variation in sobriety restrictions across states/provinces.	Sobriety restrictions for HCV treatment remain in place nationally.

	when there is variation in policy across states/provinces.		
No genotyping	Local treatment guidelines and public sector reimbursement criteria remove genotyping as standard pre-evaluation criteria when pangenotypic drugs are available.	Guidelines for HCV treatment or public sector reimbursement criteria are in the process of being updated to remove genotyping or there is variation in policy across states/provinces.	Genotyping is still required by both guidelines for HCV treatment and public sector reimbursement criteria.
Financing			
Public budget line for HBV and HCV testing and treatment	National government budget has explicit funding dedicated to HBV and/or HCV prevention, testing, and/or treatment. This funding supports direct program delivery.	The national budget covers HBV or HCV testing or treatment; There has been one-time support of the national program without the guarantee of sustained funding over time; or states/provinces have adopted HBV or HCV budgets.	There is no national budget for HBV or HCV testing or treatment.
GFTAM funds used for co-infected patients or harm reduction , as relevant	The country is eligible for Global Fund for TB, AIDS, and Malaria grant funding and this funding is being used to fund HBV and/or HCV testing and/or treatment for co-infected patients or used for harm reduction prevention activities.	Not applicable	The country is eligible for Global Fund for TB, AIDS, and Malaria grant funding but this funding is not being used to support any HBV or HCV testing or treatment or harm reduction.
Achieving health equity in hepatitis elimination	Adopted	Partially Adopted	Not Adopted
National strategy addresses populations most affected (i.e. PWID, Indigenous, MSM, Co-infected, etc)	The National Strategy on viral hepatitis acknowledges populations affected by disparities in burden of hepatitis B and C and access to care and provides specific interventions to address these disparities .	The National Strategy on viral hepatitis is in the process of being developed or updated and will acknowledge populations affected by disparities in burden of hepatitis B and C and access to care and provides specific interventions to address these disparities.	The National Strategy on viral hepatitis does not acknowledge populations affected by disparities in burden of hepatitis B and C and access to care and provides specific interventions to address these disparities.
Laws preventing discrimination against people living with hepatitis B and/or C	National laws protect people from discrimination, including employment discrimination, on the basis of hepatitis B or C status.	Discrimination protections are included in general healthcare or other law, i.e. workplace laws, but no discrimination law exists specifically for hepatitis.	There is no national law preventing discrimination against people living with hepatitis B and/or C.
Hepatitis B vaccination policy for adults	National recommendations for hepatitis B vaccination of adults, either for healthcare workers, populations at higher risk for infection, specific age-cohort, or all adults.	No federal recommendation exists and policy varies by state/province.	There is no national or state/province recommendation related to adult hepatitis B vaccination.
Harm reduction included in national policy	Harm reduction services are included in national policy and service packages for people who inject drugs.	A national policy related to access to harm reduction services for persons who injects drugs is under development. Or there is no	There is no national policy related to access to harm reduction services for persons who injects drugs.

		national policy but some states/provinces have adopted policies.	
Policy for syringe-needle exchange programs in federal prisons	Needle/syringe programs are available in federal prisons as a matter of national policy.	A policy on access to syringes/needles in federal prisons is under development.	Needle/syringe programs are not available in federal prisons.
Decriminalization of possession of syringes and paraphernalia	Federal law avoids criminalizing possession of syringes and associated paraphernalia	No federal law exists and policy varies by state/province.	There is no federal or state/province law decriminalizing possession of syringes and paraphernalia.
Decriminalization of drug use	Federal law refrains from criminalizing drug use or possession of drugs, including opioids, for personal consumption.	No federal law exists and policy varies by state/province. Or federal law refrains from criminalizing drug use or possession for personal consumption, but may still impose punitive civil sanctions.	There is no federal or state/province law decriminalizing use or possession of drugs, including opioids, for personal consumption
Decriminalization of hepatitis infection	Federal law refrains from criminalizing and prosecuting people for HBV and HCV exposure/ transmission	No federal law exists and policy varies by state/province.	