

Review paper

# Towards elimination of viral hepatitis in the Czech Republic, Hungary, Poland and Slovakia: insights from the Viral Hepatitis Prevention Board (VHPB)

Robert Flisiak<sup>1</sup>, Sona Frankova<sup>2</sup>, Sakshi Jindal<sup>3</sup>, Viktor Aster<sup>4</sup>, Bela Hunyady<sup>5</sup>, Mihaly Makara<sup>6</sup>, Pavol Kristian<sup>7</sup>, Danica V. Stanekova<sup>8</sup>, Dorota Zarębska-Michaluk<sup>9</sup>, Sara Valckx<sup>3</sup>, Greet Hendrickx<sup>3</sup>, Pierre Van Damme<sup>3</sup>, Mojca Maticic<sup>3,10</sup>

<sup>1</sup>Department of Infectious Diseases, Medical University of Białystok, Białystok, Poland

<sup>2</sup>Department of Hepatogastroenterology, Institute for Clinical and Experimental Medicine, Prague, Czech Republic

<sup>3</sup>Viral Hepatitis Prevention Board, Centre for the Evaluation of Vaccination, University of Antwerp, Antwerp, Belgium

<sup>4</sup>Department of Infectious and Tropical Diseases, Charles University and Bulovka University, Prague, Czech Republic

<sup>5</sup>University of Pécs, First Department of Internal Medicine, Pécs, Hungary

<sup>6</sup>Central Hospital of Southern Pest National Institute of Hematology and Infectious Diseases, Outpatient Clinic, Szent László Hospital Budapest, Budapest, Hungary

<sup>7</sup>Department of Infectology and Travel Medicine, Faculty of Medicine, P.J. Šafárik University, and L. Pasteur University Hospital, Košice, Slovakia

<sup>8</sup>St. Elizabeth University of Health & Social Work, Bratislava, Slovakia

<sup>9</sup>Department of Infectious Diseases and Allergology, Jan Kochanowski University, Kielce, Poland

<sup>10</sup>University Medical Centre Ljubljana, and Faculty of Medicine, University of Ljubljana, Ljubljana, Slovenia

## Abstract

The Visegrad Group – the Czech Republic, Hungary, Poland and Slovakia – face shared challenges in preventing and controlling viral hepatitis. A regional meeting convened by the Viral Hepatitis Prevention Board evaluated health systems, epidemiology, and national policies, revealing accomplishments and needs for prevention, screening, diagnosis, and linkage to care of viral hepatitis. Universal hepatitis B (HBV) vaccination exists, yet vaccine hesitancy and incomplete coverage threaten progress, while surveillance and registries remain fragmented. Access to hepatitis C (HCV) treatment has improved recently, but remains centralized, with limited engagement of marginalized populations. Elimination of HCV by 2030 is unlikely due to insufficient screening, COVID-19-related healthcare disruptions, and weak political commitment, whereas HBV control depends on maintaining high vaccination coverage and robust monitoring. Participants called for harmonized national guidelines, strengthened regional collaboration, and sustainable action plans backed up by political commitment. Urgent, coordinated efforts are needed to achieve the WHO 2030 elimination goals.

**Key words:** viral hepatitis, EU/EEA, political will, WHO 2030 elimination goals, public health.

## Address for correspondence:

Sakshi Jindal, Viral Hepatitis Prevention Board, Centre for the Evaluation of Vaccination, University of Antwerp, Antwerp, Belgium, e-mail: [VHPBboard@uantwerpen.be](mailto:VHPBboard@uantwerpen.be)

## Introduction

The Czech Republic, Hungary, Poland, and Slovakia share deep cultural and intellectual traditions, rooted in diverse religious heritages and a common historical identity. These countries, known collectively as the Visegrad Group (V4), have long sought to pre-

serve and strengthen these shared values through co-operation. The V4 framework reflects their commitment to working together on issues of mutual interest, with a strong emphasis on fostering cultural cohesion, advancing education and science, and promoting the exchange of knowledge and information. These four countries face distinct challenges in addressing

**Table 1.** Demographic, health expenditure and viral hepatitis indicators

Measure	Year of information	Czech Republic	Hungary	Poland	Slovakia	Source
Population (million)	2025	10.9	9.5	36.4	5.4	[3]
Healthcare expenditure (% of GDP)	2022	8.8	6.7	6.4	7.7	[2]
Vaccination programme – Hepatitis A	2025	Recommended and selectively reimbursed for specific high-risk populations				[4, 5]
Vaccination programme – Hepatitis B (universal)	2025	Yes*	Yes (at age 12)	Yes*	Yes*	[5]
Estimates of HBsAg prevalence in the general population	2023	< 0.50%	< 0.50%	0.50-0.99%	0.50–0.99%	[6]
National estimates of hepatitis C RNA prevalence	2023	0.50-0.99%	< 0.50%	< 0.50%	0.50–0.99%	[6]
Persons on chronic hepatitis B treatment	2022	No data	1440	8541	No data	[7]
HCV infections treated with DAAs in 2023 (approximate numbers)	2023	2600	650	3400	360	[8]

\*As recommended by the WHO, infants receive the first hepatitis B vaccine dose within 24 hours of birth (birth dose) and complete the series at 1 and 6 months  
 GDP – gross domestic product, HBsAg – hepatitis B surface antigen, RNA – ribonucleic acid, HCV – hepatitis C virus, DAAs – direct-acting antivirals

the burden and control of viral hepatitis. Factors such as fragmented surveillance systems, gaps in vaccination coverage, and limited access to screening and treatment, especially for at-risk populations, have hindered progress toward achieving WHO (World Health Organization) 2030 elimination goals. The Viral Hepatitis Prevention Board (VHPB) mobilized a regional meeting [1] to bring together leading stakeholders to assess achievements and challenges in viral hepatitis prevention and control, to explore the implementation of new strategies and monitoring systems, and to discuss the development of national viral hepatitis plans. Participants identified barriers to be overcome and charted possible ways forward. Significant meeting highlights are discussed in this review, alongside recent developments to capture the current context. A key focus was on aligning national and regional efforts with the goal of eliminating viral hepatitis as a major public health threat by 2030, as set out in the WHO Global Health Sector Strategy (GHSS) on Viral Hepatitis (2016), followed by the Action Plan (2017) for Viral Hepatitis in the European Region and the WHO GHSS on HIV, Viral Hepatitis and Sexually Transmitted Infections (2022-2030).

## Health care systems and national guidelines for viral hepatitis

Across the four countries, health care systems were generally described as robust, operating based on mandatory health insurance schemes or funds. Except for Hungary, where a health care secretariat is located within the Ministry of the Interior and supported

by an extensive county-level structure, these systems are overseen by national ministries of health. Table 1 summarizes demographic, health expenditure and viral hepatitis indicators for each of the countries [2-8].

Quoted figures for total expenditure on health as a percentage of gross domestic product (GDP) in 2022 varied but were 10% lower than the average for the European Union (EU) [2]. In all four countries, care is provided free of charge for people with social security coverage (leaving gaps for those without such coverage) [9].

Nongovernmental organisations, including patient associations, play valuable roles in the prevention and control of viral hepatitis. Their range of activities extends from testing and treatment within the community at locations other than specialized medical centres to counselling on prevention and harm reduction. Concern was expressed that their status is fragile, especially in Hungary and Slovakia. Their funding and sometimes existence have always been insecure, but the current economic and political climate does not encourage optimism.

National arrangements for the prevention, control, and treatment of viral hepatitis vary considerably. Poland, for example, maintains separate health services for prisons. In Hungary, local governments play a more prominent role, while in the Czech Republic, the private sector is involved, including pharmacies and the delivery of HCV screening in prisons.

No country has a specific overall national plan for viral hepatitis, although, in Slovakia, these plans are part of the national action plans for controlling infectious diseases [10].

The Czech Republic has national clinical practice guidelines for treatment of hepatitis B, C and D, including special clinical practice guidance on early diagnosis and treatment of hepatitis C, which focuses on screening of HCV in high-risk populations [11].

Although Hungary lacks a government-approved programme, the Hungarian government has appointed a National Hepatitis Committee to facilitate screening for HBV and HCV, access to care and to tighten the gap between WHO viral hepatitis elimination programme and current situation in Hungary. These experts have issued consensus guidelines for the management of hepatitis B, D [12] and C [13], and official financing protocols are issued by the National Health Insurance Fund.

Poland illustrates the conflict between, on the one hand, the clinical and medical establishment and, on the other, the policymakers in the health ministry. Many documents have been drafted and approved by the medical profession, only to fail to clear the final hurdle of ministerial approval. The result is that no formal national plan on viral hepatitis, including screening, exists, and implementation of plans fails because of the inability to raise funds. Among these documents are the recommendations of a Polish Group of Experts for a diagnostic and therapeutic programme for HBV, HCV and HIV [14].

## Current epidemiological trends of hepatitis B and C

Each year, national focal points for hepatitis B and C surveillance in the four countries submit data to the European Surveillance System (TESSy), coordinated by the European Centre for Disease Prevention and Control (ECDC). ECDC's consolidated reports, with data up to 2023 [15], provide insights into evolving trends. While the COVID-19 pandemic disrupted testing and reporting, leading to short-term shifts, earlier epidemiological patterns have largely re-emerged.

Acute hepatitis B has declined consistently across the region, though modest rises in chronic HBV cases have been observed in some settings, partly linked to migration. These findings are consistent with the low prevalence of HBsAg (< 1%) reported in all four countries (Table 1).

For hepatitis C, case reporting shows divergent patterns: while numbers remain broadly stable in some countries, others have reported increases in recent years. The COVID-19 pandemic significantly reduced diagnoses and treatment initiations, with recovery still incomplete in 2023. Although surveillance data suggest relatively low HCV RNA prevalence (< 1% across

this region; Table 1), a substantial proportion of infections remain undiagnosed [14].

Migration has also shaped epidemiological trends, particularly with the arrival of Ukrainian refugees, among whom HCV prevalence is relatively high (estimated at around 5%). In 2023, approximately 1.8 million Ukrainian refugees crossed the Polish border [16], and in the period 2022-2024, they accounted for 11% of all individuals treated for HCV infection in Poland [17].

## Prevention landscape: hepatitis A and B vaccination

Hepatitis B vaccination is mandatory in all four countries [6], with three implementing universal vaccination from birth, in line with WHO recommendations, including provisions for catch-up and risk groups. Hungary remains an exception, where vaccination is introduced universally at age 12, without prior HBsAg screening or post-vaccination antibody testing. Despite this difference, acute hepatitis B cases remain rare, occurring mainly in men who have sex with men (MSM), and a > 90% uptake coverage as noted by country-level representatives.

According to 2022 data, only Slovakia has achieved the 2025 interim target of 95% coverage with three doses of infant hepatitis B vaccine [7]. In contrast, coverage rates in Poland are gradually declining, with parents increasingly refusing the birth dose or delaying subsequent doses, leading to untimely vaccination [18]. This decline coincides with a broader rise in vaccine hesitancy and misinformation since the COVID-19 pandemic, a trend observed in all four countries. For instance, between 2017 and 2022, formal vaccination refusals grew more than twofold in Poland. In Slovakia, where overall vaccination willingness fell during the COVID-19 campaign, this scepticism now extends to routine immunizations [19]. The arrival of Ukrainian refugees, where hepatitis B vaccination coverage is approximately 88% (*WHO Immunization Dashboard*), additionally underscores the importance of maintaining robust infant vaccination programmes to sustain high immunization rates.

In addition to mandatory infant vaccination, the Czech Republic and Slovakia provide a combined hepatitis A and B vaccine for individuals at occupational or lifestyle-related risk [20]. Since the COVID-19 pandemic, an immunization registry including hepatitis B vaccine has been introduced and implemented.

Hepatitis A vaccination is recommended in all four countries and selectively reimbursed for high-risk populations (Table 1). The recent ECDC report on hepatitis A outbreak across Austria, Czech Republic, Hunga-

**Table 2.** Overview of hepatitis B and C screening programmes in the four countries

Recommended for	Czech Republic		Hungary		Poland		Slovakia	
	HBV	HCV	HBV	HCV	HBV	HCV	HBV	HCV
Healthcare workers	Yes**	Yes**	Yes	Yes	No	No	Yes**	Yes**
All migrant populations	No	No	No	No	No	No	Yes	Yes**
Migrants (from countries with high endemicity)	Yes**	Yes**	No	No	No	No	Yes**	Yes**
MSM	No	No	Yes	Yes	No	No	No	No
People in prison	Yes**	Yes**	No	Yes**	No*	No*	No*	No*
PLHIV	Yes	Yes**	Yes	Yes	Yes	Yes	Yes**	Yes**
Pregnant women	Yes	No	Yes	No	Yes	Yes	Yes	No
PWID	Yes**	Yes**	Yes	Yes	No	No	Yes	Yes**
Haemodialysis	Yes**	Yes**	Yes**	Yes**	Yes	Yes	Yes**	Yes**

Source: *Monitoring of the responses to the hepatitis B and C epidemics in EU/EEA countries, 2023, ECDC [21].* \*Offered but not routine. \*\*Information adapted from national guidelines and by country-level experts

HBV – hepatitis B virus, HCV – hepatitis C virus, MSM – men who have sex with men, PLHIV – people living with HIV, PWID – people who inject drugs

ry, and Slovakia [5] highlighted the need for targeted single-dose pre-exposure vaccination programmes for populations at increased risk.

National prevention strategies emphasize vaccination, harm reduction, and treatment as complementary pillars of hepatitis control. Public awareness and education campaigns remain essential to counteract vaccine hesitancy, strengthen confidence in immunization, and sustain progress towards elimination goals.

## Screening practices and programmes

Screening policies for hepatitis B and C vary across the four countries, targeting different risk groups (Table 2) [21].

### Czech Republic

The Czech Republic operates a well-established HBV surveillance system. HCV screening of the general population is not recommended, given the low prevalence; instead, testing is offered to individuals identified as at-risk by physicians [22]. In 2023, the National Screening Centre launched a programme for early HCV diagnosis and linkage to care among people who inject drugs (PWID), in collaboration with harm-reduction services [23, 24]. Positive cases confirmed by rapid PCR (polymerase chain reaction) testing were referred directly for further follow-up. The results, expected in 2026, may inform proposals for a broader high-risk screening system. Experience from this initiative highlighted that PWID are not inherently difficult to treat, but difficult to reach,

and that stable housing was a critical factor supporting adherence [25]. In psychiatric hospitals, screening is carried out upon admission and followed up after several years. Reflex testing (i.e., tests that automatically result in the order of one or more secondary tests based on pre-set criteria applied to the initial test) for HDV (hepatitis D virus) is being introduced to all HBsAg-positive persons, and all cases detected to date have been imported [26].

### Hungary

Screening in Hungary is guided by national consensus recommendations, revised twice annually. Combined rapid tests for HBV, HCV, HIV and syphilis are commonly used. The creation of a centralized blood donor registry in 2022 has enabled standardized surveillance for the first time. Groups for routine screening include healthcare workers, pregnant women and victims of needlestick injuries in healthcare settings, while migrants, Roma, sex workers, MSM, PWID, prisoners and individuals with chronic liver disease are screened more selectively. Children aged 12 years are not screened for HBsAg prior to hepatitis B vaccination under the universal immunization programme. Hungarian guidelines also recommend anti-HDV antibody testing for all HBsAg-positive patients [12]. Civil-society initiatives have complemented official programmes. HCV screening in prisons is voluntary, with a positivity rate of around 5.49% reported in 2022. This nongovernmental project reached over 20,000 inmates and screened more than 5,000 voluntary inmates, providing valuable data on prevalence and feasibility of large-scale testing [27].

## Poland

In Poland, expert groups advocate expanding HCV testing beyond pregnant women to include all women of reproductive age during gynaecological visits. Broader screening has also been recommended in primary care, hospital emergency departments, and prisons. According to recently published analysis, anti-HCV testing would be cost-effective in any population, and especially as part of mandatory medical examinations for employees aged 25 to 49 [28]. Despite these expert recommendations and analyses by the Agency of Health Technology Assessment and Tariff System indicating high cost-effectiveness, there is still no national HCV screening policy. A review of the Polish approach highlighted limited awareness of HCV and good will among politicians, and the absence of a national HCV screening policy [29]. Experts also cited the Lithuanian experience where over 12 months in 2022–2023 nearly 800,000 people (more than 25% of the population) were tested, with 1.5% testing positive [30]. This example illustrates the potential impact of large-scale testing and may serve as a model for Poland, particularly given the readiness of the medical community to engage in structured programmes. The WHO has supported NGOs to expand community-based testing for migrants and refugees, shortening the diagnostic pathway. However, confirmatory diagnosis and linkage to care are still fragmented and inconsistent. A study in psychiatric hospitals found HCV prevalence to be three times higher than in the general population. Patients have access to treatment, but no systematic programme has been established in these settings [31]. Poland has also evaluated the cost-effectiveness of HCV screening, with findings supporting consideration of universal screening [28]. The national preventive health screening programme “Moje Zdrowie” (My Health), launched in mid-2025, includes, in addition to many laboratory tests, anti-HCV tests, but because it does not take into account important risk groups, it will not significantly contribute to the elimination of HCV infections in Poland. HDV screening tests performed in a selected centre indicate the presence of anti-HDV in 0–5% of HBsAg-positive patients [32]. In a recent study covering a population of almost four hundred HBV-infected patients, a low prevalence of anti-HDV antibodies of 1.5% and HDV replication of only 0.25% were observed [33]. A significant reduction in HBV diagnoses, notably acute cases, was observed in Poland during the COVID-19 pandemic. Continued surveillance and the establishment of a national screening programme covering migrants, coupled with improved care linkage, are needed [34].

## Slovakia

In Slovakia, HCV screening is targeted, with an emphasis on patients attending HIV counselling centres, Ukrainian refugees, PWID, people in prison, pregnant women, migrants, blood donors, and recipients of blood derivatives. Universities, NGOs, healthcare providers and the WHO are actively involved. Pilot prison programmes have demonstrated high adherence rates, although discharges of untreated HCV patients remain a public health concern [35]. Discussions uncovered screening pilots among Roma communities which identified simplification of the care pathway and provision of services directly on site, without requiring hospital visits, as key to success. Reflex testing for HDV is now being introduced. As in the Czech Republic, all detected cases have been imported [26]. Experts recommend HDV testing for people at high risk of parenteral transmission and for migrants from countries where hepatitis D is endemic [36].

## Antenatal screening

Routine HBV screening of pregnant women is consistently implemented across all four countries, with coverage reaching the WHO 2025 targets of 90% and above [7]. The proportion of women testing positive for HBsAg is estimated at 0.07–0.08% in Slovakia and Hungary, 0.25% in the Czech Republic, and 0.87% in Poland. Only Poland currently offers routine HCV screening for pregnant women, suggesting an opportunity for the other three countries to consider incorporating this measure into their health plans [21] (Table 2).

Across the four countries, with the exception of the Czech Republic, HCV screening in psychiatric institutions is limited, despite evidence of higher prevalence. Screening coverage in high-risk groups remains insufficient, even though expanding testing in these populations is critical for improving treatment uptake. Concerns were raised regarding compliance with antenatal screening recommendations and the quality assurance of laboratory testing. Moreover, the absence of general HBV screening results in many cases of HBV-related hepatocellular carcinoma going undetected, as prevalence estimates are largely extrapolated rather than systematically measured [37].

## Linkage to care and access to treatment

Linkage to care remains far from optimal across the four countries. A common barrier is the number of outpatient visits required between diagnosis and treatment initiation. This could be improved through

fast-track referrals to treatment centres and the removal of administrative barriers. Staffing shortages are an increasing challenge.

Registries of screened or infected individuals are generally absent, and reflex testing (for HBV/HCV coinfection or HBV/HDV coinfection) is not consistently implemented. The exception is Hungary, which maintains a treatment registry for HBV, HCV and HDV infected [38]. Individuals tested at anonymous centres often do not reach clinics, and general practitioners' limited awareness of viral hepatitis further weakens linkage to care.

### Czech Republic

In the Czech Republic, treatment for hepatitis C is largely centralized in hepatology clinics. There is no registry of screened or infected individuals. Restrictions on the use of direct-acting antivirals (DAAs) have been lifted, and financing is no longer a major barrier. However, shortages of hepatologists and delays linked to administrative procedures remain.

### Hungary

The Hungarian national treatment registry provides complete coverage of HCV treatments but only partial coverage of HBV and HDV treatments. Treatment guidelines follow the recommendations of the European Association for the Study of the Liver (EASL). Pangenotypic DAAs are available, though treatment remains largely centralized in hepatology clinics. Access can be hindered by reimbursement restrictions. In some cases, DAAs cannot be administered during hospital stays due to overlapping reimbursement schemes, and uninsured patients may also be excluded. While financing of DAAs is now less problematic than in the past, the main challenge lies in identifying eligible patients and ensuring they are linked to care.

### Poland

Poland has regularly updated national guidelines for managing HBV and HCV, and treatment is free of charge for all health insured patients [14]. Poland was among the first countries in the world to provide access to DAAs for all HCV-infected patients, regardless of fibrosis stage, genotype, or comorbidities. As in other countries, DAAs are available without the restrictions that previously limited access, and prices are more affordable than before. Nonetheless, linkage to care is weakened by the absence of patient registries and inconsistent HBV/HCV reflex testing. Anony-

mous testing centres are often disconnected from clinical pathways, meaning individuals who test positive may not access care [39]. Centralization of HCV treatment in specialist clinics may also create access barriers, particularly for marginalized populations. Among the possible, yet unused solutions to this problem, could be the use of occupational medicine physicians, but this requires a change in the legal regulations recommended in recently published guidelines [40].

### Slovakia

In Slovakia, national guidelines recommend following EASL guidance. DAAs are available and reimbursed and financing is generally not considered a barrier. However, as in other countries, treatment tends to be centralized in hepatology clinics, with limited involvement of primary care. Pilot projects in prisons and among marginalized groups have successfully implemented HCV screening and treatment. Continuation of these programmes, however, depends on legal reinforcement of the national plan and on sustainable reimbursement of costs [41]. Costs for serological testing in primary care are reimbursed.

Across the four countries, DAAs are widely available, and financing is generally not a limiting factor. The critical bottlenecks are patient identification, access to care, and workforce shortages. Although the introduction of DAAs has been a major success, none of the countries is on course to achieve WHO's 2030 elimination goals. To meet these targets, diagnosis and treatment numbers would need to increase substantially [29, 42].

### Prevalence in people who inject drugs (PWID)

Within the EU/EEA, and particularly in this region, hepatitis C infections are primarily concentrated among people who inject drugs (PWID) [7, 43].

Hungary illustrates this dynamic acutely: among people injecting new psychoactive substances (NPS), HCV prevalence rose from 37% to 74% between 2011 and 2014, coinciding with reduced harm-reduction coverage and increased unsafe injection practices [44].

Despite the availability of highly effective DAAs, multiple structural barriers persist across the region. Restrictive abstinence requirements, fragmented care, and stigmatizing provider attitudes remain common.

In the Czech Republic, a persistent obstacle is stigma towards PWID: some providers adhere to the "moral model" of addiction, under which PWID are seen as undeserving of treatment [45]. Harm-reduction centres play a vital role in overcoming this

**Table 3.** Barriers to hepatitis elimination and corresponding needs/recommendations in the four countries

Barrier	Description	Needs/Recommendations
1. Implementation barriers	Interventions often rely on individual initiatives rather than systematic strategies. Centralized screening and treatment limit scalability, while community-based initiatives remain sporadic. The Czech “test and treat” approach demonstrates potential	Healthcare systems should be strengthened by clearly defining roles and procedures, allocating dedicated and sustained budgets, and enhancing collaboration among NGOs, healthcare providers, and public authorities
2. Political prioritization	Political commitment, particularly for HCV elimination, remains insufficient. For example, Poland does not have a national HCV program despite evidence supporting its cost-effectiveness	Governments should adopt binding national plans, link viral hepatitis elimination with broader public health programs, and harmonize roles across different ministries
3. Data gaps	Reliable epidemiological data are scarce, registries are inconsistent, and data systems often lack interoperability. Hungary’s centralized blood donor database improves surveillance, but it remains incomplete	Countries should establish and maintain registries, and enhance transparency and electronic reporting systems, including reporting mechanisms for the private sector
4. Economic and cost considerations	Very few economic evaluations exist, which limits evidence-based resource allocation	Policymakers should commission and use economic evaluations to support health-related decision-making
5. Knowledge gaps and stigma	Awareness of hepatitis varies among the public, at-risk groups, and healthcare providers. Stigma, associations with HIV, and vaccine hesitancy, which has been amplified by COVID-19, hinder uptake of prevention and treatment measures	Education for healthcare workers and the general public should be expanded, public awareness campaigns should be implemented, misinformation about vaccines should be actively countered, and outreach should be tailored to vulnerable populations
6. Gaps in screening	Screening efforts are fragmented and poorly coordinated. In Hungary, hepatologist oversight limits access for people who inject drugs, and gaps in insurance coverage persist. In Poland, current screening levels of approximately 80,000 people per year fall far below the WHO target of around 4 million per year	Guidelines should be standardized, stakeholder roles should be clarified, and point-of-care testing should be expanded. General practitioners should be involved, HIV, hepatitis, and STI screening should be integrated, and both prison-based and community-based programs should be expanded
7. Gaps in treatment	Access to treatment is restricted due to poor linkage to care, limited incentives for general practitioners, and out-of-pocket costs in Hungary	Referral pathways should be strengthened, screening-to-treatment packages should be integrated, treatment costs should be reduced, and community- and prison-based treatment programs should be expanded
8. Systemic barriers	Healthcare systems face challenges due to fragmented hierarchies, unavailability of healthcare workers, budgetary constraints, inconsistent guidelines, and underfunded harm-reduction services. Shifts in drug-use patterns create additional difficulties	Guidelines, budgets, and roles should be harmonized, the health workforce should be retained and incentivized, harm-reduction services should be expanded, and responses should be adapted to evolving patterns of drug use

barrier, linking PWID directly to “user-friendly” care facilities. Early initiation of treatment, ideally at the first visit, has proven effective in improving adherence and outcomes [46]. “Test and treat” strategies have therefore been developed and implemented to address this gap.

National responses vary widely. Poland and the Czech Republic have expanded pangenotypic DAA access and decentralized care, while Hungary still lacks a comprehensive national HCV elimination strategy. While the removal of treatment restrictions since June 2023 has significantly improved access to therapy for patients with a history of intravenous drug use including incarcerated HCV patients, Slovakia’s plan remains underfunded and only partially implemented, limiting progress toward WHO elimination goals [35].

Across all four countries, strengthening harm reduction, removing abstinence-based treatment exclusions, and scaling up targeted screening are essential to reduce hepatitis C burden among PWID [43].

## Discussion outcomes: challenges and recommendations for viral hepatitis control

At the meeting and in focused discussion groups, experts identified a range of specific as well as overlapping barriers (Table 3) to hepatitis elimination across the four countries. Alongside these challenges, participants also outlined concrete needs and recommendations to strengthen health systems, improve coordination, and accelerate progress toward elimination goals.

## Conclusions

The outcome of this meeting highlights a clear call to action: to strengthen recognition of the burden of viral hepatitis, foster greater cooperation among Central and Eastern European countries, and enhance policies and practices for prevention, screening, diagnosis, and treatment of viral hepatitis. Given the shared demographics and epidemiological profiles

of the participating countries, the harmonization and standardization of national guidelines for viral hepatitis prevention and control offer a starting point.

From 1989, Poland was one of the first European countries to introduce mass vaccinations against HBV. Early success in mass HBV vaccination demonstrates the potential impact of coordinated national efforts. If not addressed carefully, trends fuelled by misinformation, low perceived infection risk, and unequal healthcare access could gradually undermine the region's longstanding achievements in HBV prevention. Regional coordination in vaccination schedules and improved immunization data surveillance are emphasized for maintaining high coverage, addressing emerging gaps, and supporting progress toward hepatitis elimination targets.

Notable progress in HCV treatment strategies has been observed across the region, yet, the persistent challenge of the lack of comprehensive HCV programmes highlight the gap between scientific evidence, expert recommendations, and policy implementation. Despite repeated demonstrations of cost-effectiveness, national HCV screening remains fragmented and underfunded across the region, with current testing levels falling well short of the WHO 2030 targets. Without scaling up to millions of annual tests, countries in Central Europe cannot realistically achieve elimination goals.

Participants emphasized the need to institutionalize regular regional meetings and expand cooperation to additional neighbouring countries (such as Latvia, Slovenia, Moldova and others), while also strengthening ties with broader European partners. Greater inclusion of Central and Eastern European countries in EU consortia is essential, as regional underrepresentation currently limits both visibility and resource allocation. Sustained collaboration at regional and European levels will be critical to accelerate progress.

The ECDC 2024 SDG progress report reinforces this urgency: while progress has been made in reducing HIV and tuberculosis incidence, the EU/EEA remains off track to achieve the 2030 viral hepatitis targets, and viral hepatitis-related mortality shows no meaningful decline [47]. Data gaps, weak surveillance, and insufficient integrated testing services continue to hinder effective action, particularly for vulnerable groups.

Moreover, elimination of HCV by 2030, once considered within reach in parts of Central Europe, is no longer feasible. The COVID-19 pandemic sharply reduced testing and treatment uptake, and without robust national screening programmes and stronger political commitment, significant reductions in HCV prevalence cannot be achieved.

In sum, the path to hepatitis elimination in Central and Eastern Europe will not be secured through medical advances alone. It requires unwavering political will, coordinated regional strategies, and sustained investment. Without immediate and decisive action, the WHO 2030 elimination goals will remain out of reach.

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## Acknowledgments

We gratefully acknowledge all individuals and organizations who contributed to the completion of this VHPB regional overview. In particular, we thank the respective health and hepatitis committees of the four countries for their review and approval of this work. We also extend our sincere appreciation to David Fitzsimons for his comprehensive meeting report, which served as a vital framework for this review, and to the VHPB advisors for their ongoing guidance and support.

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## Disclosures

This research received no external funding.  
Institutional review board statement: Not applicable.  
The authors declare no conflict of interest.

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