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EUROPEAN CENTRE FOR DISEASE PREVENTION AND CONTROL

MONITORING

Testing of HIV, hepatitis B and hepatitis C in the European Union/ European Economic Area (EU/EEA)

ECDC MONITORING REPORT

Testing of HIV, hepatitis B and hepatitis C in the European Union/European Economic Area (EU/EEA)

Progress with the implementation of integrated HIV and viral hepatitis testing programmes in the EU/EEA countries

This report by the European Centre for Disease Prevention and Control (ECDC) was coordinated by Charlotte Deogan with support from Teymur Noori and Erika Duffell.

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Abbreviations

ART	antiretroviral therapy
BBV	blood-borne virus
ECDC	European Centre for Disease Prevention and Control
EEA	European Economic Area
EU	European Union
EUDA	European Union Drugs Agency
GAM	Global AIDS Monitoring
HBV	hepatitis B virus
HCV	hepatitis C virus
MSM	men who have sex with men
PLHIV	people living with HIV
PrEP	pre-exposure prophylaxis
PWID	people who inject drugs
SDG	Sustainable Development Goals
STI	sexually transmitted infection
UNAIDS	The Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

Executive summary

Introduction and methods

Timely and effective testing for HIV, hepatitis B virus (HBV) and hepatitis C virus (HCV) is essential to controlling these blood-borne viruses. Negative test results offer opportunities for prevention, including HIV pre-exposure prophylaxis (PrEP), condom provision and counselling, hepatitis B vaccination and harm reduction interventions for people who are at risk of blood-borne virus infection through injecting drug use. Global targets set by The United Nations Programme on HIV/Aids (UNAIDS) and the World Health Organization (WHO) aim to eliminate the epidemics of AIDS and viral hepatitis as public health threats by 2030.

This report summarises progress in European Union/European Economic Area (EU/EEA) countries towards implementing integrated testing strategies, based on the public health guidance on integrated HIV, hepatitis B and C testing published by the European Centre for Disease Prevention and Control (ECDC) in 2018. It draws on monitoring and surveillance data reported to ECDC in 2024 for HIV and in 2023 for hepatitis, covering the existence of national testing policy and guidance (and whether guidance is integrated across viruses and specific populations), the degree of guidance implementation, testing uptake and coverage, including late diagnoses and the percentage of people living with the three viruses who have been diagnosed.

Key findings on the integration of testing for HIV, HBV and HCV

Integration of testing guidance

Guidance included in national policy, strategy or recommendations on HIV, HBV and HCV testing is out of date in many EU/EEA countries and not aligned with ECDC recommendations.

- While 27 of 30 countries include HIV testing in national policy, only 17 have integrated recommendations for HIV, HBV, HCV and sexually transmitted infections (STIs).
- Over half of the countries have not updated their testing guidance since 2018 when ECDC's guidance was published.
- For hepatitis, 22 of the 30 countries reported having a national plan or strategy covering the response to hepatitis.

Coverage of key populations:

ECDC recommends that testing for HIV, HBV and HCV is offered to key populations at increased risk of infection.

- Most countries include key populations in HIV testing guidance (27 of 30 countries), while somewhat fewer do so for HBV and HCV.
- Men who have sex with men (MSM) and people who inject drugs (PWID) are most commonly included; transgender people and people in prison are less frequently taken into consideration.

Testing approaches and accessibility

- For HIV, provider-initiated testing in primary and secondary care and community-based testing by trained medical providers are the most commonly implemented approaches, while home testing and testing in other healthcare settings, such as pharmacies, remain limited.
- For hepatitis, rapid HCV tests are available in the majority of EU/EEA countries but peer-to-peer testing (for HBV and HCV) is only available in one-third of the countries and self-tests for HCV remain rare.
- HIV, hepatitis B and C disproportionately affect marginalised populations who may find testing more acceptable when delivered in community settings by peers, referred to as 'lay providers'. There are still restrictions on who can perform tests, with 22 countries requiring healthcare professionals for HIV and 23 for HBV/HCV.
- Testing is not universally free: only 24 countries offer free testing to all for HIV and 17 for hepatitis.

Testing coverage and outcomes

- Most countries lack testing data disaggregated by key population or setting for all three infections, which limits our understanding of availability and accessibility of testing among those who are most at risk. HIV positivity rates are higher in community settings than in healthcare settings. Data on testing volume and positivity by setting were available for about half of the countries for HIV but were not included in data collection for hepatitis.
- Over 50% of HIV cases are diagnosed late (CD4 count <350 cells/mm^3 blood), with individuals probably living undiagnosed for 3–5 years posing them at increased risk of morbidity, mortality, worse treatment outcomes and transmitting the virus to others.

- For hepatitis, late-stage diagnoses with chronic HBV/HCV infection (with end-stage liver disease, including decompensated cirrhosis and/or hepatocellular carcinoma) are common, exposing those who are at risk to life-threatening complications.
- In terms of progress toward the global diagnosis targets, an estimated 92% of people living with HIV had been diagnosed in 26 EU/EEA countries with available data. Seven countries had met the 95% target and an additional eight were within 5% of the target. While the target of 95% of people living with HIV being aware of their HIV status may be feasible to achieve, reaching the WHO targets (60% of those with chronic hepatitis B and C being diagnosed) will be more challenging. For hepatitis, results on progress towards the WHO targets were available from just four countries, with none having met the 60% target for HBV and only three having met the 60% target for HCV.

Priorities for action

- Update national testing policies to reflect integrated, multi-disease approaches, ensuring alignment with ECDC guidance and global targets.
- Include recommendations on the testing of key populations in national guidance and expand integrated testing policies to include all key populations, especially those that are underserved.
- Diversify testing approaches, including peer-led and self-testing, to improve reach and acceptability, particularly outside traditional healthcare settings. Peer involvement, lay-provider testing, community outreach and culturally and linguistically tailored approaches (including mobile health and use of social media) are methods that are likely to increase access and engagement with testing services among key and vulnerable populations.
- Remove legal barriers to lay provider testing and ensure free access to testing, especially for vulnerable populations.
- Strengthen monitoring systems to capture testing uptake and outcomes by population and setting, enabling targeted improvements.

1. Introduction

In 2015, the United Nations Member States adopted the Sustainable Development Goals (SDGs) for 2030, including SDG 3.3: 'Ending the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne and other communicable diseases' [1]. This commitment was followed by publication of the World Health Organization (WHO) Global Health Sector Strategies on HIV, Viral Hepatitis and Sexually Transmitted Infections (STIs) in 2016 and 2022, a UNAIDS Global AIDS Strategy in 2021 and related WHO European Action Plans – all setting ambitious and aligned targets to eliminate the epidemics of HIV, viral hepatitis and STIs as public health threats by 2030 [2-7]. The core targets, the so-called elimination targets, focus on reducing new infections and mortality, and increasing coverage with testing and treatment through a continuum of care. These targets cover critical stages towards achieving viral suppression among people living with HIV and viral hepatitis, with the option of a cure for HCV. The testing targets stipulate that 95% of all people living with HIV should be aware of their HIV infection ('the first 95 target') and 60% of people with chronic hepatitis B and C should be diagnosed by 2025.

Despite some progress in reducing HIV transmission over the past decade, 24 731 people were diagnosed with HIV in 2023 across the EU/EEA [8]. For hepatitis, a total of 37 766 cases of HBV (6% acute, 41% chronic and 53% unknown/unclassified) and 28 622 cases of HCV (5% acute, 34% chronic and 61% unknown/unclassified) were reported in 2023. Furthermore, modelled estimates suggest that 820 000 people were living with HIV, 3.2 million with chronic HBV and 1.8 million with HCV in the EU/EEA as of the end of 2023 [9,10], demonstrating that the burden of disease for all three remains high in the EU/EEA.

Testing is central to prevention and the overall public health response to HIV, hepatitis B and hepatitis C. Early testing, prompt diagnosis and linkage to treatment and care is critical to achieving the SDG goals, reducing late diagnoses, ensuring good health outcomes for people living with HIV and viral hepatitis and preventing onward transmission. A positive diagnostic test enables access to effective treatments for HIV, HBV and HCV, with the opportunity for a cure for hepatitis C. A negative diagnostic test provides prevention opportunities, including the provision of PrEP (pre-exposure prophylaxis) to prevent HIV transmission; hepatitis B vaccination; needle and syringe provision or opioid agonist treatment for people at risk of blood-borne virus (BBV) infection through injecting drug use, and other appropriate risk reduction interventions.

Individuals who are diagnosed several years after they were infected are more likely to experience negative health consequences, including increased short-term mortality, and morbidity. Late diagnosis also poses an increased risk of onward transmission [11,12]. Monitoring the proportion of people who are diagnosed at a late stage of infection over time is a key indicator of how well a testing programme is working in a given country or population.

In 2018, European Centre for Disease Prevention and Control (ECDC) released its first integrated testing guidance: 'Public Health Guidance on HIV, hepatitis B and C testing in the EU/EEA – an integrated approach' [13]. Given that the three viruses have common modes of transmission, leading to significant overlaps in the risk groups affected and high levels of co-infection, the guidance recommends strengthening integrated HIV/HBV/HCV testing programmes.

This report provides information on progress with the implementation of ECDC's integrated testing guidance across the EU/EEA, including the integration of testing guidance in policies, strategies and recommendations, implementation of testing approaches and accessibility (including costs and legal barriers), testing uptake and coverage, and proportions diagnosed or diagnosed late. Drawing on monitoring data collected by ECDC, it also outlines the status of data collection and availability of testing data for HIV and hepatitis in the EU/EEA countries.

2. Methods

This report outlines the EU/EEA country responses to the testing recommendations outlined in ECDC's testing guidance [13]. The guidance outlines core principles for integration, a range of testing approaches and settings, population groups considered for testing and suggested testing frequencies. It also calls for the development of a monitoring and evaluation framework for testing programmes (Annex 1).

This report is based on data collected by ECDC through online questionnaires disseminated to the 30 EU/EEA countries to monitor progress toward the UNAIDS and WHO global and regional targets for HIV and viral hepatitis and implementation of ECDC guidance in the area of HIV and hepatitis [7,13].

For HIV, data through the end of 2023 were collected between February and June 2024, followed by a round of data validation from May to August 2024, during which each country performed a validation exercise and made corrections where necessary. An existing questionnaire was used, which was initially developed in 2009 and then regularly updated to monitor implementation of the 2004 Dublin Declaration.

For hepatitis B and C, ECDC implemented a system to collect data in 2017 to monitor responses to the epidemics of hepatitis B and hepatitis C in the EU/EEA countries. Data are collected on a biennial basis, with each country validating their data and making corrections to the results where necessary. The initial monitoring questionnaire has been continuously revised over time in relation to feedback from the advisory group. The third data collection took place between April 2023 and August 2023 and collected data through to the end of 2022.

If no new data were reported for 2023 (for HIV) or 2022 (for hepatitis) for certain countries, data were used from the most recent year available, on the condition that these data were not more than five years old.

In addition to monitoring data, this report also uses surveillance data for 2023 regarding HIV late diagnosis.

Both monitoring questionnaires contained specific indicators and questions related to testing and diagnosis, including questions about national testing guidance in policy, strategy or recommendations, the provision of testing services, uptake and coverage of testing and the continuum of care. Indicators and questions were aligned with UNAIDS and WHO monitoring guidelines [14,15].

The monitoring questionnaires for HIV and hepatitis asked different questions on testing and integration. For HIV, countries were asked if their national testing guidelines included recommendations on integrated testing for HIV, viral hepatitis and sexually transmitted infections, in line with ECDC's 'Public health guidance on HIV, hepatitis B and C testing in the EU/EEA' [13]. This question was not included in the monitoring questionnaire for hepatitis. With regard to guidance on testing, for HIV countries were asked about national testing guidelines, while for hepatitis, they were asked whether there was a national plan or strategy available covering the response to viral hepatitis, as well as whether they had a specific hepatitis testing policy, programme or guidance for a list of key populations.

3. Policy and guidance on testing

All 30 EU/EEA countries responded to both monitoring questionnaires (HIV and hepatitis) and provided data for one or more of the questions. The number of countries responding to each specific question is provided in the respective sections.

National testing guidance and alignment with ECDC recommendations

Testing guidance informs the development, design and implementation of testing services. It sets standards for best practice and informs strategic decision-making regarding the optimal mix of approaches needed to deliver HIV and hepatitis testing services and maximise impact.

For HIV, among the 30 EU/EEA countries with information available, 27[1] reported that a national HIV testing policy, strategy or other recommendation exists from their government (Table 1). Of these 27 countries, 13 indicated that their testing guidance had not been updated for at least five years. Guidance published over five years ago may not reflect the most recent innovations in HIV testing (community-based testing, indicator-guided HIV testing, etc.) or the current epidemiological situation (population groups and indications for testing). Among the 13 countries with guidance older than five years, seven reported that they have plans to revise their guidance within the next three years. Among the three countries with no national HIV testing policy, strategy or other recommendation, two (Hungary and Ireland) reported that they used ECDC's guidance [13] and one (Germany) used guidelines from a national medical specialty association. One country (Ireland) plans to introduce national HIV testing guidance in the next two years. Annex 2 provides detailed information on HIV testing guidance by country.

Twenty-two countries[2] reported having a national plan or strategy that covered the response to viral hepatitis, with 15 of them indicating that funds were allocated from the national budget to implement the plan or strategy [16].

All countries reported having a specific testing policy, programme or guidance for at least one of the key populations listed for HBV and 29 of the 30 countries[3] for HCV, with some variation as to which population groups were targeted. Further information is provided on specific population groups in the next section and in Annex 3.

Table 1. Number of countries with national HIV testing guidance available and year of publication, EU/EEA, 2024*

Year	Number of countries	Countries
2023 or 2024	4	Czechia, Iceland, Poland, Slovakia
2022	4	Greece, Malta, Netherlands, Romania
2021	1	Norway
2020	2	Cyprus, Estonia
2019	2	Austria, Belgium
2018 or earlier	14	Bulgaria, Croatia, Denmark, Finland, France, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Portugal, Slovenia, Spain, Sweden

** Data referring to 2024 or most recent year with available data: 2023 for Croatia, Cyprus, Hungary and Norway.*
No HIV testing guidance or policy was available in Germany, Hungary and Ireland (see text above the table).

[1] No national testing policy, strategy or other recommendation on HIV was available in Germany, Hungary and Ireland.

[2] Bulgaria*, Cyprus*, Czechia*, Denmark*, Finland, France*, Germany, Greece, Iceland*, Ireland*, Italy*, Latvia*, Liechtenstein*, Luxembourg*, Netherlands, Norway, Portugal*, Romania*, Slovakia, Slovenia*, Spain* and Sweden (* indicates that funds were allocated to implement the strategy).

[3] In Czechia there were no HCV testing policies/programmes directed towards the key populations listed.

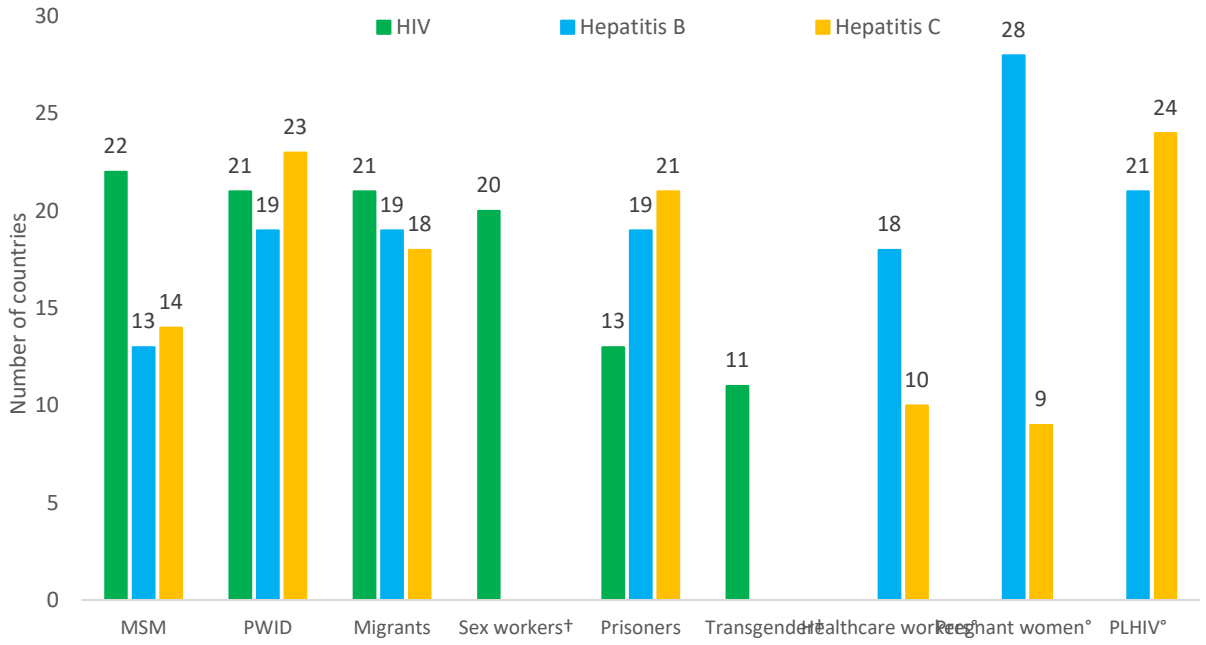
Focus on specific population groups in national guidance and testing frequency

ECDC guidance on HIV and hepatitis testing recommends that testing for HIV, HBV and HCV are offered to population groups at increased risk of acquiring a BBV infection [13][4].

For HIV, of the 27 countries that had a national HIV testing policy or strategy, 24 indicated that the policy included specific guidance for testing key populations (Figure 1).

For hepatitis, 30 countries provided information on whether they had a testing policy or programme for HBV and HCV for a number of population groups. All countries reported having a policy or programme for at least one of the key populations listed for HBV and 29 of the 30 countries[5] had a policy or programme for HCV, with some variation as to which population groups were targeted. The population groups most frequently mentioned for HIV were MSM (mentioned by 22 countries); people who inject drugs and migrants (21 countries) and sex workers (20 countries). Transgender people were the least frequently group mentioned in countries' national guidelines (11 countries). For HBV, the groups most frequently included were pregnant women (28 countries); people living with HIV (21 countries); people who inject drugs (PWID) (19 countries); migrants (19 countries) and people in prison (19 countries); and for HCV: people living with HIV (24 countries); people who inject drugs (23 countries); people in prison (21 countries) and migrants (18 countries) (Figure 1).

Figure 1. Number of countries with recommendations for testing of key populations included in national HIV, HBV and HCV testing guidance, EU/EEA, 2023/2024*



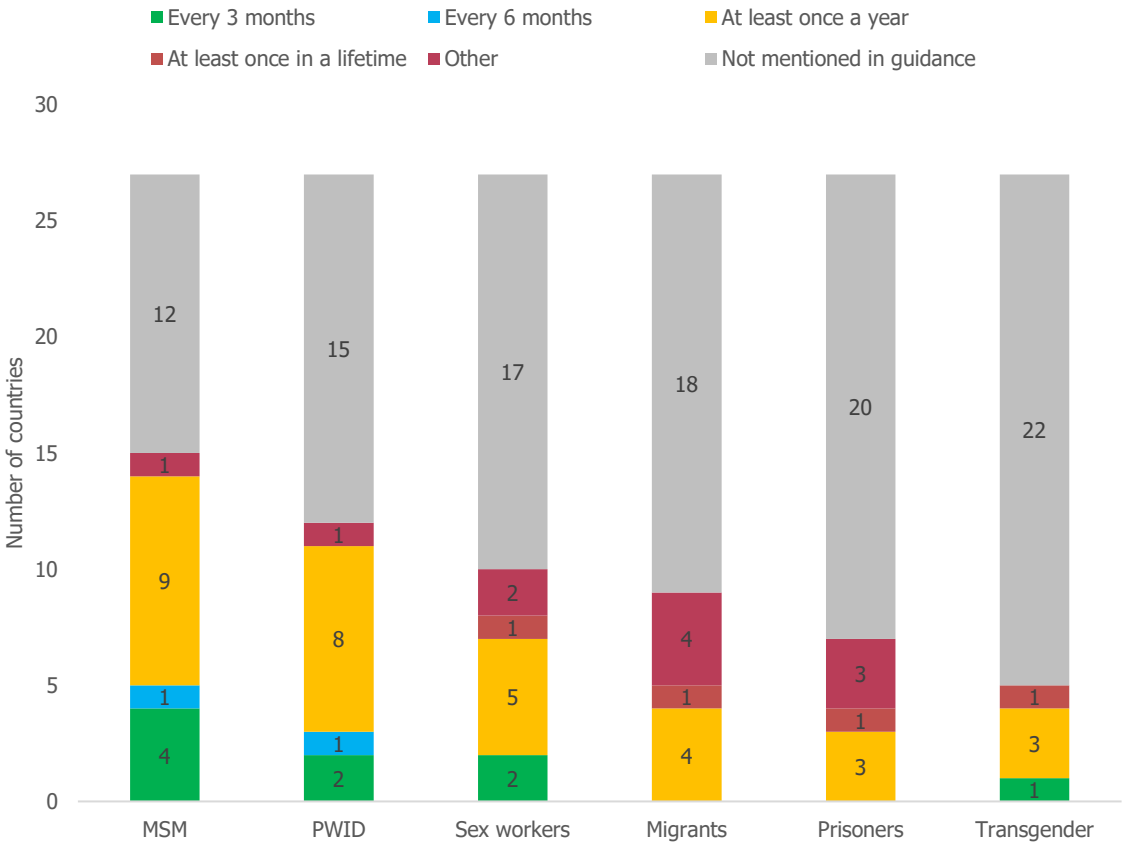
** 2023 for hepatitis and 2024 for HIV, or most recent year with available data (2023 for Croatia, Cyprus and Norway (HIV data)).*
† Information on sex workers and transgender people not requested within hepatitis monitoring.
° Information on healthcare workers, pregnant women and people living with HIV not requested within HIV monitoring.
MSM: Men who have sex with men; PWID: people who inject drugs; PLHIV: people living with HIV.

ECDC recommends that key populations should be tested for HIV, HBV and HCV every 6–12 months (up to every three months for some groups in relation to HIV), depending on local epidemiology and risk assessment [13][6]. Testing of healthcare workers for HCV is only recommended in certain circumstances or certain countries, while pregnant women should be offered and recommended HBV and HIV tests during the first two trimesters of pregnancy. Information on testing frequency recommendations for certain population groups is collected as part of HIV monitoring but not currently within ECDC's hepatitis monitoring. Eighteen of the 27 countries that had a national HIV testing policy, guidelines or recommendations reported that their guidance included recommendations on testing frequency for at least one key population (Figure 2). Countries were most likely to include recommendations on frequency of testing for men who have sex with men (15 countries) and people who inject drugs (12 countries) and least likely to include recommendations for transgender people (five countries) and prisoners (seven countries). Among the 18 countries with recommendations on testing frequency, the majority recommended annual testing (9/15 for men who have sex with men, 8/12 for people who inject drugs, 5/10 for migrants, 4/9 for sex workers, 3/7 for

[4] Table 3, page 15 https://www.ecdc.europa.eu/sites/default/files/documents/hiv-hep-testing-guidance_0.pdf
[5] In Czechia there were no HCV testing policies/programmes directed towards the key populations listed.
[6] Table 3, page 15 https://www.ecdc.europa.eu/sites/default/files/documents/hiv-hep-testing-guidance_0.pdf

prisoners and 3/5 for transgender people) and some recommended testing every three months (4/15 for men who have sex with men, 2/12 for people who inject drugs, 2/10 for migrants and 1/5 for transgender people) which is largely in line with ECDC recommendations. However, the majority of countries do not have testing frequency recommendations for all population groups, with the exception of men who have sex with men for whom recommendations were available in just over half.

Figure 2. Number of countries with specific recommendations for testing frequency for HIV, by key population, EU/EEA, 2024* (n=27)



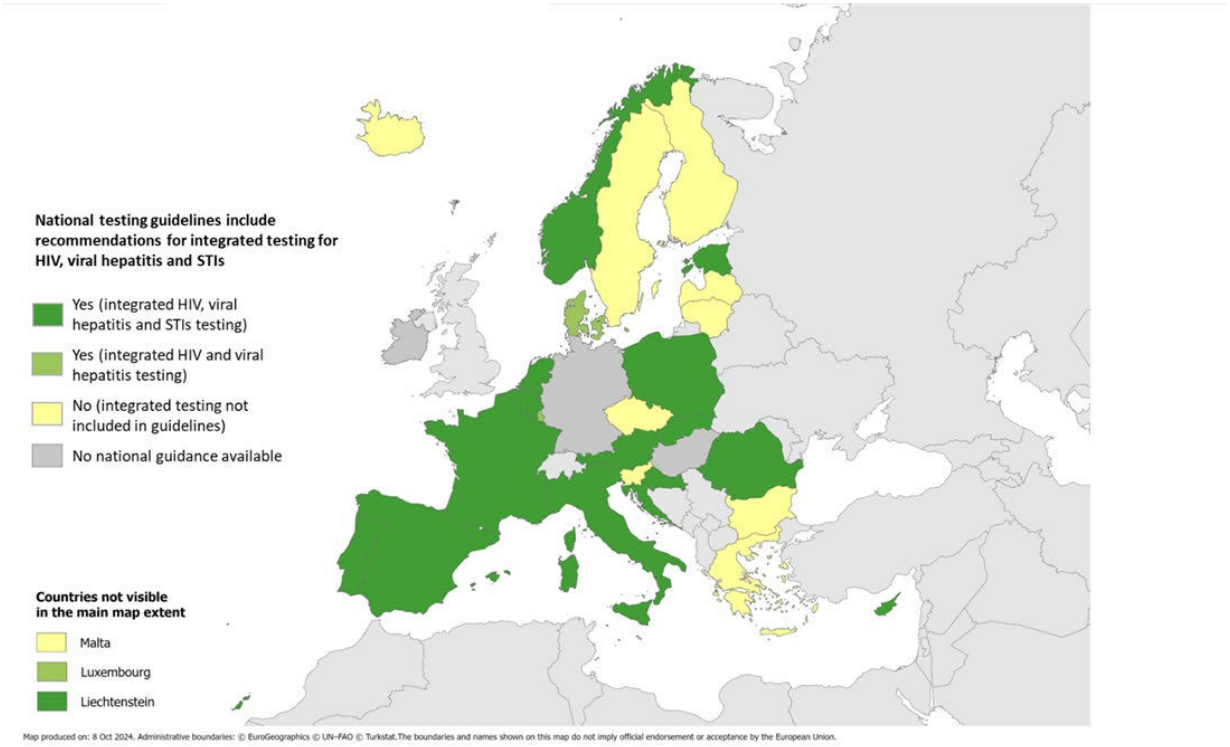
** 2024 or most recent year with available data (2023 for Croatia, Cyprus, Norway and Poland). Information on testing frequency recommendations was not available from Czechia, Finland, Iceland, Italy, Liechtenstein and Lithuania. No national testing guidance or policy was available in Germany, Hungary and Ireland.*

MSM: men who have sex with men; PWID; people who inject drugs.

Integrated HIV, STI and viral hepatitis testing

Overall, 17 of the 27 countries who reported having HIV testing policies or guidance reported that their guidance included a recommendation on integrated testing for HIV, HBV, HCV and STIs, including two that reported having guidance which only included integrated testing for HIV and viral hepatitis (i.e. not including integrated STI testing) (Figure 3).

Figure 3. Recommendations for integrated testing included within national HIV testing guidelines, EU/EEA, 2024* (n=30)



** 2024 or most recent year with available data: 2023 for Croatia, Cyprus, Hungary and Norway.*

4. Testing approaches and accessibility

Availability of different testing approaches

ECDC recommends a range of testing approaches and strategies for inclusion in national policies and implementation in national testing programmes, with the aim of increasing testing uptake and coverage (Box 1).

Box 1. Recommended testing approaches for HIV, HBV and HCV

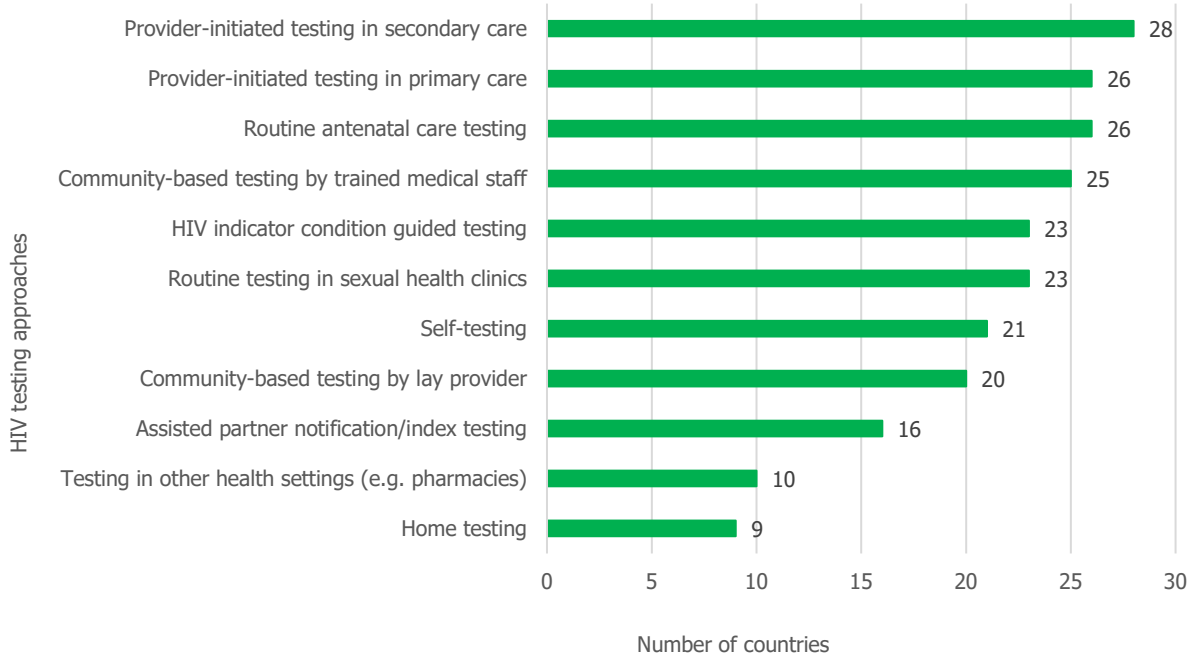
The following testing approaches are recommended by ECDC as effective and acceptable to increase the offer, uptake and coverage of testing in various settings [13Error! Bookmark not defined.]:

- Generalised testing in areas of intermediate or high prevalence.
- Birth cohort testing for HCV.
- Indicator condition-guided testing for HIV in all healthcare settings.
- Provider-initiated testing in primary care.
- Provider-initiated testing in secondary care.
- Testing in other healthcare settings (such as pharmacies, harm reduction services, prison health services etc.)
- Assisted partner notification (contact tracing) care.
- Community-based testing, including lay provider testing.
- Self-testing and self-sampling.

ECDC guidance also recommends routine antenatal care testing and routine testing in sexual health clinics.

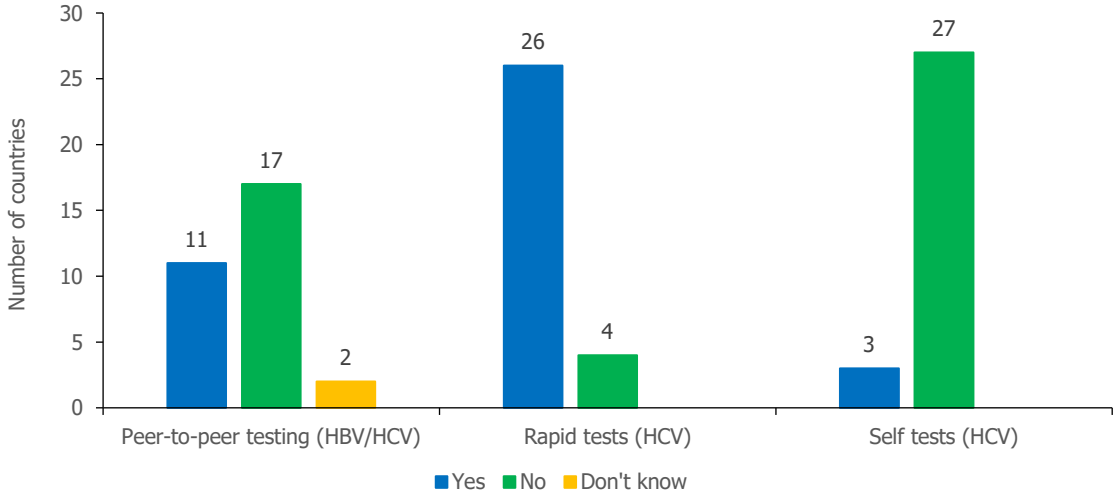
In 2024, the most commonly reported HIV testing approaches being implemented included provider-initiated testing in secondary care (reported by 28 countries); provider-initiated testing in primary care (26 countries), routine antenatal care testing (26 countries) and community-based testing and counselling by a trained medical professional (25 countries). The least frequently reported testing approaches remained home testing (nine countries) and testing in other healthcare settings, such as pharmacies (10 countries), although these were increasing (Figure 4).

Figure 4. Number of countries reporting implementation of different HIV testing approaches, EU/EEA, 2024 (n=30)



While rapid tests for HCV were reported to be available in 26 countries, the availability of HCV self-testing and peer-to-peer testing (for HBV and HCV) was lower (Figure 5). Peer-to-peer testing services were available in 11 countries and self-testing in three. Implementation of all three testing approaches has increased since 2021 when no country reported having self-tests available: 23 countries reported the availability of rapid tests and nine countries reported peer-to-peer testing services [16].

Figure 5. Number of countries reporting availability of HBV and HCV testing approaches, EU/EEA, 2023 (n=30)



Test administration – legal and regulatory barriers

Legal barriers to testing are those enshrined in law, while regulatory barriers are those contained in guidance, rules or directives made and maintained by an authority [17]. A substantial barrier to testing is the criminalisation of HIV transmission and the activities and behaviour of the key populations affected by HIV and hepatitis (e.g. criminalisation of drug use, sex work and undocumented migration) which continues to exist in some EU/EEA countries [18,19]. Within the range of possible barriers to testing posed by legal or regulatory restrictions, this report examines the restrictions on who can administer an HIV, HBV and HCV test, testing consent procedures and the costs associated with testing.

Testing by trained lay providers, which has been recommended by WHO since 2015 [20] and should be considered according to ECDC guidance [13], supports task-sharing in the health sector and alleviates work load and may be more acceptable to marginalised populations. However, in Europe there are still restrictions on who can administer a test, ranging from only doctors being able to take blood samples, to a clinician having to be present in the building while testing is taking place [17**Error! Bookmark not defined.**]. For HIV, 22 of the 30 countries (73%) reported that there are restrictions regarding who can legally carry out an HIV test. In seven countries, only healthcare workers can administer an HIV test, while nine countries reported that community/NGO workers can offer testing for HIV, but only with clinical supervision, and 13 countries reported that community/NGO workers can perform an HIV test without clinical supervision. This level of detail is not yet collected for HBV and HCV testing, however, 23 countries reported that HBV and HCV tests must be performed by a healthcare worker, suggesting that fewer countries allow lay provider testing for hepatitis than is the case for HIV.

Complicated consent procedures for blood-borne virus testing are another barrier to testing, even for the test provider and particularly in non-specialist healthcare settings. While European and global testing guidance no longer recommends written consent and individualised pre-test counselling, written or documented consent remains a requirement for HIV testing in more than a third of European countries [21].

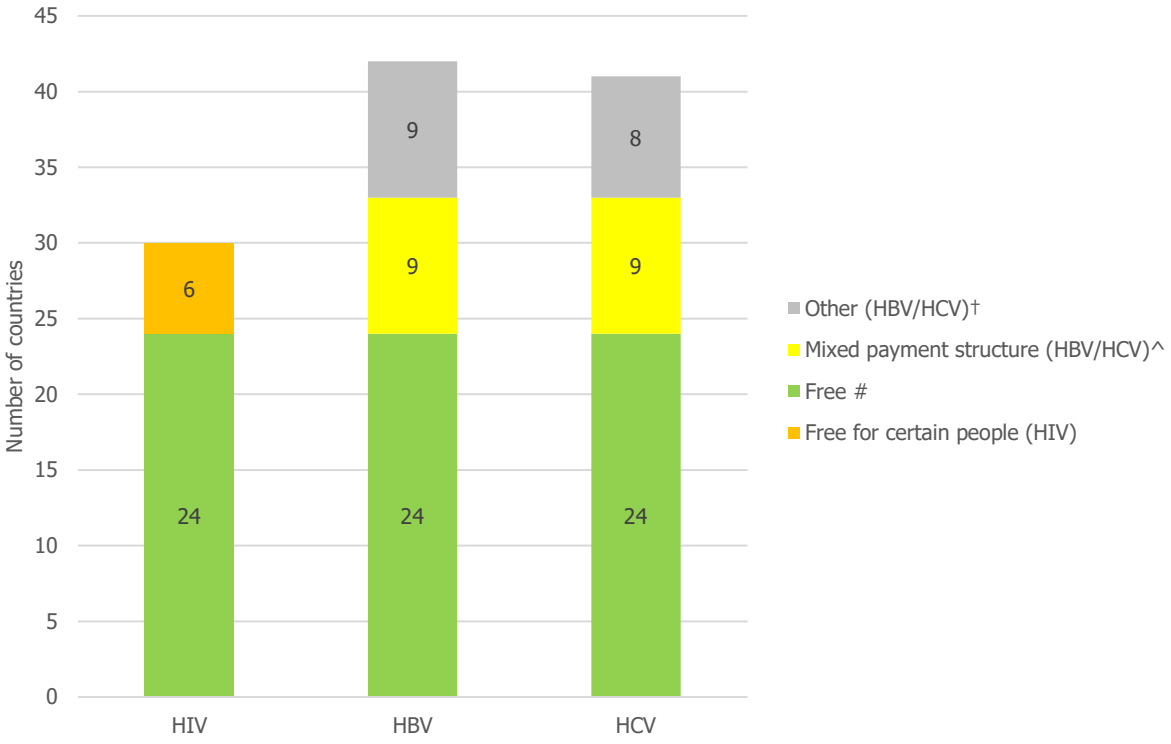
Costs associated with testing

In order to increase detection and prevent disease and onward transmission, efforts need to be made to ensure easy access and affordable HIV, HBV and HCV testing for all risk groups [13]. An important barrier to testing is cost, as affordability is key to reaching people at risk of HIV, HBV and HCV [14,22].

Information on costs associated with testing for HIV, HBV and HCV was provided by all 30 countries. For HIV, testing was free for all in 24 countries and free for 'certain people' (i.e. free for some population groups or in certain geographical areas) in six countries (Figure 6)[7]. For HBV and HCV, several response options were available, and countries could also select more than one option, meaning that the total number of responses exceeded 30 for HBV and HCV. The situation was largely similar for the two infections: fourteen countries reported some fee at point of test access for HBV and HCV, including seven reporting a mixed payment structure, five reported a user fee which was reimbursed by the health system or health insurance and two reported a non-reimbursed user fee. 'Other' types of payment structure reported included free testing when medically indicated or for people considered at risk of infection; testing that was free in some settings or for some population/age groups only, or user fees that were reimbursed for people without insurance (e.g. during screening campaigns).

[7] Costs associated with testing were monitored according to different categories, leading to discrepant labels across HIV, HBV and HCV (Figure 6).

Figure 6. Costs associated with HIV and HBV/HCV testing, EU/EEA, 2023/2024* (n=30)



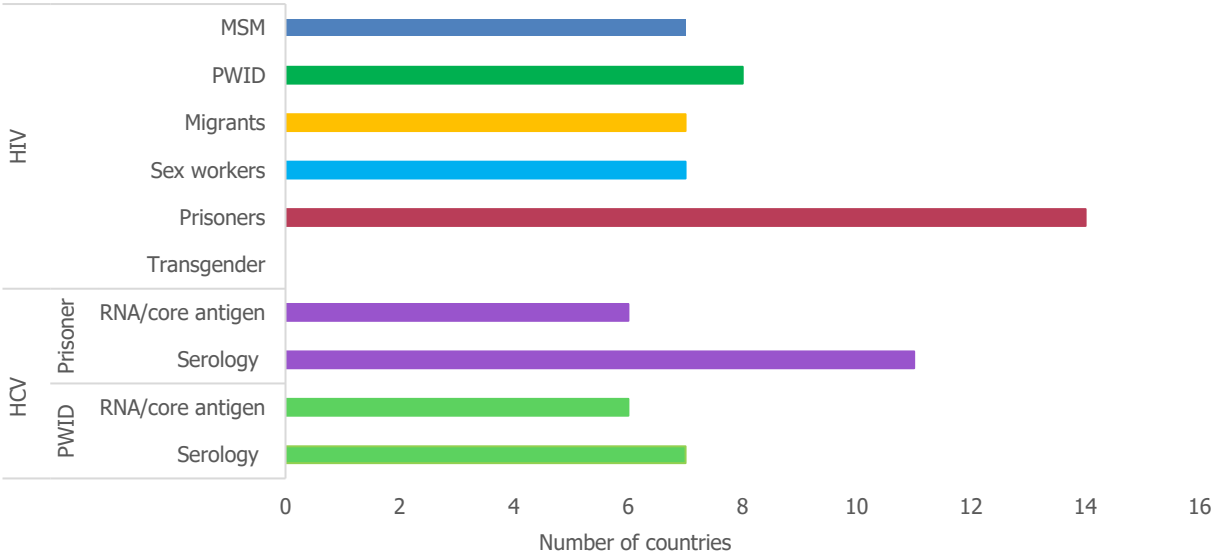
** 2023 for HBV/HCV and 2024 for HIV, or most recent year with available data (2023 for Cyprus for HIV).*
† For HBV/HCV, countries could choose more than one response option.
^ Mixed payment structure (HBV/HCV) means user fee charged and/or user fee not reimbursed by health system/insurance.
 # Free (HBV/HCV) means free at point of care or user fee reimbursed by health system/insurance. Free for HIV means free for all.

5. Testing uptake and coverage

Testing among key populations

Data on uptake of testing among key populations are limited, with no country indicating that HIV testing data are collected for transgender people, seven countries indicating that HIV testing data were collected for men who have sex with men, migrants and sex workers and eight countries for people who inject drugs. Half of the countries reported that they collected testing data for people in prison for HIV and a third for HCV (Figure 7).

Figure 7. Number of countries indicating that data on HIV and HCV testing are collected among key populations, EU/EEA, 2023/2024* (n=30)



** 2023 for hepatitis and 2024 for HIV, or most recent year with available data.*
MSM: men who have sex with men; PWID: people who inject drugs; RNA: ribonucleic acid.

HIV testing coverage and status awareness among key populations is monitored globally (and in the EU/EEA) through a survey-based indicator measuring the percentage of people from key populations who know their HIV status – i.e. the percentage that has been tested in the past 12 months or know that they are living with HIV. Among the EU/EEA countries, only very few conducted behavioural surveillance surveys enabling them to report on this indicator. Three countries (Estonia, France and Portugal) had survey data available related to HIV testing coverage or status awareness for men who have sex with men, ranging from 56% in Estonia, to 68% in France and 73% in Portugal. Four countries (Estonia, Germany, Portugal and Romania) had data available on HIV testing coverage for people who inject drugs, ranging from 46% in Germany, to 63% in Romania, 76% in Estonia and 96% in Portugal.

HIV data availability among the other key populations (migrants, sex workers, people in prison and transgender people) is very limited. Three countries (Cyprus, Malta and Portugal) reported data on testing coverage or status awareness for migrants, ranging from 16% in Poland to 56% in Portugal and 100% in Cyprus; two countries reported data for sex workers (Estonia and Portugal), with testing coverage of 60% and 71%, respectively; five countries reported data for people in prison (Czechia, Lithuania, Malta, Romania and Spain), with the reported data generally representing the results of routine screening on admission and coverage ranging from 73% in Spain to 100% in Czechia, Malta and Romania; and two countries reported testing coverage or status awareness for transgender people (Germany (23%) and Portugal (75%)).

For hepatitis, countries were asked to report on the number of people who inject drugs and the number of people in prison serologically tested for hepatitis C (anti-HCV) and tested for hepatitis C virus (HCV RNA or HCV core antigen). For people who inject drugs, national level data were reported from three countries (Greece, Italy and Slovenia) and city level from two (Germany and Romania). For people in prison, national level data were available from four countries (Austria, Croatia, Poland and Romania) and prison-level data from three (Germany, Hungary and Malta). Due to the large variation in underlying population sizes, the raw data are difficult to compare across countries and are therefore not presented here.

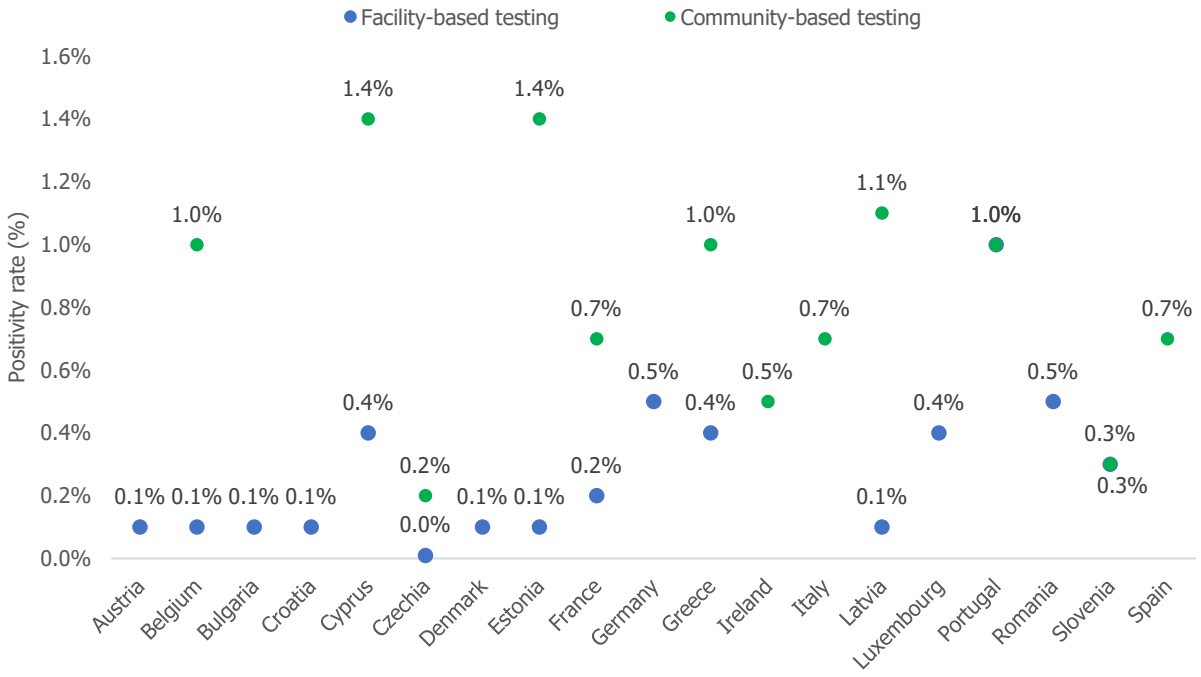
Testing uptake in different settings

Monitoring uptake of HIV testing in different settings enables national health authorities to ensure that services are delivered and tailored effectively, while being informed of trends in HIV transmission. Positivity data (percentage testing positive among those being tested) can also help countries determine the effectiveness of testing strategies, evaluate testing services and validate the number of people reported as newly diagnosed through routine reporting systems.

Overall, 19 countries were able to provide data on HIV testing volume (number of tests performed) and positivity at country level, while 17 reported data at facility level and 12 at community level. Facility-level testing services include provider-initiated testing in clinics or emergency department settings, antenatal clinics, family planning clinics, voluntary counselling and testing (VCT) within a healthcare setting, and other facility-level testing services. Community-level testing services include mobile testing, VCT not undertaken within a healthcare setting and other community-based testing services.

HIV positivity rates were generally higher in community settings than in healthcare settings, ranging from 0.01% to 0.5% in healthcare settings and from 0.2% to 1.4% in community-based settings (Figure 8). In the nine countries with data from both settings, positivity rates were higher for community settings in seven.

Figure 8. HIV testing positivity rate for healthcare and community-based testing, by country, EU/EEA, 2023* (n=20)



** 2023 or most recent year with available data (2019 for Croatia). No data available from Finland, Hungary, Iceland, Liechtenstein, Lithuania, Malta, Netherlands, Norway, Poland, Slovakia and Sweden.*

For hepatitis, data on testing volume are not collected by setting but are available at overall population level.

Ten countries were able to provide data on the number of people tested for HBV (HBsAg) in 2022, ranging from 652 per 100 000 population in Bulgaria to 6 908 per 100 000 population in France. Data on the numbers tested came from a variety of sources, including survey data, surveillance data, and cohort data. Several countries noted that the data reported represented the number of tests, rather than the number of people tested.

Ten countries provided data on the number of people tested for anti-HCV in 2022, with rates ranging from 31 per 100 000 population in Hungary to 6 595 per 100 000 population in France. The number of people tested for HCV RNA or HCV core antigen ranged from 29 per 100 000 population in Romania to 4 071 per 100 000 population in Slovenia.

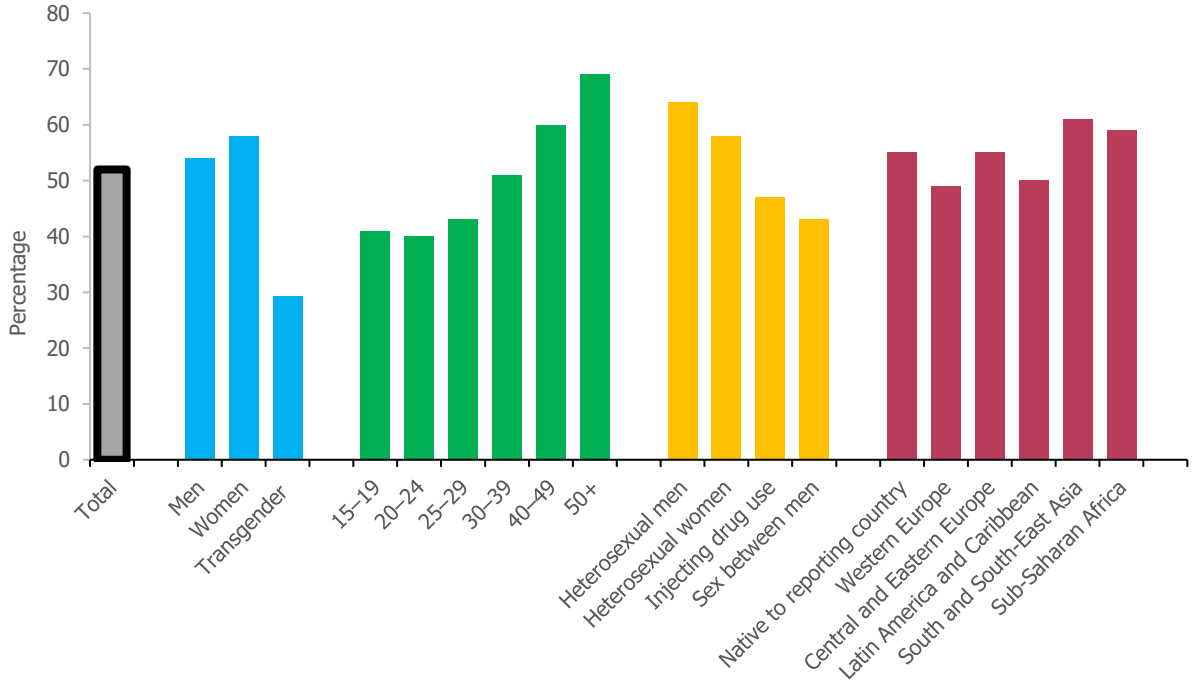
6. Late diagnosis

For HIV, about half (52.7%) of the 24 731 people newly diagnosed with HIV in the EU/EEA in 2023 were diagnosed at a late stage of infection, where the immune system had already been compromised, defined as having a CD4 cell count below 350 cells per mm^3 blood at the time of diagnosis [8] (Figure 9). This included 31.6% of cases considered to have advanced HIV infection (CD4 cell count below 200 cells/mm3) at the time of diagnosis [8]. The highest proportions of people presenting at a later stage of HIV infection (CD4 less than 350 cells/mm^3, excluding those previously diagnosed or with evidence of acute infection) were among women (58.2%), older adults (68.5% in those aged 50 years and over , 59.7% in the age group 40–49 years), men or women infected through heterosexual sex (63.8% and 58.2% respectively), people who acquired HIV through injecting drug use (47.0%), and people coming from South and South-East Asia (61.1%) and Sub-Saharan Africa (58.6%) (Figure 9).

Among all cases diagnosed in 2023 with information available on CD4 cell count (11 961), and excluding previous positive cases, 10.8% were diagnosed during acute infection[8], 24.0% and were identified as recent infections (with a CD4 cell count of 500 or over 500 cells/mm^3 at diagnosis). Specifically, among men who have sex with men diagnosed in 2023, 15.6% were reported as acute infections, and 26.4% had a CD4 cell count of 500 or over 500 cells/mm^3 at diagnosis.

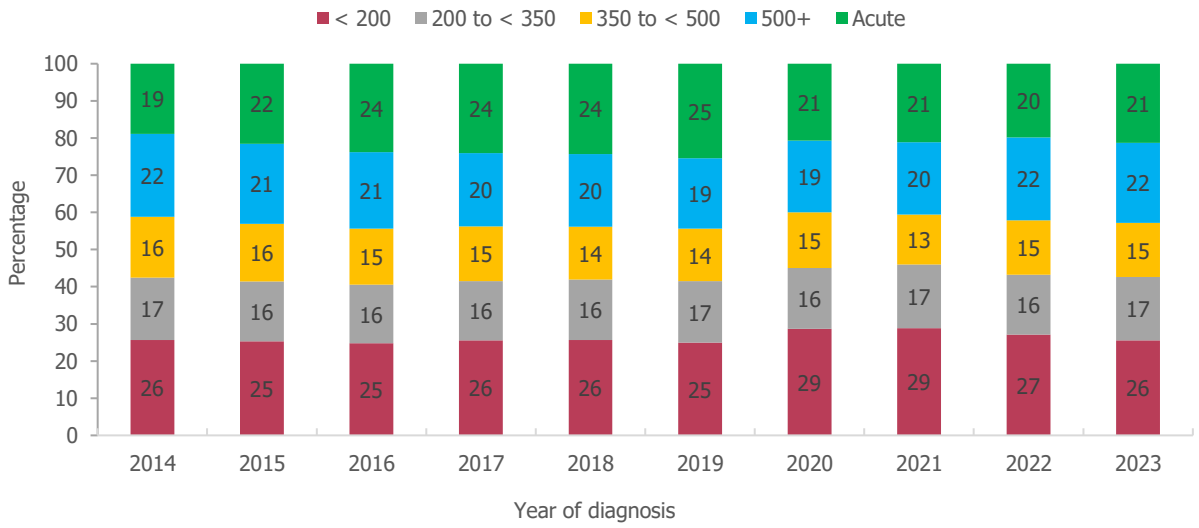
The trends for both late diagnoses and acute infections remained stable throughout the period. However, when analysing the trend in CD4 cell count data, a 23.0% decline in the number of unknown CD4 cell count values was observed, decreasing from 9 659 in 2014 to 7 434 in 2023 (Figure 10).

Figure 9. Percentage of people diagnosed late with HIV (CD4 < 350 cells per mm3) by demographic, EU/EEA, 2023 (n=11 961)



[8] Acute infection status was reported by countries to The European Surveillance System (TESSy) using one or more criteria for acute infection, including HIV negative test in the last six months, evidence of seroconversion illness, p24 antigen or an indication based on any other clinical or laboratory criteria, including how recently the person was last tested.

Figure 10. HIV diagnoses by acute infection or category of CD4 cell count per mm3 at diagnosis, EU/EEA, 2014–2023



For hepatitis B, estimates of the proportion of individuals with chronic HBV infection who had end-stage liver disease, including decompensated cirrhosis and/or hepatocellular carcinoma, at the time of diagnosis were available from only seven countries (Table 2). Estimates ranged from 1.6% in Poland to 17% in Romania. Germany reported that between 6.2 and 28% of individuals had cirrhosis at the time of their hepatitis B diagnosis and between 1.6 and 9.9% had hepatocellular carcinoma. It is important to note that geographical coverage of the estimates varied from clinic-level to national-level data and data came from a variety of different sources, making inter-country comparison difficult.

Table 2. Proportion of people with chronic HBV infection who had decompensated cirrhosis or hepatocellular carcinoma at the time of diagnosis, EU/EEA, reported in 2023

Country	Proportion of people with end-stage liver disease at time of diagnosis	Year of data	Geographical coverage and source of data
Austria	9.2% (cirrhosis)	2010–2020	City-level; cohort data
Greece	6.1% (decompensated cirrhosis); 3.4% (hepatocellular carcinoma)	1999–2016	Clinic-level; survey data
Germany	6.2–28% (cirrhosis); 1.6–9.9% (hepatocellular carcinoma)	2010–2016	Clinic-level; survey data
Hungary	10%	2023	National-level; cohort data
The Netherlands	3–4%	2013–2019	City-level; survey data
Poland	1.6%	2022	National-level; surveillance data
Romania	17%	2022	Regional-level; screening data

Eight countries reported estimates for the proportion of people with chronic HCV infection who had end-stage liver disease, including decompensated cirrhosis or hepatocellular carcinoma, at the time of diagnosis (Table 3). However, some of the estimates were over five years old and therefore do not reflect the current situation. Rates of end-stage liver disease at time of diagnosis varied greatly across countries, ranging from <1% in Iceland to 17% in Romania, with Germany reporting that 2–34% of individuals had cirrhosis at the time of their HCV diagnosis and 1.2% had hepatocellular carcinoma. As with hepatitis B, inter-country comparisons are difficult due to variation in data sources and geographical coverage.

Table 3. Proportion of people with chronic HCV infection who had decompensated cirrhosis or hepatocellular carcinoma at the time of diagnosis, EU/EEA, reported in 2023

Country	Proportion of people with end-stage liver disease at time of diagnosis	Year of data	Geographical coverage and source of data
Austria	11.5% (cirrhosis)	2014–2016	City-level; cohort data
Greece	5% (decompensated cirrhosis); 5% (hepatocellular carcinoma)	Unspecified	City-level; other data
Germany	2–34% (cirrhosis); 1.2% (hepatocellular carcinoma)	2010–2016	Clinic-level; survey data
Hungary	10%	2023	National-level; cohort data
Iceland	<1%	2016–2018	National-level; surveillance data
The Netherlands	8–9%	2013–2019	City-level; survey data
Poland	6.3%	2022	National-level; surveillance data
Romania	17%	2022	Regional-level; screening data

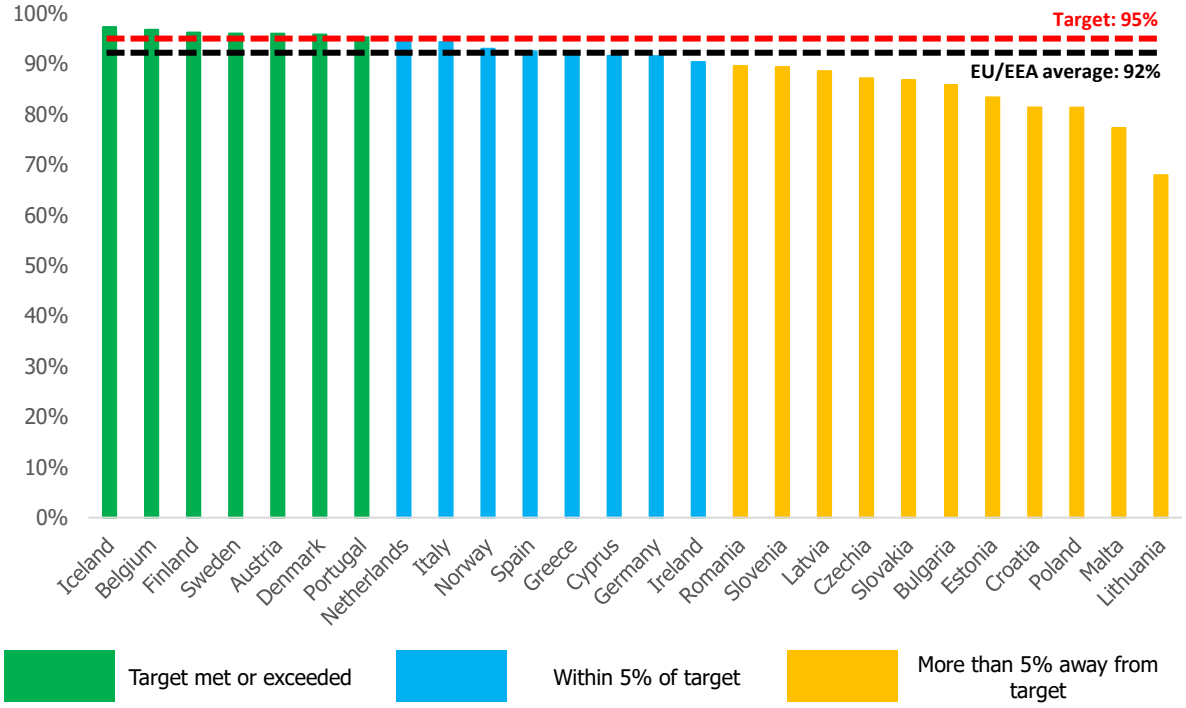
7. Percentage of people with HIV, HBV and HCV who have been diagnosed

Percentage of all people with HIV who have been diagnosed

In 2023, 26 countries in the EU/EEA reported data on the estimated number of people living with HIV who know their status (UNAIDS 95% target). Of the total 625 368 people living with HIV reported in these 26 countries, 576 550 (92%) had been diagnosed, ranging from 68% in Lithuania to 97% in Iceland and Belgium (Figure 11). Seven countries had met the first 95% target, and an additional eight were within 5% of reaching it.

These data suggest that while some countries are on track to reach the first 95% target, testing services must be scaled up in a number of countries, notably in the central and eastern part of the EU/EEA, in order for the region to reach the 2025 target of 95% of all people living with HIV knowing their HIV status.

Figure 11. Percentage of all people living with HIV who know their HIV status, EU/EEA countries, 2024* (n=26)



** Data reported for 2024 which is as of end of 2023, or most recent year with available data (2019 or later): 2022 data for Austria, Belgium, Ireland, Netherlands and Portugal; 2021 data for Cyprus, Italy, Malta, Norway and Spain; 2020 data for Slovakia. No data available from France, Hungary, Liechtenstein and Luxembourg.*

Source: ECDC Progress Progress towards reaching the Sustainable Development Goal 3.3 targets related to HIV, tuberculosis, viral hepatitis and sexually transmitted infections in the EU/EEA 2024 progress report (2022–2023 data). 2025.

Percentage of all people with HBV and HCV who have been diagnosed

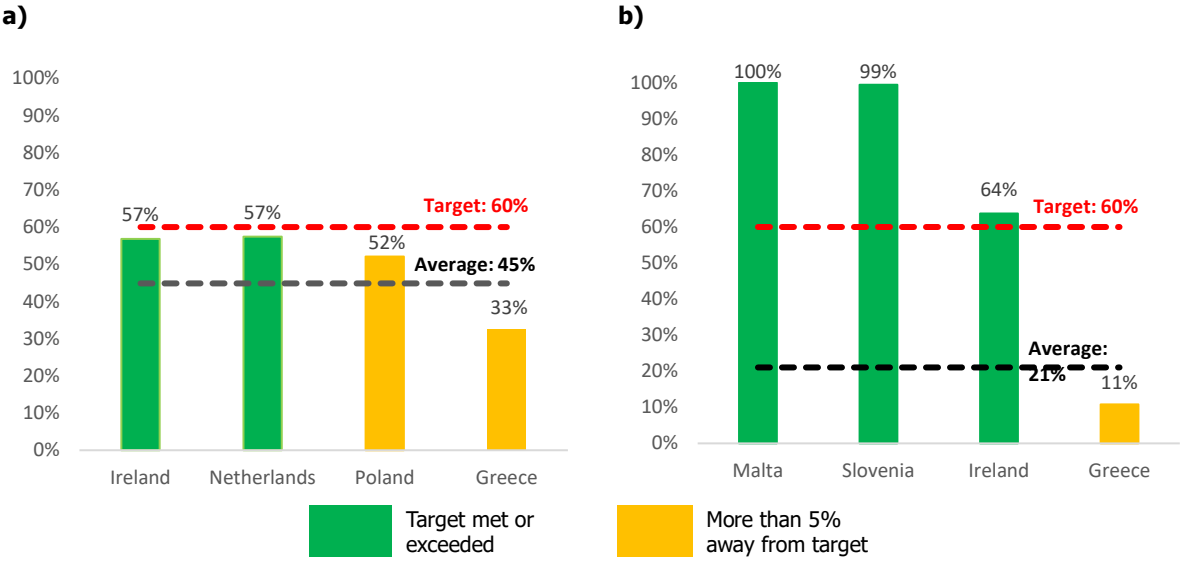
For hepatitis B, just four countries (Greece, Ireland, Netherlands and Poland) had sufficient data to report on progress toward the WHO 2025 diagnosis target of 60% of all people living with chronic hepatitis B infection being diagnosed. While none of the countries had met the target, two were within 5% of reaching it (Figure 12a). Among the estimated 491 576 people living with chronic HBV in the four countries, 220 500 (45%) had been diagnosed. At the national level, the proportion diagnosed ranged from 33% in Greece to 57% in Ireland and the Netherlands.

For hepatitis C, four countries also had sufficient data to report on progress toward the HCV diagnosis target (Greece, Ireland, Malta and Slovenia), with three having reached or exceeded the 60% target (Figure 12b). Of the estimated 55 877 people living with current chronic HCV in these four countries, 11 766 (21%) had been diagnosed with chronic HCV, excluding those with resolved infection. At country level, the proportion diagnosed ranged from 11% in Greece to 100% in Malta. However, data on the number of people ever diagnosed (the numerator) came from a wide range of sources of varying quality, including surveillance data, cohort studies, and surveys, therefore reducing comparability.

Given the low number of countries with data available to report on progress toward the diagnosis targets, the average figures provided above are unlikely to be representative of the region's progress.

Modelled estimates available for the EU/EEA as a whole suggest that 33% of people living with HBV (HBsAg) and 64% of people living with HCV had been diagnosed as of the end of 2023, suggesting that huge numbers of people continue to live with undiagnosed hepatitis B and C across the EU/EEA countries [10].

Figure 12a. Percentage of all people living with chronic HBV infection ever diagnosed, EU/EEA, 2023* (n=4); Figure 12b. Percentage of all people living with chronic HCV infection ever diagnosed, excluding those with resolved infection, EU/EEA, 2023* (n=4)



** 2022 or most recent year with available data: 2016 for Greece; 2020 for Poland.*

8. Limitations

This report brings together available ECDC monitoring and surveillance data on HIV, HBV and HCV testing policies and guidelines, implementation of testing programmes, including barriers, costs and outcomes across the EU/EEA for all three blood-borne viruses. While every attempt has been made to use standardised indicators and data, by necessity, information has had to be drawn from separate monitoring processes where data relating to the same topics have sometimes been collated in different ways. Together with differences in data availability, geographical representation and definitions, this limits the ability to make direct comparisons across infections and countries. Furthermore, countries use different modelling tools to estimate the number of people living with HIV.

Furthermore, the availability and quality of some of the reported indicators limit the ability to draw conclusions from the data presented and obtain a comprehensive understanding of the situation in terms of testing and diagnosis of blood-borne infections across the EU/EEA. In addition, information on local testing strategies, approaches and outcomes is not available, limiting the understanding of how well policies are being implemented at sub-regional level.

9. Conclusions and priorities for action

Conclusions

People's knowledge of their status through testing is crucial to the success of public health responses to HIV, hepatitis B and hepatitis C. Testing is the gateway to BBV prevention, vaccination, treatment, care and other support services. This report provides information on the implementation of integrated HIV, HBV and HCV testing guidance across the EU/EEA countries. It brings together information on the existence of national testing guidance (and whether guidance is integrated across viruses and specific populations), implementation, and outcome indicators: late diagnoses and proportions diagnosed.

Up-to-date, country-specific testing guidelines are an important prerequisite for high-quality blood-borne virus testing services. Most of the EU/EEA countries have national HIV testing guidance available (information not available for hepatitis), and half of the countries have guidance that is integrated across all three blood-borne viruses. Furthermore, most countries have specific guidance for key populations across the three infections, including recommendations for the frequency of HIV testing. However, half of the national policy or guidance documents were over five years old. This is a cause for concern as guidance may be out-of-date and not reflect recent innovations in testing (e.g. community-based testing, indicator condition-guided testing, etc.)

Since HIV and viral hepatitis disproportionately affect certain key populations, it is worrying that most countries in the EU/EEA do not have policies in place for testing to be undertaken in community settings by lay provider staff. This is despite evidence suggesting that this may be more acceptable for affected communities and that positivity rates appear to be higher in community-based testing services. There is a need to scale up coverage of such testing interventions, while at the same time ensuring linkage to care from this setting. Financial barriers to testing also persist across the region, with one in five countries reporting that HIV testing carries a cost, and two in five for hepatitis B and C. These costs represent a real constraint for testing and removing such barriers will help increase the accessibility and uptake of testing, in particular among vulnerable and marginalised groups.

Provision of people-centered, integrated services for key populations that offer testing and linkage to care in combination with other health and social services is vital to address the often complex needs of population groups such as migrants, people who inject drugs, transgender people, sex workers and other key and vulnerable population groups. This will often require collaboration and integration across several parts of the health system and other sectors to ensure access and linkage to support services, such as social, housing and financial services.

The fact that more than half of HIV diagnoses in the EU/EEA were made at a late stage of HIV infection is also a cause for concern. The proportion of late diagnoses for hepatitis (using end stage liver disease as a proxy) ranged from 0% to 34%, with more than one in 10 people having end stage liver disease at the time of diagnosis in three countries. This indicates that current efforts need to be urgently scaled up and more efficiently tailored to the needs of people at risk, not only so as to save lives and reduce morbidity, but also to prevent onward transmission.

There is a paucity of data in relation to testing outcomes, such as testing volume, uptake and positivity, overall and by key population group, for all three infections. It is vital to collect these data to enable comprehensive monitoring of the effectiveness of testing programmes and to facilitate adequate decision-making around resource allocation.

By 2023, 92% of people estimated to be living with HIV in the EU/EEA had been diagnosed and several countries were on track to meet the 95% diagnosis target. For hepatitis, with information available from just four countries, the lack of data limits the ability to make a sound assessment of progress towards the WHO target of 60% of people with chronic hepatitis B and C being diagnosed by 2025. However, available estimates for the EU/EEA suggest that only one third of people living with HBV, and two thirds of people living with HCV have been diagnosed [10].

Priorities for action

Self-testing and community-based testing are still not universally provided across the EU/EEA and need to be scaled up. To effectively reach key and vulnerable groups, a mix of testing approaches should be explored, as outlined in ECDC testing guidance [13]. Scaling up indicator condition-guided testing, emergency department testing, mobile health communication, such as reminders and social media communications, peer and lay provider involvement, and support and increased frequency of testing for those at greatest risk are approaches that are likely to increase access and engagement with testing services.

Despite improvements in trends in HIV diagnoses [21] and implementation of testing guidance for HIV, more than half of those diagnosed still receive late diagnoses. This suggests further work is needed to ensure testing is accessible, acceptable and affordable for populations at increased risk of acquiring HIV infection.

In many countries and settings, guidance on testing is not aligned with ECDC guidance on integrated testing. Therefore work is needed to ensure the availability of integrated testing, including guidance that also makes specific testing recommendations for key populations.

Major inequalities prevail across the three disease areas, both with regard to diagnosis, treatment and mortality [23]. The percentage of people who have been diagnosed varies from 92%, 34% and 38% for HIV, HBV and HCV, respectively. Given the difference in disease burden (820 000, 3.2 million and 1.8 million people living with HIV, chronic HBV and HCV, respectively), these figures reveals large variations in the numbers of people living with undiagnosed infections: up to around 65 000 for HIV, 2.1 million people for HBV and 1.1 million for HCV. Strong and urgent policy-level commitment is required for the EU/EEA countries to effectively identify all undiagnosed infections and increase efforts to address the undiagnosed fraction of HBV and HCV.

The lack of testing data for hepatitis B and C is a cause for concern. Although the first 95 target (95% of people living with HIV being aware of their HIV status) may be feasible for HIV, reaching the WHO targets for 60% awareness for those with chronic hepatitis B and C will be far more challenging, and it is unlikely that the targets will be achieved without broadening and expanding the response to these epidemics.

In line with the ECDC testing guidance, it is recommended that testing data, including disaggregation per key population, are collected at all places offering testing services and reported to national monitoring and surveillance systems.

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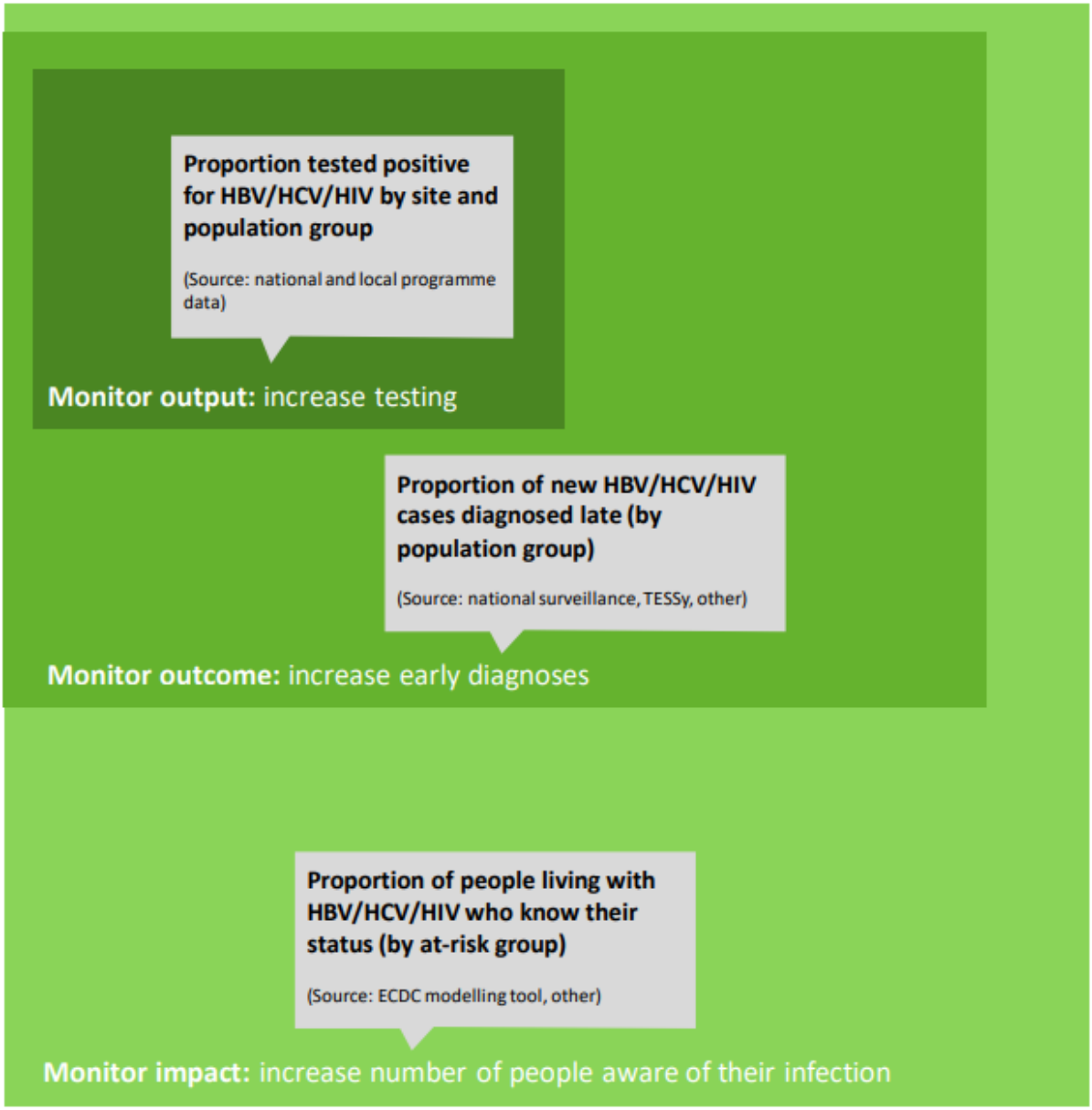
Annex 1. Monitoring and evaluation of testing programmes

ECDC's testing guidance outlines a monitoring and evaluation framework of testing programmes (Figure A) for which the expert consultation also developed key recommendations on the metrics and data sources to use in monitoring testing. These include:

- number of tests;
- basic demographic data of the person tested (e.g. age, sex and population group);
- location/setting of the test;
- number of reactive/positive tests.

Figure A. Monitoring and evaluation framework of testing programmes



Source: ECDC Public health guidance on HIV, hepatitis B and C testing in the EU/EEA, page 40 [13]

Annex 2. National HIV testing guidelines

Table A1. Details of national HIV testing guidelines

Country	Year published	Revision planned	Plans to introduce guidelines	Integrated testing recommended	Key populations included in guidance						
					MSM	PWID	Migrants	Sex workers	People in prison	Trans-gender	Other
Austria	2019										
Belgium	2019										
Bulgaria	2018										
Croatia	2017										
Cyprus	2020										
Czechia	2023										
Denmark	2013										
Estonia	2020										
Finland	2010										
France	2018										
Germany											
Greece	2022										
Hungary											
Iceland	2023										
Ireland											
Italy	2017										
Latvia	2014										
Liechtenstein	2018										
Lithuania	2010										
Luxembourg	2018										
Malta	2022										
Netherlands	2022										
Norway	2021										
Poland	2023										
Portugal	2014										
Romania	2022										
Slovakia	2024										
Slovenia	2009										
Spain	2014										
Sweden	2017										

Testing policy or programme exists *Testing policy or programme does not exist* *No data*

MSM: men who have sex with men; PWID: people who inject drugs

** Testing recommendations from a) association of specialised doctors (Germany) or ECDC integrated testing guidance (Hungary) are being used as a substitute for national testing guidance.*

Annex 3. National hepatitis testing policies in EU/EEA, 2023

Table A2. Hepatitis B key populations – testing policies and programmes

Country	Healthcare workers	All migrant populations	Migrants (high-endemicity countries)	Other migrant populations	MSM	People in prison*	PLHIV	Pregnant women	PWID	None of the above	Other	Details relating to 'other migrant populations' and/or 'other'
Austria												Patients prior to surgery; no comprehensive national testing programme for PWID, but certain addiction/drug treatment services offer testing.
Belgium												
Bulgaria												Screening in the general population aged 40, 45, 50, 55, 60 years and dialysis patients.
Croatia												
Cyprus												
Czechia												
Denmark												People accessing HIV pre-exposure prophylaxis.
Estonia												
Finland												
France												Migrant populations from intermediate and high-endemicity countries.
Germany												Screening in primary care for people over 35 years.
Greece												Migrants who report that they are HBsAg-positive.
Hungary												
Iceland												Migrant populations from outside the EU.
Ireland												Sex workers, dialysis patients.
Italy												Migrants who are pregnant or who have with risk factors for infection.
Latvia												Haemodialysis patients, contacts of HBV patients.
Liechtenstein												
Lithuania												Post-exposure dialysis patients.
Luxembourg												Asylum-seekers.
Malta												Healthcare workers employed within the Foundation for Social Welfare Services.

Country	Healthcare workers	All migrant populations	Migrants (high-endemicity countries)	Other migrant populations	MSM	People in prison*	PLHIV	Pregnant women	PWID	None of the above	Other	Details relating to 'other migrant populations' and/or 'other'
Netherlands												Sex workers; patients at increased risk of infection.
Norway												People who have/have had hepatitis C, sex workers, dialysis patients.
Poland												Dialysis patients, blood donors, healthcare workers (post-exposure).
Portugal												People accessing HIV pre-exposure prophylaxis.
Romania												Children born to an HBsAg positive mother, insured adults >=40 years if suspected of having hepatitis, 'disadvantaged' people.
Slovakia												
Slovenia												Any individual can be tested.
Spain												
Sweden												Migrant populations, depending on their legal status (asylum/refugees).

Testing policy or programme exists *Testing policy or programme does not exist* *No data*

MSM: men who have sex with men; PWID: people who inject drugs; PLHIV=people living with HIV

** Testing is offered to all those in prison.*

Source: ECDC Monitoring of the response to the hepatitis B and C epidemics in the EU/EEA countries, 2023 [14]

Table A3. Hepatitis C key populations – testing policies and programmes

Country	Healthcare workers	All migrant populations	Migrant populations (high-endemicity countries)	Other migrant populations	MSM	People in prison*	PLHIV	Pregnant women	PWID	None of the above	Other	Details relating to 'other migrant populations' and/or 'other'
Austria												Patients prior to surgery; no comprehensive national testing programme for PWID, but certain addiction/drug treatment services offer testing, counselling, directly-observed therapy.
Belgium												
Bulgaria												Screening in the general population for those aged 40, 45, 50, 55, 60 years, dialysis patients.
Croatia												People at risk of infection.
Cyprus												
Czechia												
Denmark												People receiving pre-exposure HIV medications (PrEP).
Estonia												
Finland												People infected with HBV, sexual partners of HCV positive people, newborns of HIV-positive mothers.
France												People infected with HBV or HIV, household/sexual partner of HCV-infected person, haemodialysis patients.
Germany												General population >35 years of age (since 2021).
Greece												Migrants who report that they are HCV positive.
Hungary												
Iceland												All migrant populations from outside the EU.
Ireland												International protection applicants, beneficiaries of temporary protection, healthcare workers who perform exposure-prone procedures.
Italy												Migrants considered at risk of infection; people born from 1969 to 1989; PWID; people in prison.
Latvia												Haemodialysis patients, contacts of HCV patients
Liechtenstein												
Lithuania												Healthcare workers (post-exposure), dialysis patients, age cohort (1945–1994), people with a family member diagnosed with hepatitis C, people undergoing treatment in addiction clinics.
Luxembourg												Asylum-seekers.
Malta												Healthcare workers employed within specific services; pregnant women who are substance users.

Country	Healthcare workers	All migrant populations	Migrant populations (high-endemicity countries)	Other migrant populations	MSM	People in prison*	PLHIV	Pregnant women	PWID	None of the above	Other	Details relating to 'other migrant populations' and/or 'other'
Netherlands												
Norway												People who have hepatitis B infection, sex workers, dialysis patients.
Poland												Patients on chronic dialysis; healthcare workers (post-exposure), blood donors.
Portugal												Haemophiliac patients, patients on dialysis, organ or blood recipients prior to 1992; sex workers, people accessing HIV pre-exposure prophylaxis.
Romania												All insured adults >=40 years if suspected of having hepatitis.
Slovakia												
Slovenia												Any individual can obtain free anonymous HCV testing at one testing point. Pregnant women are not screened as the prevalence in Slovenia is <0.1% (per WHO recommendations).
Spain												
Sweden												Migrants are offered health screening depending on their legal status (asylum and quota refuges).

Testing policy or programme exists *Testing policy or programme does not exist* *No data*

MSM: men who have sex with men; PWID: people who inject drugs; PLHIV=people living with HIV

** Testing is offered to all persons in prison*

Source: ECDC Monitoring of the response to the hepatitis B and C epidemics in EU/EEA countries, 2023 [16]

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