Elimination of viral hepatitis in the Czech Republic, Hungary, Poland and Slovakia

Prague

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Health care systems

- Robust systems, based on mandatory health insurance schemes or funds
- Hierarchical, under the health ministry, except Hungary which has a health care secretariat in the ministry of the interior and extensive organization at county level; national arrangements vary for viral hepatitis, some with separate system for prisons and military, local governments contributing (e.g. Poland), and the private sector (e.g. the Czech Republic, to conduct testing in prisons
- Reported total expenditure on health as a % of GDP ranges from around 4.5% in Hungary to 6.5% in Poland, 8.5% in Slovakia (2022 data) to 9.5% (2021 data) in the Czech Republic; care is free for people with social security coverage in all four countries
- Vaccination: mandatory (legal basis) and universal for hepatitis B (with some specifications for catch up and risk groups) but only for adolescents (12 years old) in Hungary

Health care systems (contd)

- National guidelines on treatment for clinicians available and in Slovakia use of EASL guidelines is recommended; pangenotypic DAAs for hepatitis C available in all countries. In Poland treatment guidelines for HBV and HCV exist and are regularly updated
- Slovakia needed to improve the effectiveness of its health care system, having the highest mortality rates from preventable and treatable diseases in the EU with more investment in prevention and health promotion
- Nongovernmental organizations, including patient associations, play valuable roles (including prevention and harm reduction) but their status is fragile in some countries

National plans

- Hepatitis B and C (the Czech Republic) and management of hepatitis B and C (Hungary); none yet on viral hepatitis adopted in Poland although many documents have been drafted and circulated for consideration; it also have a good diagnostic and therapeutic programme for HBV and HCV but not for screening
- Slovakia has a management plan but it is generally ignored by policy-makers
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Epidemiolgical situation

- Scoring factors affecting the achievement of the WHO goal of eliminating HCV by 2030 revealed particular weaknesses in national screening programmes, linkage to care and lack of political will, particularly in Poland. Overall there was pessimism about reaching the goal.
- Public health and clinical contact points in the European Hepatitis B and C Network provide data to ECDC; annual reports for the four countries
- All four countries showed declines in acute HBV over the decade to 2022; a slight increase in chronic cases was seen in the Czech Republic but steady values for Poland and few acute cases
- Acute and chronic hepatitis C cases generally remained steady, with higher rates in the Czech Republic, mainly in people aged 25-44 and mostly acquired through injecting drug use
- COVID-19 resulted in significant epidemiological changes but previous trends have subsequently been restored
- In Hungary a unified database of blood donors enabled centralization of laboratory testing and a unified algorithm for testing; results showed low rates of confirmed HBV and HCV positive first-time donors

Screening

- Antenatal HBV screening claimed to be good in all four countries, but improvements sought in Slovakia – indication for databases to track indicators
- A review of the Polish approach critically evaluated its expense and the lack of an HCV screening policy; the Lithuanian example was held up as a much better and more efficient way forward, especially given the willingness of the Polish medical community to engage in already designed projects
- Poland has no routine screening for HBV in the general population; even though screening of pregnant women is mandatory
- HCV screening in Slovakia illustrated how special populations can be reached, engaging health providers, universities, NGOs and intergovernmental organizations such as WHO; targeted populations included Roma, Ukrainian refugees, and people in prison

Screening (contd)

- A country example from Hungary illustrated screening for HBV and HDV in those groups for whom all should be screened (such as pregnant women and victims of needlestick injuries) and those who should be screened occasionally (including migrants, Roma, sex workers, MSM, PWID and prisoners). Children aged 12 are not screened for HBsAg before vaccination against hepatitis B as part of the universal immunization programme. A national guideline contains recommendations.
- Screening was not generally practised in mental hospitals or psychiatric institutions although a study in Poland found a three-fold higher prevalence than in the general population; no such screening was done in the Czech Republic or Slovakia
- Reflex testing for HDV is being introduced in Slovakia; as in the Czech Republic all cases of hepatitis D have been imported. In Poland screening for HDV has recently begun in selected centres and cases in Polish residents have been identified (rates 0-5% in different regions). Screening for HDV is covered in the Hungarian guidelines.
- Questions were raised about compliance with recommendations for screening of pregnant women and quality control of laboratories involved in testing

Screening (contd)

- No consistency in policies for different groups was seen within and between countries; WHO's recommendations for testing vulnerable populations should be observed
- Screening in high-risk population is generally regarded as inadequate, although good examples exist – a non-governmental programme in Hungary has screened more than 25,000 inmates. Nevertheless, increasing testing in these groups is recognized as critical to increasing treatment
- The cost-efficacy of screening has been evaluated twice by a government-related agency in Poland; the results support screening for HCV

Treatment and linkage to care

- Pangenotypic DAAs are available with some limitations in all countries
- Even though the introduction of DAAs has been a success, countries are not on course towards WHO's elimination goal: about twice as many people as at present need to be treated a year to begin to approach the target
- Linkage to care far from optimal: no registries of screened individuals or infected people, no reflex testing everywhere for HBV and HCV coinfections or HDV, reflex PCR not everywhere, limited funding for GPs to do serology tests (reimbursed in Slovakia) , and those testing positive at anonymous centres do not reach clinics
- In some countries, DAAs cannot be given while patients are in hospital (owing to overlap of reimbursed health services), lack of insurance, waiting time (few hepatologists), awareness and education of GPs
- DAA treatment of HC managed in hepatology centres; prior restrictions of treatment have been lifted
- DAAs generally available and prices are more affordable nowadays than previously; seemingly the bottleneck is finding the cases and linking them to care

Prevention

- The main elements of prevention are still vaccines, harm reduction and treatment as prevention
- Vaccine refusal has increased since the COVID-19 pandemic
- Vaccine hesitancy and misinformation have become widespread, for a variety of reasons and motivations
- A Polish study observed that coverage rates of hepatitis B vaccine are slowly declining and that parents are delaying bringing children for the next due vaccinations after longer and longer periods (untimely vaccination); new cases of acute and chronic hepatitis B are being seen - tot what extent these are related to declining vaccination or to other factors remains to be determined
- Post-COVID-19, an immunization registry including hepatitis B vaccine has been introduced and implemented in the Czech Republic

Challenges

- What is needed to persuade politicians when professional willingness and plans exist – data on burden of disease, financial or economic arguments, or is it merely a question of personalities? (Low absolute numbers of cases mean very low burden, as in Slovakia)
- Reaching people and populations at risk, including Roma, Ukrainian refugees, PWID and MSM
- Access to screening; despite good access generally to treatment, some people have been diagnosed but not treated owing to problems with linkage to care
- Lack of information about how many people have been diagnosed and received treatment, underlining the need for databases and tracking mechanisms
- Lack of decentralization of screening and treatment to primary health care level; care still focused in specialized centres, thereby hindering scale up of testing and treatment
- Lack of awareness among general population, infected and affected people, and even general physicians

Challenges (contd)

- As PWID switch to other drugs such as crystal meth other means of harm reduction than OST need to be envisaged
- Despite some positive examples, barriers remain to accessing testing and treatment in community settings (outside hepatology centres)
- Vaccine hesitancy and confidence is topic that needs serious attention and dedicated action

Themes and issues

- Are viral hepatitides notifiable diseases? (They are in Hungary)
- Data – unreliable, when and how are they collected, where are they collated; are there registries (e.g. of vaccinees); interoperability of systems
- What are the denominators – how many people are infected but unaware?
- Are there economic studies on the costs and potential savings of different strategies? Cost of DAAs not a problem in Poland or Hungary
- Should national guidelines (e.g. on treatment), where they exist, be harmonized and how?
- Screening: many issues remain to be resolved, from continued screening of elder people for HCV, the pros and cons of screening the general population or risk groups and whether the former is cost-effective to the screening of migrants

Needs

- Greater political will, for everything from national plans and the need for HCV screening to supporting harm reduction and NGOs
- Process of validating data at all levels needs to be understood and clarified
- Hungary: aligning its HB vaccination programme with WHO recommendations
- Better and more reliable data, with more efficient and modern means of reporting through electronic systems; more transparency
- Health education
- Methods to counter vaccine hesitancy – understanding the concerns (including cost to individuals), better and more socially powerful communication as well as better information and restoration of trust

In the breakout session four groups looked at screening and diagnosis, prevention, treatment, and healthcare needs and data gaps. The conclusions and recommendations will be integrated into the final meeting report.

Opportunities

- Integrate screening for HIV, viral hepatitis and sexually transmitted infections, generating economic benefits, with care to avoid stigmatization of HCV infection as solely related to drug users and MSM
- Use the output of the meeting as a call for action to enhance policies and practices of screening

Thank you for your attention

Děkuji za pozornost

Köszönöm a figyelmet

Dziękuję za uwagę

ďakujem za pozornosť