

SURVEILLANCE REPORT

Hepatitis C

Annual Epidemiological Report for 2024

Key facts

- In 2024, 28 540 cases of hepatitis C were reported in 29 European Union/European Economic Area (EU/EEA) countries, corresponding to a crude rate of 7.1 cases per 100 000 population.
- Of all reported cases, 7% were acute, 41% chronic, and the remainder were reported as being at an undetermined stage of disease, or could not be classified.
- Hepatitis C was more commonly reported among men than women, with a male-to-female ratio of 1.9:1. The most affected age group among males was 35–44 years, and among females 45–54 years.
- The most common transmission mode was injecting drug use, which accounted for 48% of acute cases and 70% of chronic cases with complete information on transmission route.
- The majority (82%) of hepatitis C infections were locally acquired in the reporting country.
- Notification rates declined between 2015 and 2020, followed by an increase from 2021 onwards to levels higher than those observed before the COVID-19 pandemic. These trends probably reflect changes in testing, diagnosis and reporting practices rather than changes in the underlying incidence of infection.
- Differences in surveillance systems, testing policies and case definitions, together with low completeness for key variables, continue to limit comparability between countries and over time. Improvements in data quality are needed to better monitor progress towards hepatitis C elimination goals.

Introduction

Hepatitis C is a liver infection caused by the hepatitis C virus (HCV) [1-3]. HCV is primarily transmitted through exposure to infected blood, including through the use of contaminated needles or medical equipment, unsafe blood transfusions, and, less commonly, through sexual contact or vertical transmission [1,3].

HCV commonly causes a short-term and asymptomatic acute infection, but up to 70% of people who are infected with the virus can develop chronic hepatitis C (CHC) [1]. CHC is a leading cause of severe liver disease, including cirrhosis and liver cancer [1,2,4-6].

Hepatitis C is a major public health threat worldwide with a global prevalence estimated at 0.6%, corresponding to 47 million people with a viraemic HCV infection, an incidence of 0.9 million new cases per year, and 240 000 attributable deaths in 2024 [7]. In the EU/EEA, the disease burden remains high, with an estimated 1.8 million people living with CHC in 2019 [8]. In 2023 (the latest year with available data), an estimated 35 300 people (7.8 per 100 000 population) died due to HCV [9,10].

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The epidemiology of hepatitis C has evolved substantially in recent years following the introduction of highly effective direct-acting antiviral (DAA) therapies, which have enabled a cure and contributed to reductions in prevalence in several countries. In the EU/EEA, hepatitis C disproportionately affects specific populations, particularly people who inject drugs.

Surveillance data for hepatitis C primarily reflect patterns of testing and diagnosis rather than the true incidence of new infections. Differences in testing strategies, case definitions and reporting systems across countries need to be considered when interpreting surveillance data.

Methods

This report is based on 2024 data retrieved from The European Surveillance System (TESSy) as of 30 April 2026.

For a detailed description of the methods used to produce this report, refer to the Methods chapter of the 'Introduction to the ECDC Annual Epidemiological Report' [11]. An overview of the national surveillance systems is available online [12]. A subset of the data used for this report is available through ECDC's online 'Surveillance Atlas of Infectious Diseases' [13].

EU/EEA countries reported data on newly diagnosed cases of hepatitis C to ECDC according to the EU 2018 case definition of acute and chronic hepatitis C or other definitions (Table 1) [12].

Table 1. Case definition for acute and chronic hepatitis C

Stage	Definition
Acute	Recent HCV seroconversion (prior negative test for hepatitis C in last 12 months) OR Detection of hepatitis C virus nucleic acid (HCV RNA) or hepatitis C virus core antigen (HCV-core) in serum/plasma and no detection of hepatitis C virus antibody (negative result).
Chronic	Detection of hepatitis C virus nucleic acid (HCV RNA) or hepatitis C core antigen (HCV-core) in serum/plasma in two samples taken at least 12 months apart*.
Undetermined	Any newly diagnosed case which cannot be classified in accordance with the above description of acute or chronic infection.

* if the case was not notified the first time.

Surveillance systems across EU/EEA countries are heterogeneous. Twenty-one countries submitted national data for 2024, based on the 2012 or 2018 EU case definitions. Four countries used the 2008 EU case definition, and four countries used national case definitions.

All reported cases were included in the analysis, regardless of which case definition was used. Data collected represent confirmed cases. Two countries (Belgium and Bulgaria) submitted aggregate data only and did not differentiate between stages of infection. Italy submitted two different datasets: the data source 'IT NRS' was used for age and gender and to calculate the totals (n=343, acute=48, chronic=70, undetermined=225 cases), the sentinel data from the data source 'IT SEIEVA' was used for all other variables (only acute cases n= 61, with rounded correction factor n=71 cases). The sentinel system covers approximately 76% of the population in Italy and a correction factor of 1.16 was applied to scale the number of cases, which were finally rounded to avoid decimals in case numbers.

Annual notification rates were calculated per 100 000 population for countries with comprehensive surveillance systems using Eurostat population data [14].

Epidemiology

For 2024, 29 EU/EEA countries reported 28 540 cases of HCV infection, corresponding to a crude rate of 7.1 cases per 100 000 population. Excluding Hungary and Romania that only reported acute cases, the number of cases was 28 521. No data were reported from France. Of all cases, 1 841 (7%) were reported as being acute, 11 615 (41%) as chronic, and 12 932 (45%) as at an 'undetermined' stage of hepatitis (Table 2). A total of 2 152 cases (8%) could not be classified because of aggregated data combining cases.

In 2015, the overall rate decreased from 6.8 per 100 000 to the lowest levels over the 10-year period in 2020 and 2021 (4.2 and 4.4 per 100 000), followed by an increase to 7.1 per 100 000 in 2024 (Table 1). If only the 24 countries that consistently reported data since 2015 are included, the overall rate was 7.7 per 100 000 population in 2024, 0.7 for acute and 3.5 for chronic cases (Figure 1). Country-specific overall rates ranged from <0.1 cases per 100 000 population in Romania to 67.4 cases per 100 000 population in Lithuania (Table 2, Figure 2).

In total, 23 countries were able to provide data on acute cases (Table 2). The rate of reported acute cases was 0.5 per 100 000 population, ranging from <0.1 to 4.6 per 100 000.

Overall, 23 countries submitted data on chronic infections. The notification rate for chronic cases was 3.3 cases per 100 000 population, ranging from <0.1 to 65.8.

Table 2. Number of reported hepatitis C cases and rates per 100 000 population by country and year, 2020–2024

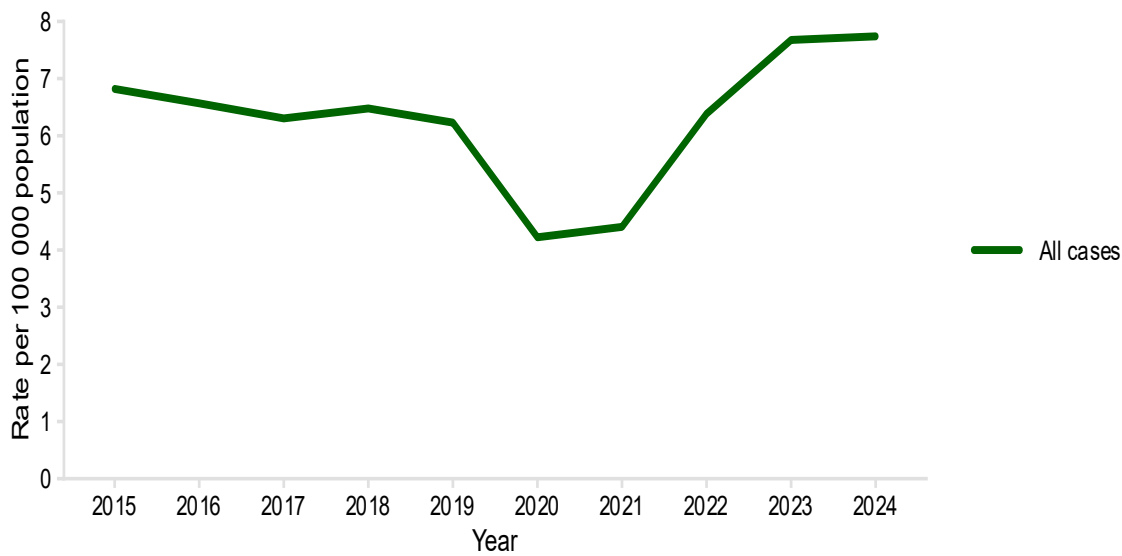
Country	2020		2021		2022		2023		2024							
	All [*]		All [*]		All [*]		All [*]		All		Acute		Chronic		Undetermined	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Austria	848	9.5	855	9.6	916	10.2	923	10.1	1 048	11.4	64	0.7	382	4.2	602	6.6
Belgium ^a	701	NRC	468	NRC	695	NRC	854	NRC	2 037	NRC	NDR	NRC	NDR	NRC	NDR	NRC
Bulgaria	44	0.7	25	0.4	51	0.8	80	1.2	115	1.8	NDR	NRC	NDR	NRC	NDR	NRC
Croatia	95	2.4	112	2.9	42	1.1	55	1.4	64	1.7	4	0.1	34	0.9	26	0.7
Cyprus	9	1.0	7	0.8	13	1.4	16	1.7	9	0.9	1	0.1	8	0.8	0	0.0
Czechia	771	7.2	764	7.3	979	9.3	1 313	12.1	1 274	11.7	318	2.9	956	8.8	NDR	NRC
Denmark	162	2.8	149	2.6	206	3.5	222	3.7	99	1.7	5	0.1	94	1.6	NDR	NRC
Estonia	135	10.2	134	10.1	119	8.9	125	9.2	152	11.1	9	0.7	143	10.4	NDR	NRC
Finland	1 143	20.7	1 063	19.2	1 148	20.7	1 126	20.2	1 096	19.6	NDR	NRC	1 095	19.5	1	0.0
France	NDR	NRC	NDR	NRC	NDR	NRC	NDR	NRC	NDR	NRC	NDR	NRC	NDR	NRC	NDR	NRC
Germany	4 538	5.5	4 789	5.8	8 138	9.8	10 617	12.8	9 539	11.4	765	0.9	3 320	4.0	5 454	6.5
Greece	54	0.5	43	0.4	104	1.0	244	2.3	172	1.7	0	0.0	172	1.7	0	0.0
Hungary	5	0.1	10	0.1	24	0.3	18	0.2	18	0.2	18	0.2	NDR	NRC	NDR	NRC
Iceland	88	24.2	66	17.9	122	32.4	107	27.6	126	32.8	NDR	NRC	NDR	NRC	126	32.8
Ireland	327	6.5	419	8.3	477	9.3	545	10.3	456	8.5	14	0.3	70	1.3	372	7.0
Italy	48	0.1	22	0.0	49	0.1	33	0.1	343	0.6	48	0.1	70	0.1	225	0.4
Latvia	1 068	56.0	954	50.4	890	47.4	930	49.4	672	35.9	13	0.7	659	35.2	NDR	NRC
Liechtenstein	NDR	NRC	4	10.2	2	5.1	2	5.0	6	15.0	1	2.5	4	10.0	1	2.5
Lithuania	73	2.6	59	2.1	847	30.2	2 038	71.3	1 945	67.4	45	1.6	1 900	65.8	NDR	NRC
Luxembourg	526	84.0	368	58.0	411	63.7	361	54.6	232	34.5	NDR	NRC	NDR	NRC	232	34.5
Malta	26	5.0	32	6.2	61	11.7	136	25.1	126	22.4	26	4.6	65	11.5	35	6.2
Netherlands	428	2.5	474	2.7	450	2.6	431	2.4	468	2.6	38	0.2	424	2.4	6	0.0
Norway	469	8.7	382	7.1	475	8.8	632	11.5	579	10.4	NDR	NRC	NDR	NRC	579	10.4
Poland	955	2.5	1 244	3.4	2 527	6.9	3 267	8.9	3 565	9.7	10	0.0	0	0.0	3 555	9.7
Portugal	163	1.6	175	1.7	220	2.1	243	2.3	483	4.5	11	0.1	16	0.2	456	4.3
Romania	NDR	NRC	NDR	NRC	1 234	6.5	931	4.9	1	0.0	1	0.0	0	0.0	0	0.0
Slovakia	204	3.7	183	3.4	325	6.0	583	10.7	566	10.4	25	0.5	541	10.0	NDR	NRC
Slovenia	96	4.6	95	4.5	113	5.4	135	6.4	133	6.3	5	0.2	67	3.2	61	2.9
Spain	699	1.5	1 266	2.7	2 142	4.5	2 232	4.6	2 380	4.9	284	0.6	995	2.0	1 101	2.3
Sweden	1 024	9.9	1 132	10.9	1 138	10.9	1 009	9.6	836	7.9	136	1.3	600	5.7	100	0.9
Total EU/EEA (30 countries)	14 694	4.1	15 284	4.2	23 894	6.2	29 208	7.6	28 540	7.1	1 841	0.5	11 615	3.3	12 932	3.9

Sources: country reports; NDR: no data reported; NRC: no rate calculated.

*: includes cases reported by countries as acute, chronic or undetermined using differentiation criteria. Countries reporting aggregate data only (Bulgaria and Belgium) were not able to classify cases into acute, chronic, or undetermined.

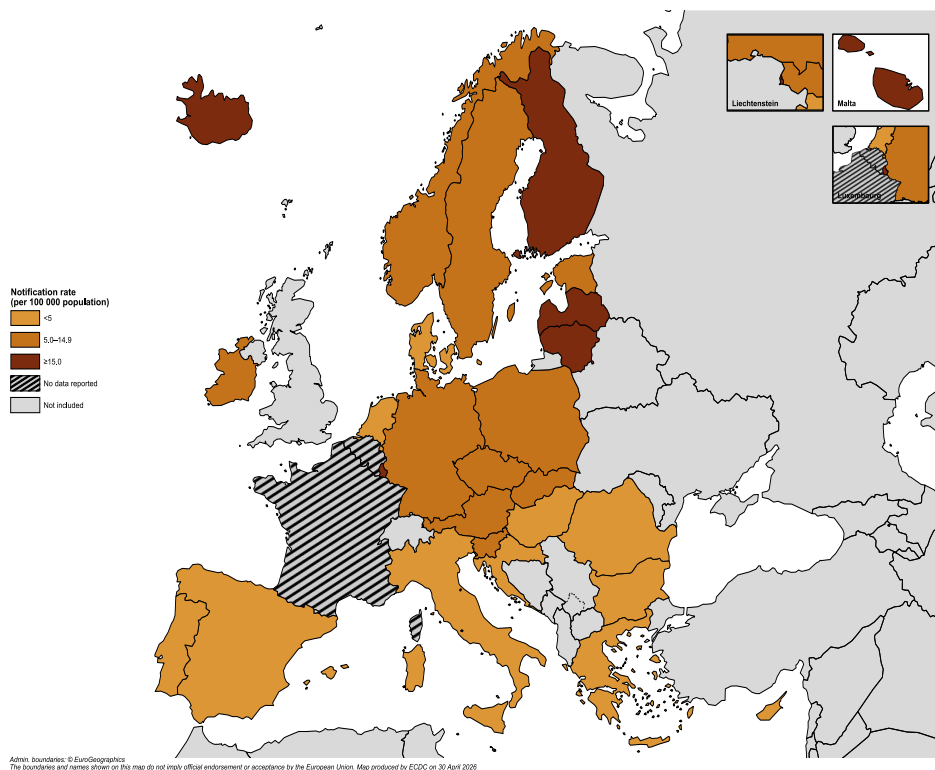
^a. Data from Belgium came from a sentinel system with undefined coverage, therefore population rates could not be calculated.

Figure 1. Notification rates of hepatitis C per 100 000 population by year, EU/EEA countries reporting consistently, 2015–2024



Sources: country reports from Austria, Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, Germany, Greece, Iceland, Ireland, Italy, Latvia, Luxembourg, Malta, Norway, Poland, Portugal, Slovakia, Slovenia, Spain and Sweden.

Figure 2. Notification rate of hepatitis C cases per 100 000 population by country*, EU/EEA, 2024



*: Countries with comprehensive surveillance systems. Data from Belgium came from a sentinel system with undefined coverage, therefore population rates could not be calculated.

Sources: country reports from Austria, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, Germany, Greece, Iceland, Ireland, Italy, Latvia, Luxembourg, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain and Sweden.

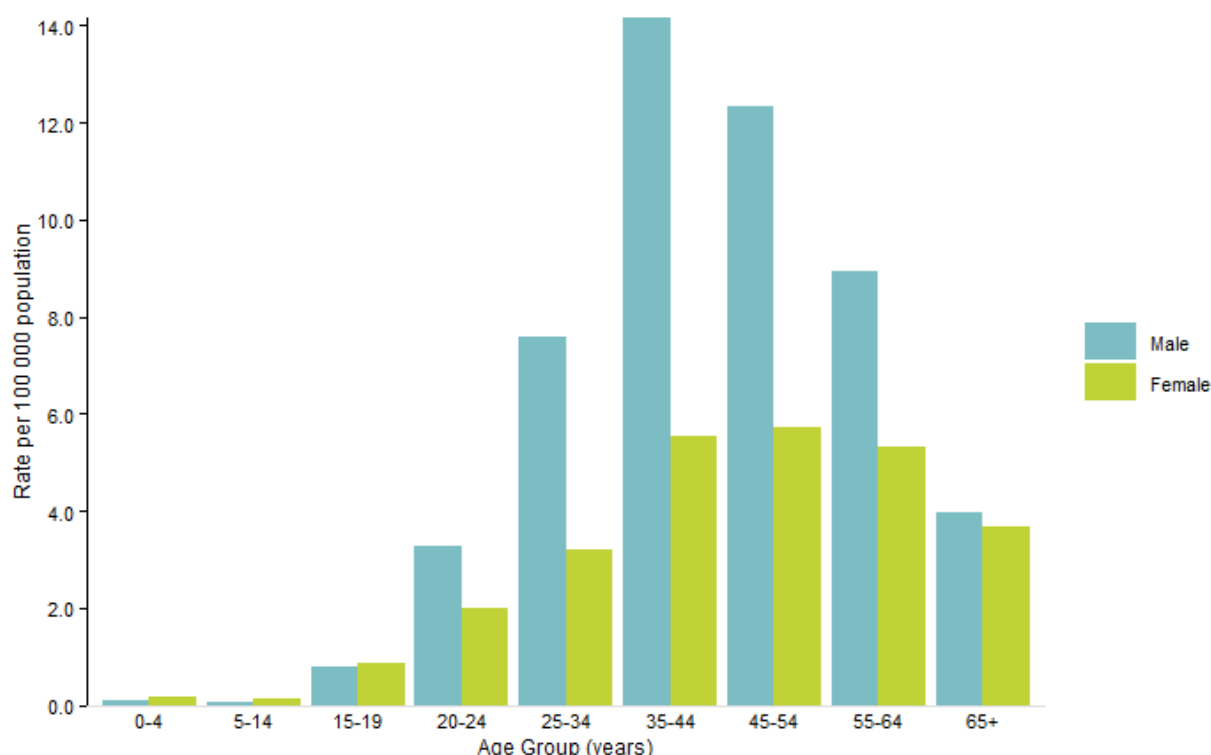
Age and gender

In 2024, 16 952 cases were reported in males (7.2 cases per 100 000 population) and 9 385 in females (3.8 cases per 100 000 population). The male-to-female ratio was 1.9. Rates were higher among males than females for all age categories from 20 years and above (Figure 3).

For males, those most affected were the age group 35–44 years (14.2 cases per 100 000 population) and for females the age group 45–54 years (5.7 cases per 100 000 population). Only 0.3% of all cases (81) were reported in people under 15 years.

Among countries reporting consistently every year since 2015, the proportion of cases below 25 years of age declined from 9% in 2015 to 5% in 2024.

Figure 3. Notification rate of newly-diagnosed hepatitis C cases per 100 000 population by age and gender, EU/EEA, 2024

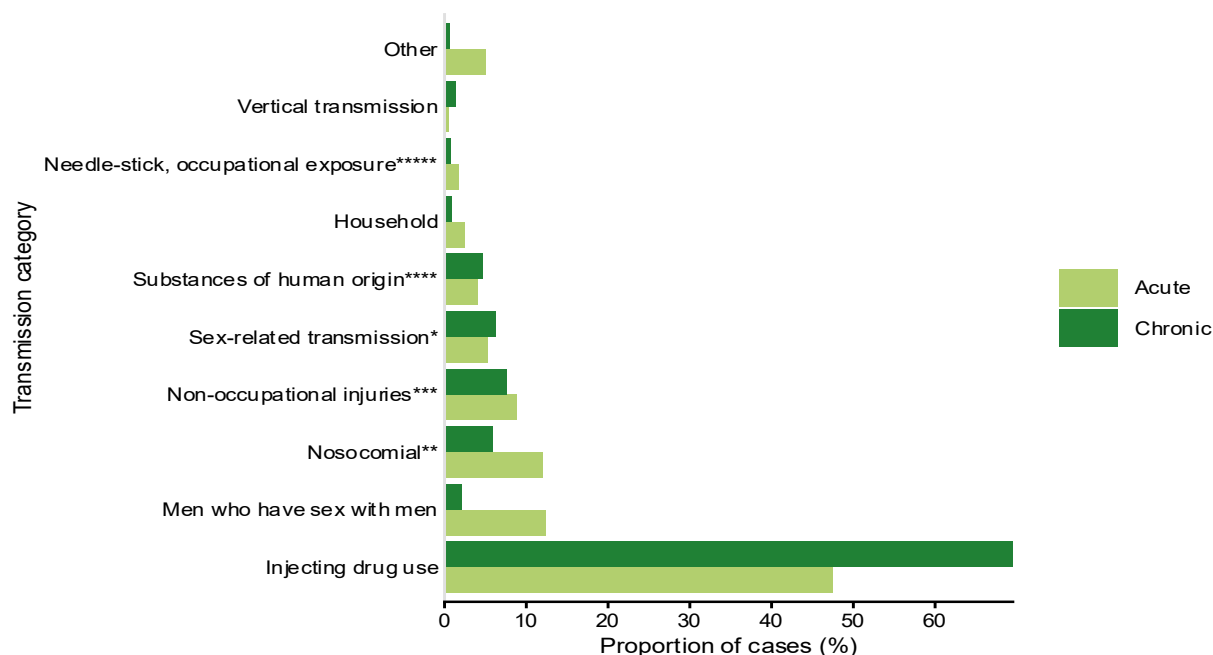


Sources: country reports from Austria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain and Sweden.

Route of transmission

Data regarding the most likely transmission route of hepatitis C were complete for only 30% of all cases in 2024 – 30% of acute, 26% of chronic cases and 33% of cases with an undetermined disease status (Table 3). Despite the limited and potentially non-representative subset, the most reported route across all disease categories was injecting drug use, accounting for 42% of cases with known transmission route. The percentage of transmission attributable to injecting drug use was 48% among acute cases, 70% among chronic cases (Figure 4), and 22% among cases with an undetermined disease status. For acute cases, the second largest percentage of transmission was attributable to men who have sex with men (13%), followed by nosocomial transmission (12%) as the third most commonly reported route. Sex-related transmission (heterosexual or unspecific contact, sex work, excluding men who have sex with men) was reported for 5% of the acute cases.

The majority of acute and chronic infections with known transmission route were acquired within the country of reporting (Figure 5).

Figure 4. Transmission category of hepatitis C cases by acute and chronic disease status, EU/EEA, 2024

Sources: acute cases reported from Austria, Croatia, Cyprus, Czechia, Denmark, Estonia, Germany, Hungary, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden. Chronic cases reported from Austria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, Germany, Greece, Ireland, Latvia, Liechtenstein, Lithuania, Malta, Netherlands, Portugal, Slovakia, Slovenia, Spain, Sweden.

* Sex-related transmission includes unspecified sexual contact, sex work, and heterosexual transmission. Sex between men is presented as a separate category to represent risk for this population, but many of these cases can probably also be attributed to sexual transmission.

** Nosocomial transmission includes transmissions that occurred in hospitals, nursing homes, psychiatric institutions and dental services as well as through haemodialysis. This category refers to patients exposed in healthcare settings, as distinct from needle-stick and other occupational exposure, which refers to staff.

*** Non-occupational injuries include bites and needle sticks that occur outside of a healthcare setting, tattoos and piercings.

**** Substances of human origin includes transmission through blood or transplantation of organs or cells.

***** Needle-stick, occupational exposure refers to occupational injuries.

Table 3. Transmission category of hepatitis C cases by acute/chronic/undetermined stage of infection, EU/EEA, 2024

Mode of Transmission	Acute	Chronic	Undetermined	Total
Injecting drug use	269	2 063	928	3 260
Men who have sex with men	70	63	145	278
Nosocomial**	68	177	1 883	2 128
Non-occupational injuries***	50	227	214	491
Sex-related transmission*	30	186	212	428
Substances of human origin****	23	140	456	619
Household	14	26	59	99
Needle-stick, occupational exposure*****	10	25	107	142
Vertical transmission	3	40	17	60
Other	29	21	198	248
Not reported	1 296	8 577	8 488	18 361
Total	1 862	11 545	12 707	26 116

Sources: acute cases reported from Austria, Croatia, Cyprus, Czechia, Denmark, Estonia, Germany, Hungary, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden. Chronic cases reported from Austria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, Germany, Greece, Ireland, Latvia, Liechtenstein, Lithuania, Malta, Netherlands, Portugal, Slovakia, Slovenia, Spain, Sweden.

See 'Methods' section regarding reporting and differences in total numbers.

* Sex-related transmission includes unspecified sexual contact, sex work, and heterosexual transmission. Sex between men is presented as a separate category to represent risk for this population, but many of these cases can also probably be attributed to sexual transmission.

** Nosocomial transmission includes transmissions that occurred in hospitals, nursing homes, psychiatric institutions and dental services as well as through haemodialysis. This category refers to patients exposed in healthcare settings, as distinct from needle-stick and other occupational exposure, which refers to staff.

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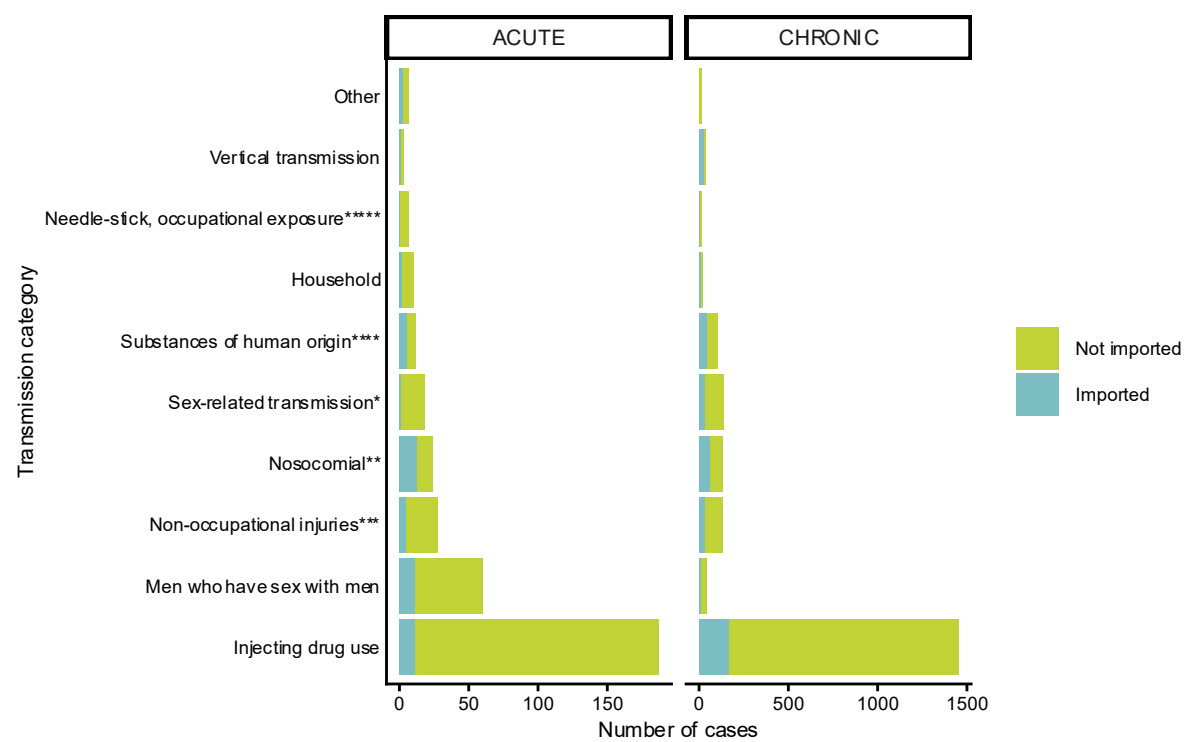
**** Substances of human origin includes transmission through blood or transplantation of organs or cells.

***** Needle-stick, occupational exposure refers to occupational injuries.

Importation status

In 2024, 21 countries provided data for 13 283 cases (47%) on whether an infection was considered ‘imported’ from outside the reporting country or acquired in the country itself. The majority (82%) of infections were reported as locally acquired and 2 339 (18%) were imported (Figure 5).

Figure 5. Transmission category of hepatitis C cases by acute and chronic disease and importation status, EU/EEA, 2024



Sources: reports from Austria, Croatia, Czechia, Estonia, Finland, Germany, Hungary, Iceland, Ireland, Latvia, Liechtenstein, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain and Sweden.

* Sex-related transmission includes unspecified sexual contact, sex work, and heterosexual transmission. Sex between men is presented as a separate category to represent risk for this population, but many of these cases can probably also be attributed to sexual transmission.

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*** Non-occupational injuries include bites and needle sticks that occur outside of a healthcare setting, tattoos and piercings.

**** Substances of human origin includes transmission through blood or transplantation of organs or cells.

***** Needle-stick, occupational exposure refers to occupational injuries.

Discussion

Hepatitis C remains a significant public health concern in the EU/EEA, with a substantial number of newly-diagnosed cases reported in 2024. Interpretation of surveillance data for hepatitis C requires caution, as notifications primarily reflect patterns of testing and diagnosis rather than the true incidence of new infections. Differences in testing strategies, case definitions, and reporting practices across countries contribute to variation in notification rates and trends over time.

The decline in notification rates observed between 2015 and 2020 is difficult to interpret. While it may partly reflect the impact of prevention and control measures, it is also probably influenced by changes in testing practices, increased access to direct-acting antiviral (DAA) treatment, and shifts in case-finding strategies. The subsequent increase in notifications from 2021 onwards probably reflects the recovery of testing services following disruptions caused by the COVID-19 pandemic, as well as continued scaling up of screening and diagnostic activities in some countries [4,8,15].

Marked geographical variability in notification rates persists across the EU/EEA. Countries with extensive testing and screening programmes, including those implementing population-based or targeted testing initiatives, tend to report higher notification rates, as seen in recent examples from Lithuania and Germany. Conversely, lower rates in some countries may reflect more limited testing or reporting rather than lower underlying prevalence [15-19]. Increases may therefore reflect the substantial efforts in the countries to reduce the number of undiagnosed cases through testing/screening intervention policies for the general population and among vulnerable groups [16,18,20-24]. Nevertheless, recent estimates have shown that the number of diagnosed hepatitis C cases largely underestimated the global picture of the epidemic in populations [1,5,8].

Data on transmission routes are incomplete and may not be representative of all cases. Among cases with available information, most hepatitis C infections are attributed to local transmission events within the country of reporting and to injecting drug use, with men being more affected than women, particularly in the age group 35–54 years. There is consistent evidence that people who inject drugs remain disproportionately affected by hepatitis C infection in Europe [25]. Estimates of hepatitis C seroprevalence in the EU/EEA highlight the high prevalence of hepatitis C among people who inject drugs in most countries and the ongoing risk of exposure in this population [8,26,27]. Harm reduction programmes and, more recently, treatment with DAA drugs may have contributed to reducing transmission in many countries. However, the burden of infection remains high among people who inject drugs and evidence of ongoing transmission emphasises the need for comprehensive and integrated harm reduction interventions, tailored to the most vulnerable populations [6,25,28]. Reports of hepatitis C transmission among men who have sex with men, particularly those living with HIV, highlight the importance of targeted prevention and control measures in specific sub-populations [29,30]. In addition, the presence of infections attributed to healthcare-associated exposure underlines the need to maintain high standards of infection prevention and control.

The majority of cases reported lack information on disease stage, and a large proportion are classified as undetermined. This reflects the challenges of distinguishing acute from chronic hepatitis C infection in routine surveillance and further limits the interpretation of trends over time. Improving case classification would enhance the ability to monitor recent transmission and evaluate prevention strategies.

The burden of hepatitis C in the EU/EEA remains high, with an estimated 1.8 million people living with HCV [31]. Considerable variation was observed between EU/EEA countries, with national estimates of prevalence in the general population ranging from 0.04% to 2.26% [8]. While the incidence of new infections and the prevalence of chronic infections have declined in many European countries due to prevention strategies, modelling studies suggests that the attributable mortality will remain substantial [5,8,15,32-35].

Overall, surveillance data remain essential for identifying affected populations and informing public health responses. Improving the completeness and quality of surveillance data, particularly transmission route and disease stage, is essential to better characterise the epidemiology of hepatitis C in the EU/EEA. Enhanced data quality would enable more robust analyses of transmission patterns and trends over time, supporting more targeted and effective public health interventions. Furthermore, these data should be interpreted in conjunction with information on testing practices, prevalence estimates, and programme data to provide a more complete picture of the epidemiological situation.

Public health implications

The first WHO 'Global Health Sector Strategy on Viral Hepatitis' aimed to eliminate viral hepatitis as a public health threat [36] by reducing the incidence of chronic infections by 90% and the associated mortality by 65% by 2030. Achieving these targets will require a scaling-up of key interventions, including preventing transmission among people who inject drugs [37], and increasing testing with linkage to care and treatment [28].

To achieve the elimination goals as defined in the Global Strategy, robust epidemiological information is essential to plan and monitor effective prevention and control programmes. Although surveillance data alone do not provide a clear epidemiological picture and should be analysed carefully alongside other information (e.g. on local screening policies and practices, testing and positivity rates, and seroprevalence data), improvements to the quality of hepatitis C surveillance data are important to increase data utility. The findings highlight the importance of strengthening surveillance systems. Improving the completeness and quality of data, particularly for disease stage, transmission route and importation status, is essential in order to enhance the interpretation of trends and support evidence-based decision-making. Greater integration of surveillance with additional data sources, including seroprevalence studies, health insurance or testing data and programme indicators, would provide a more comprehensive understanding of the epidemiology.

Expanding testing and screening remains a priority in order to identify undiagnosed infections. Targeted approaches focusing on populations at increased risk, including people who inject drugs, migrants from higher prevalence settings, and other vulnerable groups, are essential. ECDC and the European Union Drugs Agency have published a European toolkit for the elimination of viral hepatitis in prison settings which provides guidance on this issue for populations in prison, where viral hepatitis prevalence tends to be disproportionately high [38]. For all populations, diagnosis must be accompanied by effective linkage to care, access to treatment, and retention in care to reduce morbidity, prevent onward transmission and achieve elimination targets.

Given the continued importance of injecting drug use as a driver of hepatitis C transmission, comprehensive harm reduction programmes remain central to prevention efforts. These include access to sterile injecting equipment, opioid substitution therapy, testing services and integrated models of care. Strengthening these interventions, particularly in settings with ongoing transmission, is critical [37].

Targeted prevention and testing strategies are also needed for other affected populations, including men who have sex with men, especially those with HIV infection, and individuals exposed in healthcare settings. Maintaining high standards of infection prevention and control in healthcare remains essential for preventing transmission.

Accelerating progress towards hepatitis C elimination will require a comprehensive approach that combines improved surveillance, expanded testing, effective prevention strategies, and universal access to DAA treatment. Coordinated efforts across these areas are essential to reduce transmission, lower disease burden, and achieve elimination goals in the EU/EEA.

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