

Addressing hepatitis A in Europe in 2026

Challenges, strategies and opportunities

13 and 14 October 2026

Antwerp, Belgium

Objectives

- Review the current hepatitis A landscape, burden of disease and immunity gaps in the WHO European Region
- Discuss transmission risks and diagnosis
- Compare and evaluate national hepatitis prevention strategies and outcomes
- Assess long-term protection
- Promote evidence-based, cost-effective policy-making for prevention of hepatitis A
- Help to draw attention to a vaccine-preventable and entirely controllable disease, aspects of which have been covered in previous VHPB meetings by building on previous VHPB meetings between 1994 and 2020.

Epidemiology and surveillance

- **Changes** have been seen in epidemiological features of hepatitis A virus infection in several countries, with growing populations of susceptible adults.
- **VHPB meetings**: first in 1994 but now looking at uneven policies across Europe and the effective relegation of hepatitis A from WHO's global health sector strategy on viral hepatitis.
- While seroprevalence profiles in the EU/EEA have substantially decreased, **susceptibility rates** have proportionately increased and notification rates of hepatitis A are slowly but steadily rising, especially for non-travel-related cases and in older age groups. Policies (e.g. national immunization schedules) are still disparate.
- The **epidemiology in** Europe is shifting from a silent disease to a more clinical disease.

Epidemiology and surveillance (contd)

- **Good, safe vaccines** exist and are being shown to continue to induce immunity that lasts at least 25 years. Single-dose childhood schedules work at population levels. New surveillance tools are becoming available. Registration systems are improving.
- **Outbreaks continue** to occur, catalysed by homelessness, migration, international travel to endemic countries, import of foods and food-borne transmission, sexual practices including chem sex, injecting drug use and lack of knowledge and awareness.
- A major international outbreak in Europe following a Gay Pride event prompted a major study in Berlin, which demonstrated that **investigation became an intervention** and underlined the value of an interdisciplinary team working in parallel on areas from surveillance to creating demand and ensuring access to vaccine. HA vaccine uptake increased dramatically in MSM.

Epidemiology and surveillance (contd)

- Recent investigations of two **outbreaks in Portugal** underlined the impact of immigrants from countries with higher HA prevalence rates and changes in sexual practices (e.g. chemsex) and other social changes. Support for preventive work was gained through considerably efforts to raise awareness through television and Parliament.

Surveillance

- Effective control of HA needs surveillance of HAV strains – vital for public health decisions and monitoring effectiveness of public health measures. The **EU Reference Laboratory for Public Health on Food- and Water-borne Viruses** focuses on molecular typing of HA and HE viruses and quality assurance.
- EURL develops protocols for surveillance, case definitions for outbreaks, facilitation of data sharing and research collaboration, and support to Member States. Strain sequencing and phylogenetics have been applied to food materials, resulting in removal of items from market, and elucidating outbreaks and origin tracing. RNA detection needs reference laboratory capacity and such laboratories need support and linked to diagnostic laboratory networks.
- **Waste-water monitoring** has already been used for testing for pathogens such as polioviruses to detecting antimicrobial resistance. Its application in monitoring an outbreak of hepatitis A in a school demonstrated the successful use of passive sampling of sewage as a practical second-best alternative to individual monitoring and a promising tool to guide public health responses to silent, asymptomatic outbreaks but no conclusions about the number of infected persons can be made. The public health authorities in the Netherlands have drafted a framework for its application and factors to consider.

Surveillance (contd)

- Further developments include application in low-resource locations and potential linkage with **portable DNA sequencing devices** (nanopore technologies), but the large costs owing to the need for frequent sampling are prohibitive.
- **Testing and diagnostic tests** are crucial to surveillance and control; commercial platforms are available for anti-HAV IgM and IgG antibodies and HAV RNA detection. In England, a reference laboratory in-house assay based on a modification of a commercially-available test uses **oral fluid for IgM and IgG testing**. This convenient method offers great potential for informal (self) testing – an approach proven during the COVID-19 pandemic.
- Seroprevalence studies of immunity are handicapped by the inability to differentiate between a vaccine response and natural infection. **Targets such as the 3C protease** of HAV show promise for filling that gap but these antibodies wane a relatively short time period after exposure. False-positive results are an impediment.

Vaccination

- **Strategies** for HAV vaccination are either risk-based targeted programmes or universal childhood immunization programmes with catch-up for adolescents and adults. In the EU, two countries have a one-dose universal vaccination schedule (Spain has it in part of the country) and eight have programmes targeted at risk groups, as far as is known.
- Data needed to adapt **the former to universal childhood vaccination** depend on the proportion of people with an indication of special characteristics – travel to endemic countries, occupational health and risk behaviours.
- The 25-year history and results of the **Alaska Hepatitis A Study** are salutary. The State was the first to offer universal HA vaccination (to 2-18 year olds), in 1996, resulting in dramatic falls in infection rates. The State now has the lowest incidence rate in the world. Protection lasts at least 25 years.

Vaccination (contd)

- Countering the Alaskan success is the recent highly controversial and contested decision of the CDC **to remove vaccines including HA and HB from routine childhood immunization**. Low incidence of HAV is a result of an efficient vaccine programme and decision could result in an increased reservoir of HAV in communities.
- WHO's SAGE issued a **HAV vaccine position paper in 2022**. WHO's guidance provides a framework; country evidence informs implementation. The **recommendation** is to include HAV vaccine in the national immunization programme for individuals over the age of 12 months if the national trends of acute disease, changes from high to intermediate endemicity and cost-effectiveness are indicated. Two doses are recommended for adults >40 years and the immunocompromised; this risk-based targeted approach is recommended for low-endemicity countries.
- **Powerful arguments were put for adopting the universal approach** – the best way to prevent HAV in children and further spread in the community. A global application would eliminate the risk of importation. A **position paper from the European Society of Clinical Microbiology and Infectious Diseases Study Group for Viral Hepatitis** underlines the need and means of achieving global immunity against HAV through vaccination, proposing a measurable roadmap for 2025 to 2045. Six actions are proposed for immediate action by countries (a policy architecture) and for Europe to connect evidence (for example through susceptibility maps) to delivery.

Vaccination (contd)

- **The SAGE recommendation** is supported by scientific evidence for the efficacy of one dose from studies in Nicaragua, Kazakhstan, Argentina and Brazil. Data generated after the SAGE publication continue to confirm Antibody persistence, immune memory, efficacy and effectiveness, and impact. No data support the idea that immunity can be boosted by contact with natural infections.
- **Spain:** A 20-year follow-up study showed that incidence of hospitalization was lower in regions with **universal vaccination** several years after vaccination. A statistical study of people who reach the age of 60 years found that the main HA risk group was men having sex with men. The characteristics of two large autonomous regions (one with universal vaccination, including Catalonia 7.5 million) and another (population 16 million) where the policy is targeted vaccination were compared; the cumulative incidence rate of outbreaks was lower in the former, but outbreaks were more frequent, and MSM were less frequently the first case in the latter.
- A large **European Internet survey among MSM (EMIS-2017)** (before the COVID-19 pandemic) looked at knowledge about viral hepatitis general and awareness of vaccination among men who have sex with men. It showed wide variations between countries regarding vaccination knowledge and coverage. Knowledge about where to get vaccinated and the offer of vaccines was poor, with more than half of those not vaccinated reporting that HAV or HBV vaccine had never been offered. Only a small proportion of those not vaccinated knew where to get vaccinated. Men at younger age, lower education level, financial insecurity, not having come out regarding their sexual orientation had poorer knowledge about basic hepatitis facts. The experienced stigma and discrimination together with vaccination policies influence vaccine uptake and knowledge about hepatitis A.

Needs

- Vaccination, vaccination, vaccination
- Vaccination programmes should be tailored to the susceptibility gaps, the endemicity and the virus in circulation
- Increased awareness and knowledge of viral hepatitis in general
- Cost-effectiveness studies of different vaccination strategies with consideration of the costs of surveillance and control of outbreaks
- More and better surveillance data (including asymptomatic cases, case histories including travel, risk behaviours, etc)
- Mandatory reporting of positive laboratory results for HAV infection
- Non-invasive sampling methods for diagnostic testing, with possibility of RNA testing (PCR not possible with oral fluids)
- New targets and assays for anti-HAV antibodies and differentiation of effects of vaccination from the antibody profiles of natural infection

Needs (contd)

- Establishment of networks of national reference laboratories
- Taking opportunities for vaccination (e.g. free HAV vaccination for children in the UK about to travel or coming back from endemic countries and outreach during outbreak investigations)
- Ways to improve uptake vaccination in risk groups
- Identification by countries of susceptibility gaps
- Considerations of combined vaccines: existing (A+B) and in the pipeline (A+E)
- Political commitment and funding

Discussion group outcomes

- ***Aspects to consider regarding current surveillance system***
- Wastewater sampling, but as an add-on rather than stand alone
- Molecular typing performed in reference laboratories that are well connected through international networks.
- Serological assays for HAV antibodies to differentiate between vaccine-induced antibodies and those induced by natural infections
- ***Vaccination strategies***
- Data for changing to universal childhood vaccination, including cost-effectiveness studies
- Universal vaccination (childhood and adult) would reduce stigma and increase uptake; if introduced, a risk-based approach will need to accompany it for a considerable period of time because of the risk of importation of HAV
- Risk-group approaches mean that denominators of risk groups need to be determined regarding population sizes
- Self-identification as a risk group (hand in hand with knowledge and awareness of HA)

Discussion group outcomes

Elimination

- HA and its vaccine fulfil all the requirements to eliminate hepatitis A as a public health problem
- Political will is vital
- Single-dose approaches for adults are way to increase uptake and as a tool for elimination but needs studies on long-term protection
- Raise elimination up the political agenda – WHO, ECDC, scientific and medical conferences (EASL for example)
- Raising awareness in the general population is essential so that outside risk groups even a healthy lifestyle is threatened by the potential risk of contaminated foods

Concluding remarks

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- Safe journeys home

Expected outcomes

1. Strategic guidelines for effective policies for hepatitis A prevention and vaccination
2. Policy-relevant evidence and economic analyses
3. Strengthened collaboration between policy-makers, public health specialists, healthcare professionals and academic researchers

Achieved?

- 1.
- 2.
- 3.