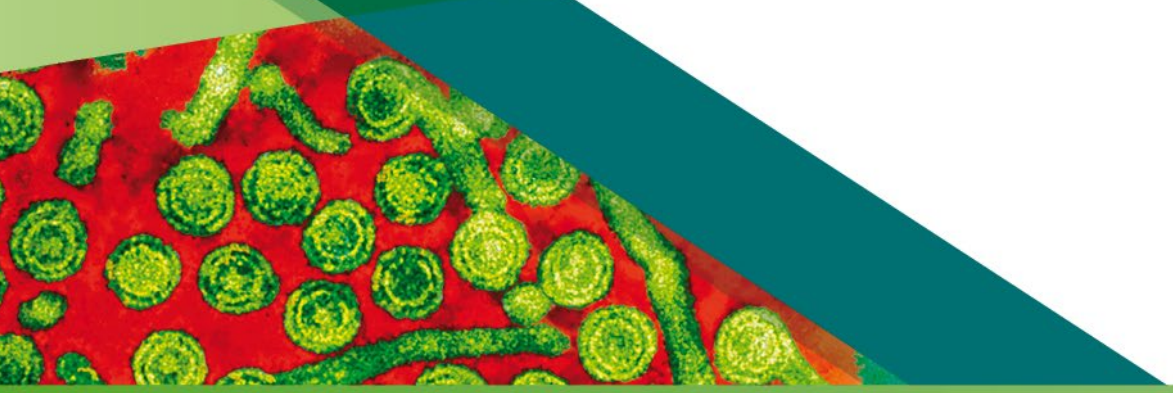


SURVEILLANCE REPORT

Hepatitis B

Annual Epidemiological Report for 2024

Key facts

- For 2024, 30 EU/EEA countries reported 37 605 cases of hepatitis B virus (HBV) infection, corresponding to a crude rate of 7.5 cases per 100 000 population.
- A total of 6% were reported as acute infections, 40% as chronic, 42% as being at an undetermined stage of infection and 12% could not be classified due to aggregate reporting.
- The highest notification rates for both acute and chronic infections were observed among adults aged 35–44-years. Overall, more cases were reported in men than women (male-to-female ratio 1.5:1), with a higher ratio among acute cases (2.4:1) than chronic cases (1.4:1).
- Among acute cases with available information on transmission (23% with complete information), sex-related transmission (heterosexual or unspecified contact, sex work, excluding men who have sex with men) was the most frequently reported category (28%), followed by transmission among men who have sex with men (12%) and nosocomial transmission (13%), with most infections acquired in the reporting country (82%). Among chronic cases (7% completeness for transmission), vertical transmission was the most reported route of transmission (52%) with most infections reported as imported (94%).
- The overall notification rate of acute hepatitis B cases was 0.6 per 100 000 population in 2024. Among countries reporting consistently since 2015, notification rates for acute cases declined from 0.6 in 2015 to 0.3 in 2020, followed by an increase and stabilisation at approximately 0.6 per 100 000 between 2022 and 2024. The overall low numbers, particularly in the younger age groups, probably reflect the impact of national vaccination programmes.
- The overall notification rate of chronic cases was 4.8 cases per 100 000 population in 2024. Among countries reporting consistently over time, the rate decreased from 5.0 per 100 000 in 2015–2016 to 2.2 in 2020–2021, with a subsequent increase to 2.9 per 100 000 in 2024.
- Data completeness for key variables, including disease stage, transmission category and importation status, remains limited, restricting the interpretation of epidemiological patterns.

Introduction

Hepatitis B is a liver infection caused by the hepatitis B virus (HBV) [1]. The virus enters the body through infected blood or other bodily fluids. The transmission can occur via unprotected sex with an infected person, contaminated needles or medical equipment, contaminated blood transfusions, or vertically from mother-to-child during pregnancy or delivery [1,2].

HBV commonly causes an acute short-term and asymptomatic infection, but some individuals can develop chronic hepatitis B (CHB). Up to 95% of infections acquired in childhood before five years of age will progress to CHB, compared to less than 5% of infections acquired in adulthood [1,2]. CHB can lead to severe liver damage, including cirrhosis and liver cancer.

Hepatitis B is a major global public health concern [3]. An estimated 240 million people are living with chronic HBV infection worldwide, corresponding to a prevalence of approximately 2.9% [4]. Approximately 1.1 million deaths are attributable to hepatitis B globally each year, with a mortality rate in the World Health Organization (WHO) European

Suggested citation: European Centre for Disease Prevention and Control. Hepatitis B. In: ECDC. Annual epidemiological report for 2024. Stockholm: ECDC; 2026.

Stockholm, July 2026

Region of 4.2 per 100 000 population [4]. In the European Union/European Economic Area (EU/EEA), the disease burden remains high, with an estimated 3.2 million people living with CHB [5,6]. In 2023 (the latest year with available data), an estimated 17 400 people in the EU/EEA (3.8 per 100 000 population) died due to HBV [7,8].

Although surveillance data capture diagnosed infections, these data are influenced by testing and reporting practices. Effective vaccines have been available for several decades and remain central to prevention strategies.

Methods

This report is based on data for 2024 retrieved from EpiPulse Cases 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' [9]. An overview of the national surveillance systems is available online [10]. A subset of the data used for this report is available through ECDC's online 'Surveillance Atlas of Infectious Diseases' [11].

EU/EEA countries reported data on newly diagnosed cases of hepatitis B to ECDC in accordance with the EU 2018 case definition and differentiated acute and chronic cases using defined criteria (Table 1) [9]. If it was not possible to use the EU 2018 case definition, other case definitions were also accepted [9,12,13].

Table 1. Case definitions for acute and chronic hepatitis B

Stage	Definition
Acute	Any of the below, with or without symptoms and signs (e.g. jaundice, elevated serum aminotransferase levels, fatigue, abdominal pain, loss of appetite, intermittent nausea, vomiting, fever): • detection of IgM core antigen-specific antibody (anti-HBc IgM); OR • detection of hepatitis B surface antigen (HBsAg) and previous negative HBV markers less than six months ago, OR • detection of hepatitis B nucleic acid (HBV-DNA) and previous negative HBV markers less than six months ago.
Chronic	• Detection of HBsAg or HBeAg or HBV-DNA; AND • No detection of anti-HBc IgM (negative result); OR • Detection of HBsAg or HBeAg or HBV-DNA on two occasions that are six months apart[a].
Undetermined	• Any newly diagnosed case that cannot be classified in accordance with the above definition of acute or chronic infection.

[a] *If the case was not notified the first time.*

Surveillance systems across EU/EEA countries are heterogeneous [10]. Twenty-six countries submitted national data for 2024 based on the 2012 or 2018 EU case definitions [12,13]. Two countries (Austria and Spain) used the 2008 EU case definition, and two countries (Denmark, and Germany) used national case definitions. All reported cases were included in the analysis, regardless of the case definition used. Three countries (France, Hungary and Spain) only submitted data on acute 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=357, acute=196, chronic=50, undetermined=111 cases), and the sentinel data from the data source 'IT SEIEVA' was used for all other variables (only acute cases n= 186, with rounded correction factor n=216). 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 then 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

Overall trends

For 2024, 30 EU/EEA Member States reported 37 605 cases of hepatitis B virus (HBV) infection, corresponding to a crude rate of 7.5 cases per 100 000 population. Of those cases, 2 437 (6%) were reported as acute, 14 860 (40%) as chronic, 15 737 (42%) with 'undetermined' hepatitis stage, and 4 571 (12%) could not be classified because of aggregated data combining cases. The total number of cases was 37 027 excluding the three countries that only reported acute cases. If only the 24 countries that have reported data consistently since 2015 were included, the overall notification rate was 11.6 per 100 000 population in 2024, which was comparable to 2023 (11.9 per 100 000 population). This rate has increased from 5.2 per 100 000 population in 2015.

In total, 27 countries were able to provide data on acute cases (Table 2). The overall rate of acute cases was 0.6 per 100 000 population, ranging from <0.1 to 2.3 cases per 100 000 population (Figure 2). Among the 24 countries reporting consistently since 2015, acute rates declined from 0.6 in 2015 to 0.3 in 2020, followed by an increase until they stabilised at approximately 0.6 per 100 000 between 2022 and 2024 (Figure 1).

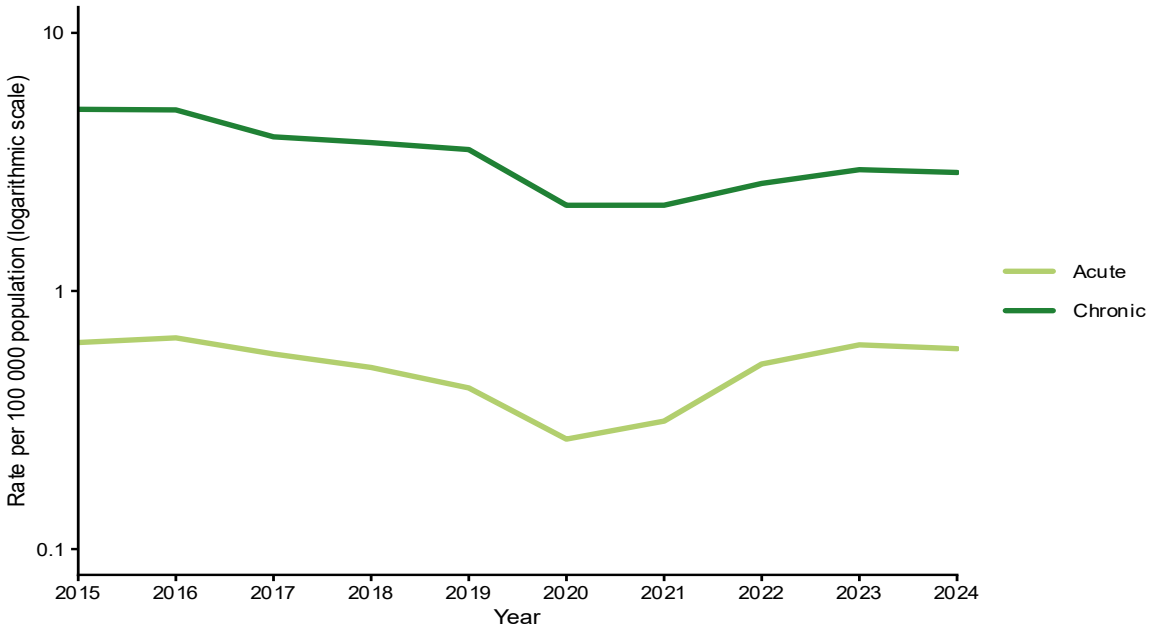
For chronic infections, 24 countries submitted data. The overall notification rate was 4.8 cases per 100 000 population, ranging from <0.1 to 16.0 (Table 2). Among the 19 countries that reported consistently between 2015 and 2024, the rate of chronic cases decreased from 5.0 per 100 000 in 2015–2016 to 2.2 in 2020–2021, before increasing again to 2.9 per 100 000 in 2024 (Figure 1).

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

Country	2020		2021		2022		2023		2024							
	All[a]		All[a]		All[a]		All[a]		All		Acute		Chronic		Undetermined	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Austria	950	10.7	998	11.2	887	9.9	997	11.0	1 050	11.5	55	0.6	472	5.2	523	5.7
Belgium[b]	1 423	NRC	1 029	NRC	1 670	NRC	2 073	NRC	4 309	NRC	NDR	NRC	NDR	NRC	NDR	NRC
Bulgaria	112	1.7	83	1.3	152	2.3	246	3.8	262	4.1	NDR	NRC	NDR	NRC	NDR	NRC
Croatia	22	0.6	23	0.6	23	0.6	45	1.2	46	1.2	9	0.2	21	0.5	16	0.4
Cyprus	30	3.3	18	2.0	43	4.8	52	5.5	59	6.1	1	0.1	58	6.0	NDR	NRC
Czechia	170	1.6	171	1.6	312	3.0	412	3.8	424	3.9	36	0.3	388	3.6	NDR	NRC
Denmark	153	2.6	126	2.2	106	1.8	125	2.1	104	1.7	16	0.3	88	1.5	0	0.0
Estonia	23	1.7	23	1.7	34	2.6	34	2.5	34	2.5	1	0.1	33	2.4	NDR	NRC
Finland	166	3.0	235	4.2	379	6.8	511	9.2	437	7.8	131	2.3	306	5.5	NDR	NRC
France[c]	61	0.09	86	0.13	99	0.15	139	0.2	134	0.2	134	0.2	NDR	NRC	NDR	NRC
Germany	6 673	8.0	8 857	10.7	17 570	21.1	23 597	28.4	22 049	26.4	1 030	1.2	10 018	12.0	11 001	13.2
Greece	14	0.13	165	1.5	183	1.7	217	2.1	167	1.6	5	0.0	162	1.6	NDR	NRC
Hungary[c]	14	0.14	14	0.15	23	0.24	17	0.2	17	0.2	17	0.2	NDR	NRC	NDR	NRC
Iceland	33	9.1	31	8.4	57	15.1	90	23.2	48	12.5	2	0.5	46	12.0	0	0.0
Ireland	335	6.7	430	8.5	501	9.7	597	11.3	605	11.3	14	0.3	582	10.9	9	0.2
Italy	172	0.3	144	0.2	92	0.2	287	0.5	357	0.6	196	0.3	50	0.1	111	0.2
Latvia	233	12.2	227	12.0	256	13.6	263	14.0	180	9.6	12	0.6	168	9.0	NDR	NRC
Liechtenstein	NDR	NRC	5	12.8	2	5.1	2	5.0	5	12.5	0	0.0	2	5.0	3	7.5
Lithuania	25	0.9	27	1.0	27	1.0	34	1.2	224	7.8	26	0.9	198	6.9	NDR	NRC
Luxembourg	518	82.7	283	44.6	296	45.9	364	55.1	347	51.6	NDR	NRC	NDR	NRC	347	51.6
Malta	39	7.6	45	8.7	54	10.4	83	15.3	119	21.1	12	2.1	90	16.0	17	3.0
Netherlands	801	4.6	817	4.7	920	5.2	937	5.3	945	5.3	90	0.5	831	4.6	24	0.1
Norway	225	4.2	257	4.8	367	6.8	442	8.1	416	7.5	7	0.1	409	7.4	NDR	NRC
Poland	992	2.6	1 546	4.2	2 500	6.8	3 142	8.5	3 545	9.7	32	0.1	0	0.0	3 513	9.6
Portugal	132	1.3	147	1.4	181	1.7	190	1.8	215	2.0	55	0.5	75	0.7	85	0.8
Romania	21	0.1	18	0.1	1 823	9.6	1 678	8.8	76	0.4	69	0.4	7	0.0	0	0.0
Slovakia	89	1.6	79	1.4	99	1.8	332	6.1	371	6.8	24	0.4	347	6.4	NDR	NRC
Slovenia	94	4.5	128	6.1	121	5.7	110	5.2	155	7.3	18	0.8	69	3.2	68	3.2
Spain	202	0.43	261	0.55	318	0.67	364	0.8	427	0.9	427	0.9	NDR	NRC	NDR	NRC
Sweden	806	7.8	745	7.2	831	8.0	663	6.3	478	4.5	18	0.2	440	4.2	20	0.2
Total EU/EEA (30 countries)	**14 528**	**3.0**	**17 018**	**3.6**	**29 926**	**6.4**	**38 043**	**8.1**	**37 605**	**7.5**	**2 437**	**0.6**	**14 860**	**4.8**	**15 737**	**5.9**

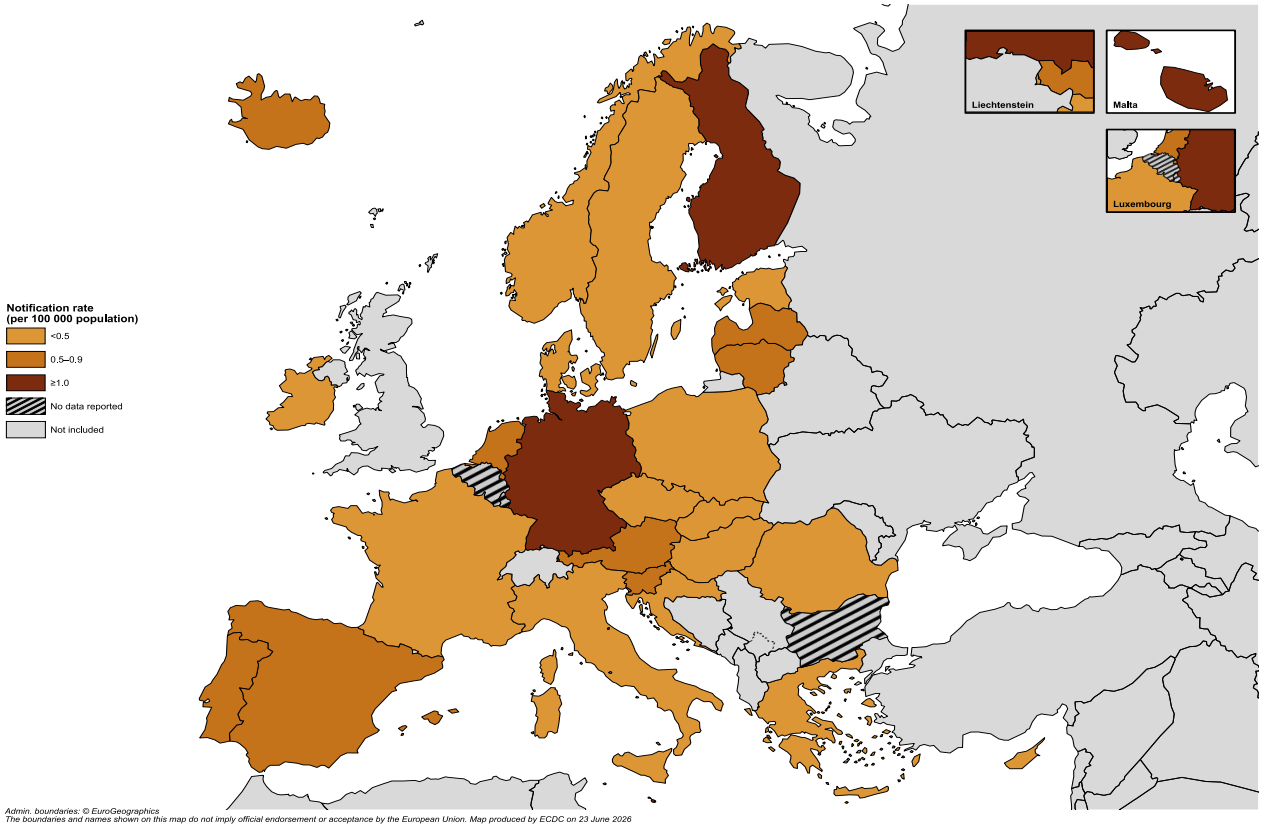
NDR: no data reported; NRC: no rate calculated.
a: includes cases reported by countries as acute, chronic or undetermined using differentiation criteria. Countries reporting aggregate data only (Bulgaria and Belgium) were not able to classify cases into acute, chronic, or undetermined.
b: Data from Belgium came from a sentinel system with undefined coverage, therefore population rates could not be calculated.
c: These countries reported only acute cases.

Figure 1. Notification rates of acute and chronic hepatitis B per 100 000 population by year, EU/EEA countries reporting consistently, 2015–2024 (y-axis: log scale)



Source for acute cases: country reports from Austria, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Latvia, Lithuania, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain and Sweden.
Source for chronic cases: country reports from Austria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, Iceland, Ireland, Latvia, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia and Sweden.

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



** Countries reporting aggregate data only (Bulgaria and Belgium) were not able to classify cases into acute, chronic, or undetermined.*

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

Age and gender

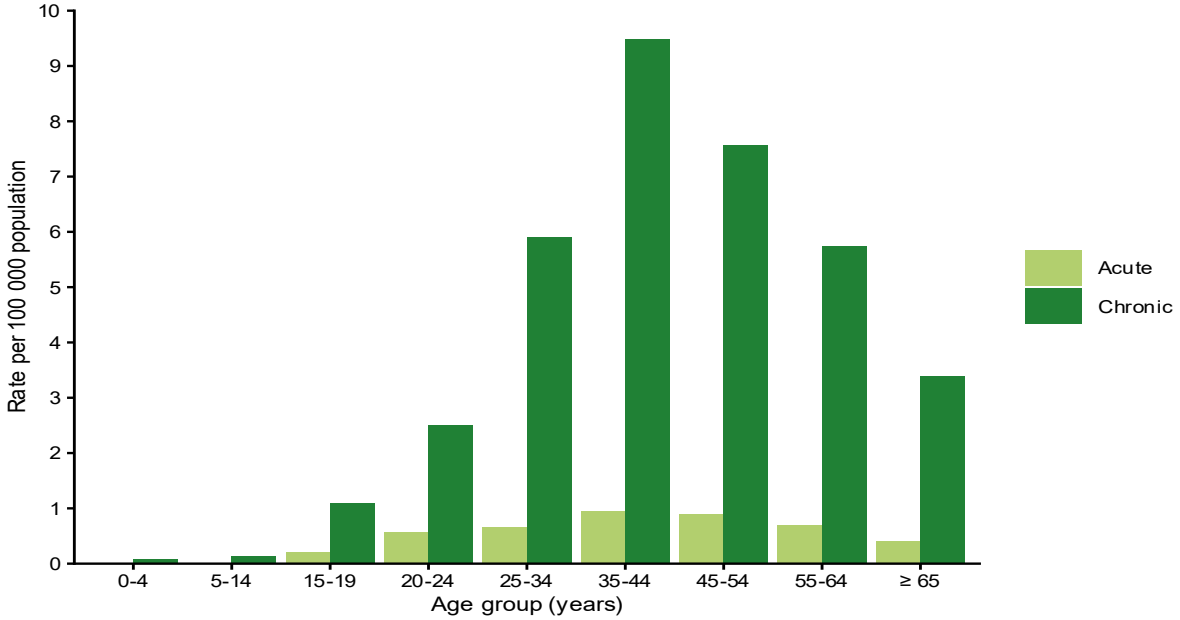
In 2024, 22 032 cases of hepatitis B were reported in men (13.8 cases per 100 000 population) and 15 451 cases were reported in women (9.4 cases per 100 000 population), excluding countries that only reported acute cases. This represents a male-to-female ratio of 1.5:1. The male-to-female ratio was higher among acute cases (2.4:1) than chronic cases (1.4:1).

Most cases were among 25–54-year-olds (63%). The age distribution among reported cases of acute and chronic infections were similar (Figure 3), with 8% of acute and 4% of chronic cases diagnosed in people under 25 years of age.

Among countries reporting consistently every year since 2015, the proportion of acute cases under 25 years declined from 11% in 2015 to 8% in 2024. The proportion of chronic cases under 25 years decreased from 18% in 2015 to 4% in 2024.

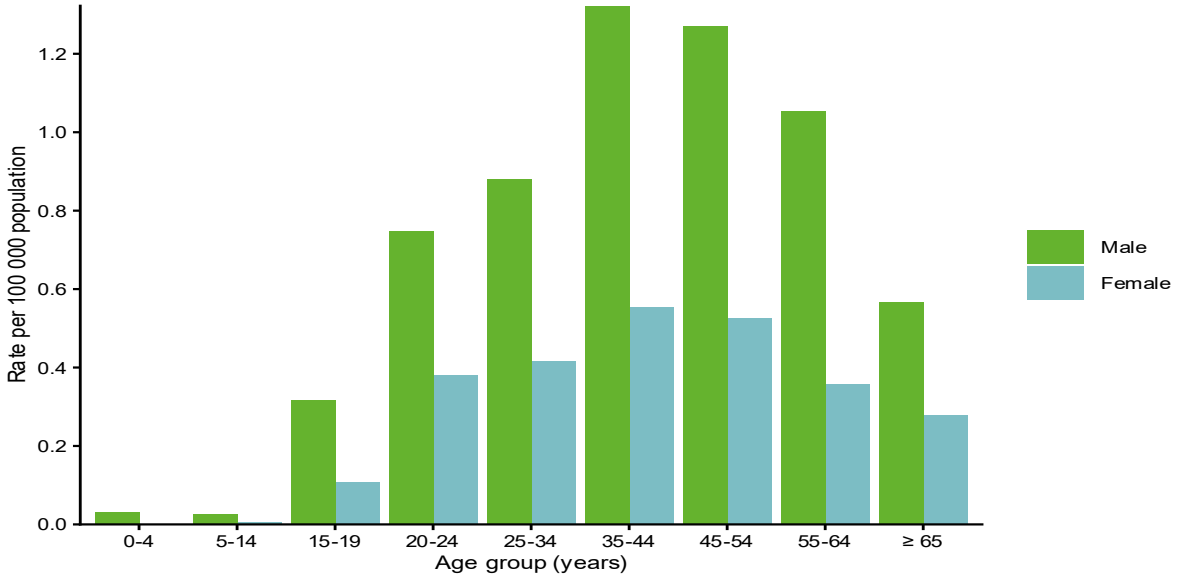
Notification rates were higher among men in all age groups (Figure 4).

Figure 3. Notification rates of acute and chronic hepatitis B per 100 000 population by age group and disease status, EU/EEA, 2024



Source for acute cases: country reports from Austria, Cyprus, Czechia, Denmark, Estonia, Finland, France Germany, Greece, Hungary, Iceland, Ireland, Latvia, Lithuania, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain and Sweden.
Source for chronic cases: country reports from Austria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, Germany, Iceland, Ireland, Latvia, Malta, the Netherlands, Norway, Portugal, Romania, Slovakia, Slovenia and Sweden.

Figure 4. Notification rate of acute hepatitis B cases per 100 000 population by age group and gender, EU/EEA, 2024



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

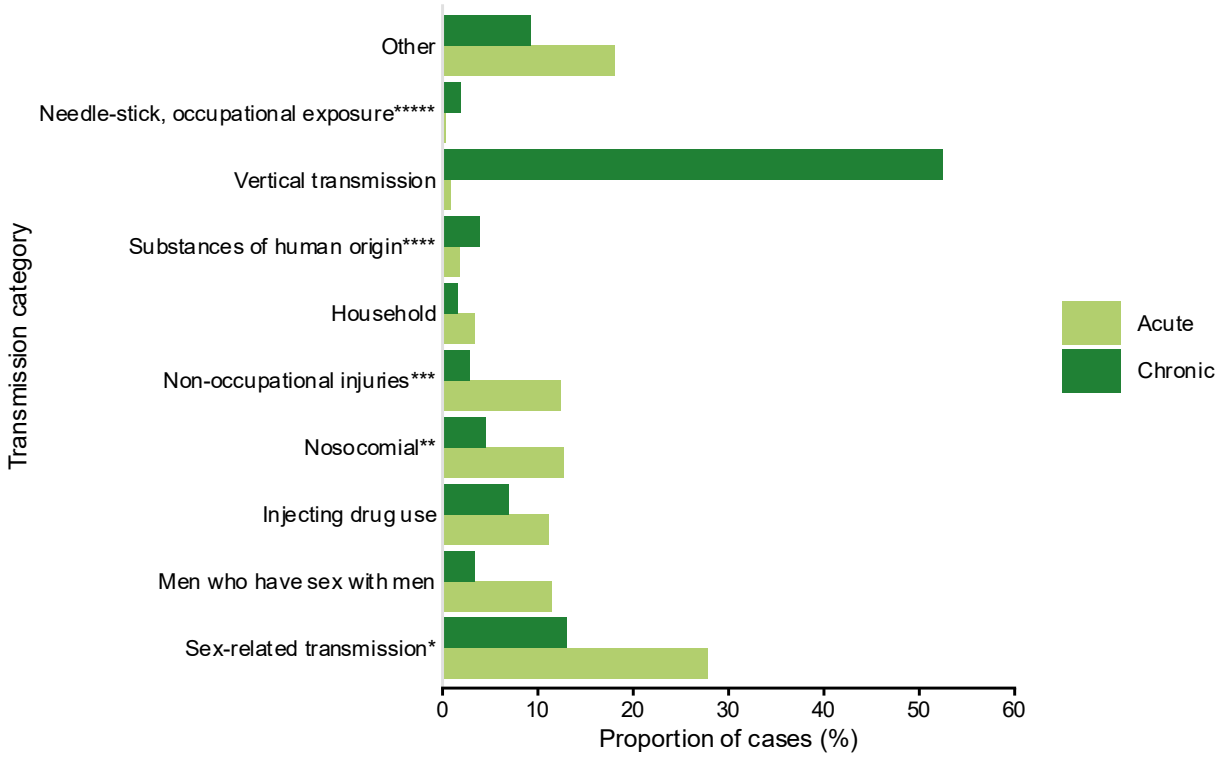
Route of transmission

Data on mode of transmission were reported from 29 countries and were complete for 13% of all reported hepatitis B cases, 23% of the acute and 7% of the chronic cases in 2024 (Table 3). Due to data incompleteness and variation of reporting over time, trends are difficult to interpret and are not reported here.

For the 566 acute cases with complete information, sex-related transmission (heterosexual or unspecific contact, sex work, excluding men who have sex with men) was the most reported (28%), followed by transmission among men who have sex with men (12%) and nosocomial transmission (13%; Figure 5). Italy accounted for 41% of the 66 acute cases attributed to nosocomial transmission.

For the 1 016 chronic cases with complete information, vertical transmission was the most common route of transmission (52%) with 94% of the infections reported as imported (Figure 6). Among chronic cases attributed to vertical transmission, 76% were reported by the Netherlands, 14% by Sweden and 11% by Denmark.

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



Source for acute cases: country reports from Austria, Croatia, Czechia, Denmark, Finland, France, Hungary, Ireland, Italy, Latvia, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia and Spain.
Source for chronic cases: country reports from Austria, Croatia, Czechia, Denmark, Estonia, Finland, Germany, Ireland, Latvia, Liechtenstein, Malta, the Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia 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 are also likely to 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 through healthcare settings, 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 B cases by acute, chronic and undetermined stage of infection, EU/EEA, 2024

Mode of Transmission	Acute	Chronic	Undetermined	Total
Sex-related transmission*	157	132	66	355
Nosocomial**	72	46	2 032	2 150
Non-occupational injuries***	70	29	76	175
Men who have sex with men	65	35	10	110
Injecting drug use	63	71	14	148
Household	19	16	111	146
Substances of human origin****	10	40	145	195
Vertical transmission	5	533	36	574
Needle-stick, occupational exposure*****	2	20	74	96
Other	102	94	53	249
Not reported	1 891	13 794	13 009	28 694
Total	**2 457**	**14 810**	**15 626**	**32 893**

Source for acute cases: country reports from Austria, Croatia, Czechia, Denmark, Finland, France, Hungary, Ireland, Italy, Latvia, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia and Spain.
Source for chronic cases: country reports from Austria, Croatia, Czechia, Denmark, Estonia, Finland, Germany, Ireland, Latvia, Liechtenstein, Malta, the Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia 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 are also likely to 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 through healthcare settings, 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.*

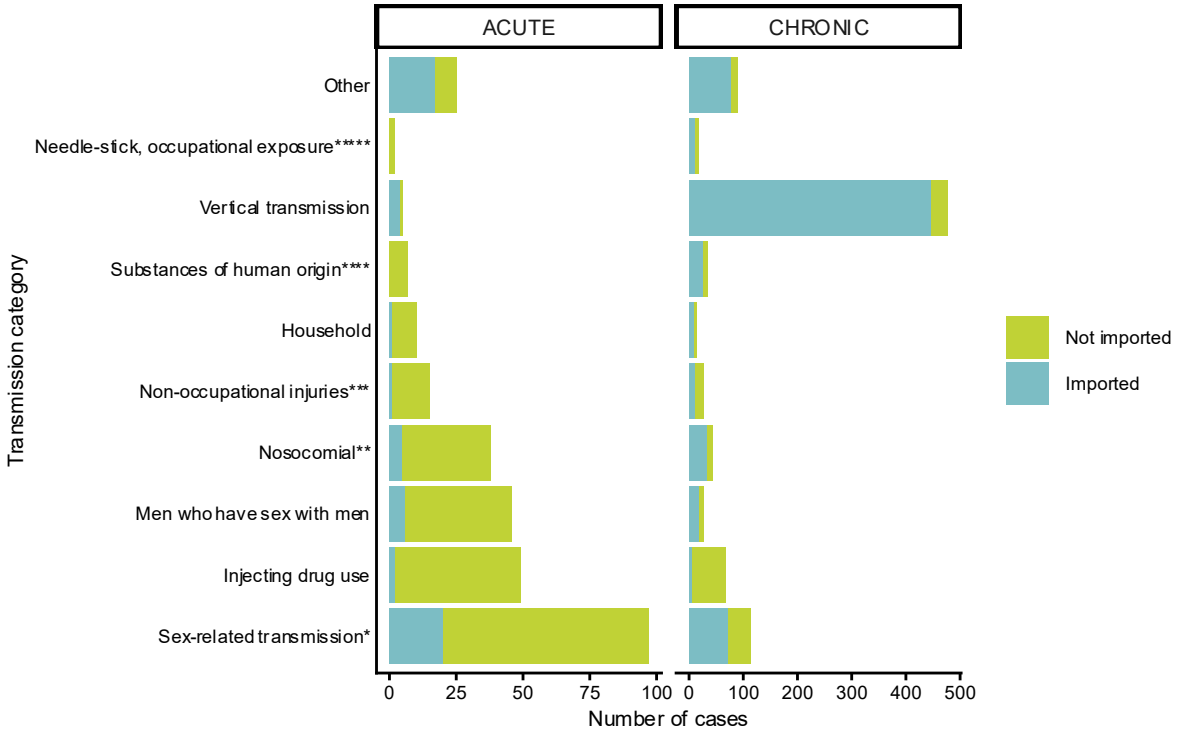
Importation status

Of 13 372 cases (36% of all reported cases) with information on importation status from 29 countries, 4 931 (37%) were reported as imported. Most imported cases (74%) were chronic infections. A total of 1 252 (51%) of acute cases had information on the importation status. The majority (81%) of acute infections were locally acquired, 19% were imported.

Despite the data limitations, the majority (79%) of the acute infections that were related to sexual contact (heterosexual, undefined sexual interaction and sex work) and to men who have sex with men (87%) were not imported, but acquired in the country of reporting. Four of the five (80%) acute infections related to vertical transmission were imported and acquired outside of the reporting country (Figure 6).

Chronic infections were mostly related to vertical transmission, with 93% of them reported as imported, while the majority (91%) of infections related to injecting drug use were locally acquired (Figure 6).

Figure 6. Transmission category of hepatitis B cases by acute and chronic disease and importation status, EU/EEA, 2024



Source for acute cases: country reports from Austria, Czechia, Finland, France, Hungary, Ireland, Latvia, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Spain and Sweden.
Source for chronic cases: country reports from Austria, Czechia, Finland, Germany, Ireland, Latvia, Malta, the Netherlands, Norway, Portugal, Slovakia, Slovenia 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 are also likely to 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 through healthcare settings, 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.*

Discussion

The surveillance data for 2024 indicate that hepatitis B continues to represent a substantial public health burden in the EU/EEA, despite relatively low notification rates for acute infection. The large proportion of cases reported as chronic or with undetermined stage reflects both the natural history of the infection and ongoing challenges in case classification within surveillance systems.

Interpretation of transmission patterns is limited by low data completeness, particularly for chronic infections. Among cases with available information, sex-related transmission was the most frequently reported route among acute infections, while vertical transmission was most frequently reported for chronic infections. However, these findings are based on a small subset of cases and are strongly influenced by reporting practices in a limited number of countries. As such, they should not be considered representative of the overall epidemiological situation in the EU/EEA.

Similarly, the higher proportion of chronic infections reported as imported likely reflects testing and screening strategies, particularly among migrant populations from countries with higher HBV prevalence, rather than current transmission dynamics within EU/EEA countries. Surveillance data for chronic hepatitis B therefore primarily reflect patterns of diagnosis and testing rather than incidence of new infections.

The persistently low rates of acute hepatitis B, especially among younger age groups, probably partially reflect the impact of long-standing hepatitis B vaccination programmes across the EU/EEA [15]. Nevertheless, in 2024 only nine EU/EEA countries reached the WHO target of 95% coverage with three doses of HBV vaccine. Most other countries have a vaccine coverage within 10% of the target [15,16]. Maintaining and strengthening vaccination programmes remains essential in order to sustain progress.

The decline across all stages of infection observed in 2020 was probably due the impact of the COVID-19 pandemic [16-19]. Disruption in prevention services and behavioural changes were reported to have hampered case detection and reporting [17]. In addition, COVID-19 restrictions limited migration and possibly sexual exposure [20-22]. The subsequent increase in notifications from 2021 onwards may reflect a combination of factors, including recovery of testing services, delayed diagnoses, changes in surveillance practices, and shifts in population dynamics.

Recent prevalence estimates have shown that the number of notifications largely underestimates the true burden of hepatitis B, with a substantial proportion of the infections remaining undiagnosed [5,6,23,24]. In this context, the substantial effort undertaken by countries such as Romania, Lithuania and Germany to reduce the number of undiagnosed cases through testing/screening intervention policies for the general population should be highlighted and encouraged in other areas [25-31].

Geographical variations reflect variations in testing policies, reporting practices and underlying epidemiological differences across the EU/EEA. The highest hepatitis B prevalence was observed in southern and eastern Europe [5,6]. Discrepancy between notifications and prevalence estimates highlight the difficulty of accurately assessing the disease burden in populations through routine surveillance data, particularly for chronic infections. The reported chronic hepatitis B cases reflect the intensity of local or national testing and screening policies, the highest rates mainly being observed in countries that are known to have comprehensive testing programmes [32].

Improving the completeness and quality of surveillance data, particularly for disease stage, transmission category and importation status, is essential to better characterise the epidemiology of hepatitis B 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.

Public health implications

In May 2017, the World Health Assembly adopted the first global health sector strategy on viral hepatitis that aims to eliminate the disease by 2030 [3]. The main elimination criteria require a reduction in the incidence of chronic infections by 90%, and associated mortality by 65% by 2030 compared with 2015 levels. Achieving these targets requires robust and comprehensive epidemiological data to guide and evaluate prevention and control efforts.

The findings from 2024 highlight important gaps in surveillance data across the EU/EEA, particularly for key variables such as disease stage, mode of transmission and importation status. Improving the completeness and quality of surveillance data is essential to better characterise transmission patterns, monitor trends over time and support targeted public health action. Strengthening standardisation of reporting and enhancing the integration of surveillance with complementary data sources, such as health insurance, seroprevalence studies and programme data, would further improve the interpretation of the epidemiological situation. ECDC supports EU/EEA countries by developing and fostering alternative surveillance methods, such as seroprevalence surveys, and monitoring of the continuum of care to complement routine data.

The persistently high number of chronic and undetermined cases, together with the known underdiagnosis of hepatitis B infection, underscores the need to expand and sustain testing and screening strategies. Targeted testing in populations at increased risk, including migrants from high-prevalence countries and people who inject drugs, remains essential to identify undiagnosed infections. ECDC and the European 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 [33]. In all populations, diagnosis must be accompanied by strengthened linkage to care, monitoring and access to treatment in order to reduce morbidity, prevent transmission and contribute to achieving mortality reduction targets.

Vaccination remains the cornerstone of hepatitis B prevention. The low number of acute infections, particularly among younger age groups, likely reflects the impact of longstanding immunisation programmes. However, gaps in vaccine coverage persist in several countries. Maintaining and strengthening routine childhood vaccination, as well as ensuring timely birth dose and targeted vaccination of at-risk populations, is critical in order to sustain progress and prevent new infections, particularly in the context of changing population dynamics and vaccine hesitancy.

Continued efforts are also needed to prevent sexual transmission through catch-up vaccination of at-risk populations and safer sex messaging. There is also a need to prevent transmission in healthcare and community settings. The occurrence of nosocomial infections highlights the importance of maintaining high standards of infection prevention and control. Harm reduction programmes for people who inject drugs, including access to sterile injecting equipment and testing services, remain essential components of prevention strategies.

Overall, accelerating progress towards hepatitis B elimination in the EU/EEA will require a comprehensive approach that integrates high-quality surveillance, expanded testing, effective vaccination, and strong linkage to care and treatment. Strengthening these elements in a coordinated manner will be critical to reducing transmission, decreasing disease burden and achieving regional and global elimination goals.

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