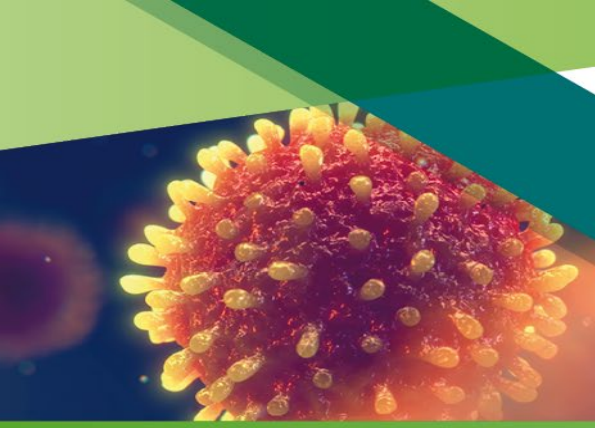

ECDC MONITORING

Progress in the prevention of vertical transmission of viral hepatitis B in the EU/EEA

July 2026

2025 World Health Organization (WHO) interim targets related to the prevention of vertical transmission of hepatitis B virus (HBV) [1-3]

Coverage targets

- 90% of pregnant women screened for hepatitis B surface antigen (HBsAg).
- 95% coverage with three doses of hepatitis B virus (HBV) vaccine in countries that implement universal childhood vaccination.
- 90% coverage with timely (within 24 hours of birth) HBV birth dose vaccination.

Impact targets

- A ≤2% vertical (mother-to-child) transmission rate (for countries using targeted timely HBV birth dose).
- HBsAg prevalence of ≤0.1% among children aged ≤5 years.

This evidence brief is based on data collected by the European Centre for Disease Prevention and Control (ECDC) from European Union/European Economic Area (EU/EEA) countries in 2025 and supplemented by data reported by countries in previous monitoring rounds.

It provides an overview of progress across the EU/EEA countries toward achieving the WHO 2025 interim targets for eliminating vertical transmission of HBV.

Key messages

- Transmission of hepatitis B virus (HBV) from a mother to a child (also referred to as vertical transmission), is low in European Union/European Economic Area (EU/EEA) countries, with few cases attributed to this route among acute notifications. In all of the countries with data available on HBV vertical transmission, the rate was below 2%. aged ≤5 years are limited, but estimates from the four countries providing data were all under 0.1%.
- All EU/EEA countries implement universal antenatal screening for HBsAg in pregnant women and most countries reporting data had met the 2025 World Health Organization (WHO) interim target of 90% coverage. However, data are not available for all countries, limiting the ability to assess progress comprehensively across the European region.
- Data on treatment coverage among eligible HBsAg-positive pregnant women were only available from four countries, but coverage was high, ranging from 75% to 100%. Treatment eligibility criteria are in place in all of the reporting countries and included in national guidelines for 25 countries.
- The hepatitis B vaccine is an effective, safe and inexpensive tool for preventing hepatitis B infection which has significantly reduced the incidence of HBV across the region. A universal childhood vaccination programme is in place in 27 EU/EEA countries, yet only nine have reached the WHO target of 95% HBV vaccination coverage. Efforts to strengthen childhood vaccination coverage are needed to minimise the risk of HBV transmission, particularly in areas where vaccine acceptance is low and in communities with large populations of migrants from high-endemicity countries who may have missed routine vaccination.
- Five EU/EEA countries (Bulgaria, Lithuania, Poland, Portugal and Romania) have introduced HBV birth dose vaccination to all infants as part of their national immunisation programmes. All other countries only provide HBV birth dose vaccination to infants born to HBsAg-positive pregnant women. Data on coverage with timely (within 24 hours of birth) targeted HBV birth dose vaccination from 10 countries indicate that nine of them had reached the 2025 interim target of 90% coverage with timely HBV birth dose vaccination.
- The limited availability and completeness of data across EU/EEA countries may mean that the vertical-transmission burden is under-estimated and could also result in a failure to identify gaps in intervention coverage which may limit the effectiveness of timely programmatic responses. This highlights the need for improved and harmonised systems to monitor screening practices and outcomes.

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Background

Hepatitis B is an infection of the liver caused by the hepatitis B virus (HBV) which is transmitted through blood and other bodily fluids. Acute HBV infection in adults usually clears naturally and less than 5% progress to having a chronic infection with the virus, however, among infants and children under five years of age infected through vertical or horizontal transmission (from infected household or community contacts through exposure to infected blood or body fluids), up to 90% will develop lifelong chronic HBV after acute infection [4]. Chronic HBV infection can lead to severe liver damage, such as cirrhosis and hepatocellular carcinoma (HCC), the most common type of primary liver cancer [4]. Preventing vertical transmission is therefore a cornerstone of hepatitis B elimination strategies. Without effective prevention, transmission during pregnancy, delivery or early childhood remains a key driver of the ongoing burden of chronic infection.

The EU/EEA is a low endemicity (under 2% HBsAg prevalence) region for HBV, with prevalence across the region estimated at 0.7% [5]. In areas of the world that have a higher prevalence of HBV, the virus is commonly transmitted from mother to child at birth or during the first five years of childhood due to exposure within the household [4].

Surveillance data for 2024 indicate that vertical transmission was the most common mode of transmission among newly diagnosed chronic HBV cases reported across EU/EEA countries, accounting for 52% of cases, with 94% of these cases classified as being imported [6]. Among acute hepatitis B cases, most of which are acquired within the EU/EEA, vertical transmission accounted for <1% of cases reported in 2024, with the majority of cases being attributed to transmission via sex, injecting drug use or nosocomial transmission [6]. However, information on transmission routes was only available for a subset of cases (23% of acute and 7% of chronic cases) and is therefore unlikely to be representative of the situation across the EU/EEA.

Essential measures for minimising vertical transmission of HBV include testing of pregnant women in antenatal care settings; prompt access to antiviral treatment for all women who test positive; appropriate follow-up of exposed infants, including an HBV vaccine birth dose; treatment with immunoglobin where indicated; access to medical care for mothers with HBV, and to antiviral treatment for those who are eligible, and universal childhood HBV vaccination [7, 8]. WHO guidance provides a comprehensive strategy for governments, healthcare providers and relevant stakeholders to plan, assess, improve and expand elimination programmes while considering aspects of implementation, such as the strengthening of health systems to better provide effective person-centred care and cross-programmatic coordination [7].

Two EU/EEA countries, Italy and the Netherlands, have reached the regional hepatitis B control targets set by the WHO Action Plan for the Health Sector Response to Viral Hepatitis in the WHO European Region [9, 10]. Validation of having achieved these control targets is based on each country's vaccination coverage for the hepatitis B birth dose and subsequent doses; additional measures to prevent vertical transmission, and the results of serosurveys or modelling, demonstrating that successful vaccination programmes have led to significant reductions in hepatitis B prevalence among vaccinated cohorts. In 2021, WHO launched its global 'Triple Elimination Initiative' for elimination of the vertical transmission of HIV, syphilis and HBV [2]. This initiative encouraged countries to provide effective, high-quality and person-centred care to all pregnant and breastfeeding women. Global criteria, processes and targets for validating elimination were also released in 2021 [3].

This evidence brief provides an overview of the progress made across the EU/EEA countries to achieve the WHO targets for eliminating vertical transmission of HBV. It presents and analyses data collected by ECDC in 2025[1] to monitor progress toward the Sustainable Development Goals (SDGs) for viral hepatitis in the 30 EU/EEA countries, highlighting areas where further action is needed.

[1] Although reported in 2025, data for most of the indicators relate to 2024. If no new data were reported in 2025, data from the most recent year available were used, unless the data were over 10 years old.

Progress toward the 2030 targets

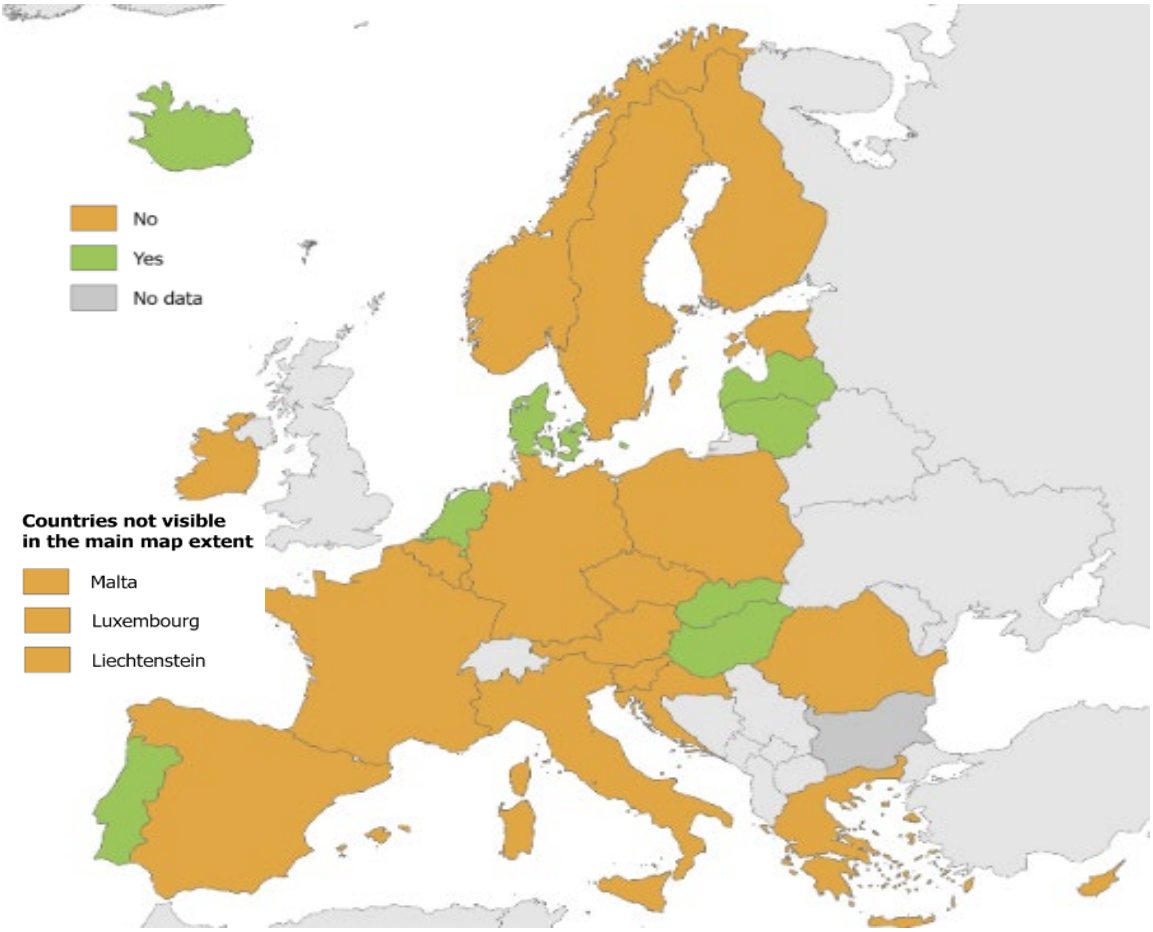
Universal screening of pregnant women

WHO interim 2025 target: 90% of pregnant women screened for hepatitis B surface antigen (HBsAg)

Testing pregnant women for HBV (HBsAg) is a key component of antenatal care services, alongside prompt and effective interventions for mothers who test positive and their babies, in order to prevent vertical transmission of HBV infection [8].

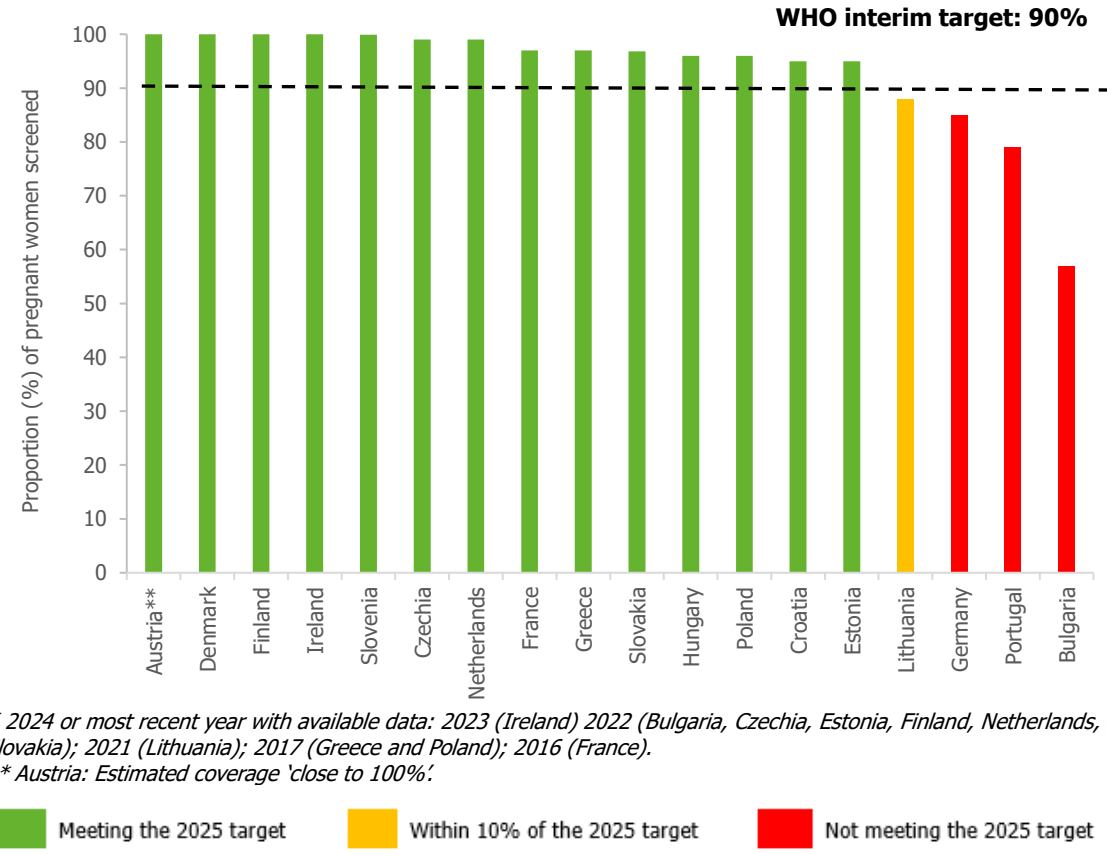
Universal screening of pregnant women for HBV infection is implemented in all 30 EU/EEA countries. Eight countries reported having a national coordinator for antenatal care (Figure 1), based either in the national public health institute (three countries), the Ministry of Health (two countries) or another entity (three countries).

Figure 1. National coordinator for the antenatal care programme for HBV, EU/EEA countries (n=30), 2024



Of the 30 EU/EEA countries having implemented universal antenatal screening, 18 had data available on screening coverage (Figure 2). Coverage varied from 57% to 100% (median: 97%) and 14 of the 18 countries had met the WHO 2025 target of 90% of pregnant women screened for HBsAg. This is an improvement on nine out of 13 countries with available data that reached the target in 2022.

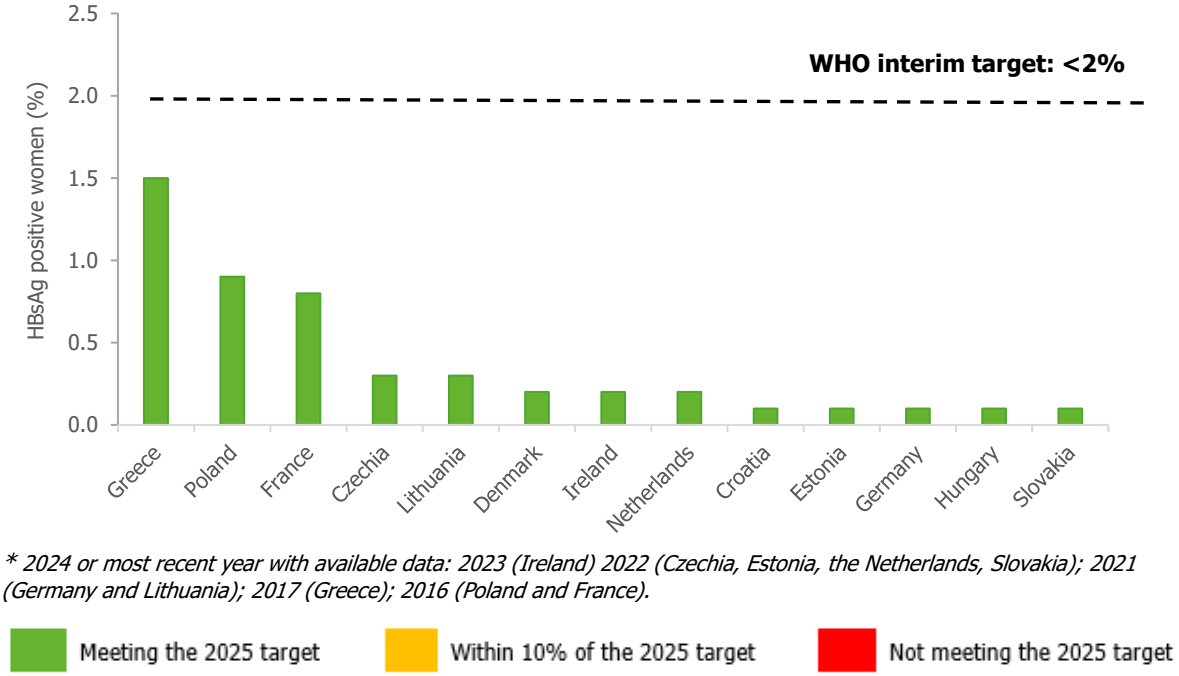
Figure 2. Coverage of antenatal screening for HBV, EU/EEA countries (n=18), 2024*



** 2024 or most recent year with available data: 2023 (Ireland) 2022 (Bulgaria, Czechia, Estonia, Finland, Netherlands, Slovenia, Slovakia); 2021 (Lithuania); 2017 (Greece and Poland); 2016 (France).*
*** Austria: Estimated coverage 'close to 100%'.*

Of the 18 countries with data on HBsAg screening coverage of pregnant women, 13 have data available on the positivity rate (Figure 3). The proportion who tested positive was below 2% in all reporting countries.

Figure 3. Proportion of pregnant women screened for HBV (HBsAg) who tested positive, EU/EEA countries (n=13), 2024*



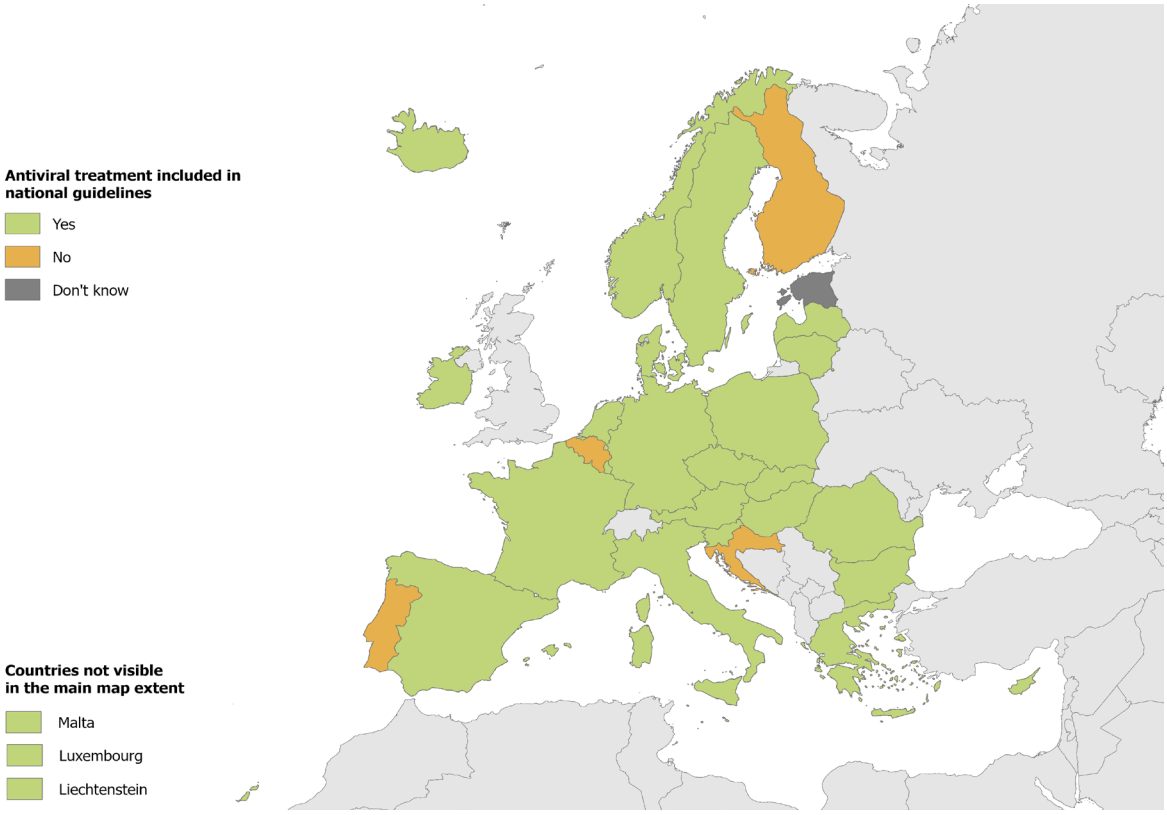
** 2024 or most recent year with available data: 2023 (Ireland) 2022 (Czechia, Estonia, the Netherlands, Slovakia); 2021 (Germany and Lithuania); 2017 (Greece); 2016 (Poland and France).*

Treatment of HBsAg-positive pregnant women

To prevent vertical transmission of HBV, WHO recommends treatment with tenofovir disoproxil fumarate (TDF) from the 28th week of pregnancy until delivery [11]. In 2024, WHO updated the Guidelines for the prevention, diagnosis, care and treatment for people with chronic hepatitis B infection that extended the recommendations on antiviral prophylaxis among pregnant women. In settings where HBV DNA or hepatitis B e-antigen (HBeAg) testing is available, pregnant women who are HBsAg-positive, should receive TDF if their HBV DNA is ≥200 000 IU/mL or if they are HBeAg-positive. Treatment should ideally begin in the second trimester and continue at least until the birth of the baby, or until the baby's HBV vaccination series is completed. Furthermore, a new recommendation was added in settings where neither HBV DNA nor HBeAg is available, TDF prophylaxis may be considered for all HBsAg positive pregnant women, thereby simplifying implementation.

A total of 25 countries reported that provision of antiviral treatment to pregnant women testing positive for HBV is included in the national guidelines, as a measure to prevent vertical transmission of HBV. Four reported that this was not the case and one country indicated that they did not know (Figure 4).

Figure 4. Antiviral treatment for pregnant women testing positive for HBV included in national guidelines, EU/EEA countries (n=30), 2024*



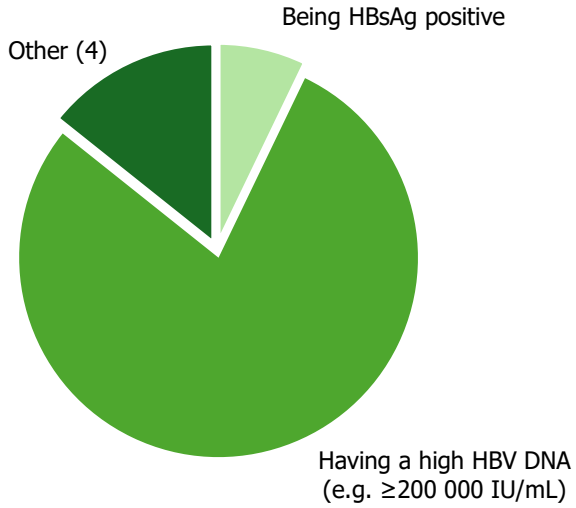
** 2024 or most recent year with available data: 2023 (Bulgaria, Cyprus).*
NB. Belgium reported that although specific guidelines do not exist, the country strictly follows European Association for the Study of the Liver (EASL) guidelines.

Coverage data on the percentage of HBsAg-positive pregnant women who received antiviral treatment are not available from all EU/EEA countries. Of the four countries providing coverage data for 2024, estimates ranged from 75–100%.

A total of 28 countries provided detailed information on the specific eligibility criteria in place for HBsAg positive pregnant women to access antiviral treatment (Figure 5). All four of the countries reporting that antiviral treatment of HBsAg-positive pregnant women was not included in their national guidelines (Figure 4) provided information on eligibility criteria for treatment.

The majority of countries (22) reported that mothers with high viremia (HBV DNA ≥200 000 IU/mL) were eligible for antiviral treatment. In addition, two countries (Hungary and Luxembourg) reported that mothers who were HBsAg positive were eligible for treatment and four countries (Austria, Czechia, Germany and Romania) specified other criteria, such as being HBeAg positive, the stage of liver disease and HBsAg being ≥ 4 log*10 IU/ml in weeks 24–28 of the pregnancy.

Figure 5. Eligibility criteria for HBsAg-positive pregnant women having access to antiviral treatment, EU/EEA countries (n=28), 2024*



** 2024 or most recent year with available data: 2023 (Belgium, Bulgaria, Croatia, Cyprus, Estonia, Finland and Latvia). No data available from Portugal and Slovakia.*

HBV vaccination

National vaccination policy

WHO recommends universal vaccination against hepatitis B and that infants should receive their first dose of hepatitis B vaccine as soon as possible after birth, preferably within 24 hours [8]. All EU/EEA countries have implemented different birth dose vaccination strategies that aim to reduce the risk of vertical transmission. These involve either universal hepatitis B vaccination at birth, or antenatal screening combined with post-exposure prophylaxis that includes targeted HBV birth dose vaccination for infants born to mothers with an HBV infection.

Of the 30 EU/EEA countries, 27 recommend universal vaccination against hepatitis B either during infancy (26 countries) or in adolescence (one country) (Annex A). The three countries without universal childhood vaccination recommendations (Denmark, Finland and Iceland) all provide a targeted approach, focusing on defined groups at high risk of infection (such as men who have sex with men, people who inject drugs and healthcare workers).

HBV childhood vaccination

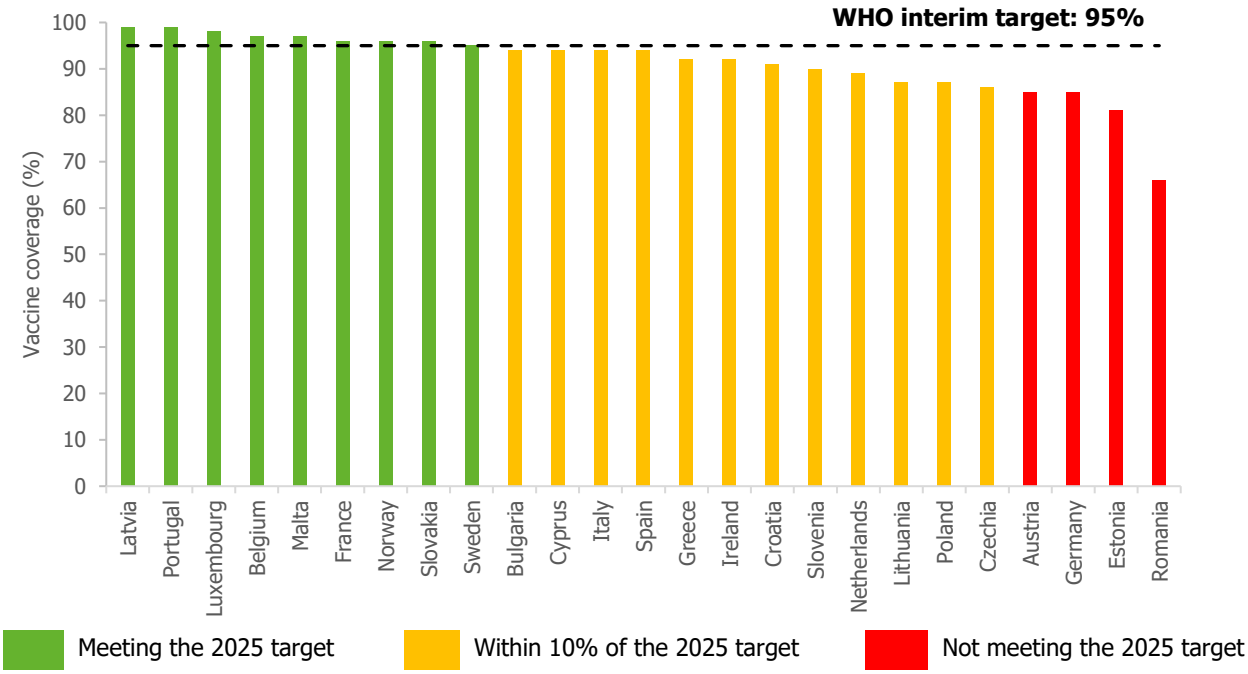
WHO interim 2025 target: 95% coverage with three doses of HBV vaccine in countries that implement universal childhood vaccination

HBV vaccination is the primary method for preventing HBV infection. The vaccine offers highly effective (over 95% in healthy individuals) and long-lasting protection and is both safe and inexpensive [8]. Vaccination programmes have led to a significant decline in the incidence of HBV infection worldwide, including the incidence of hepatitis B among children under the age of five years. Furthermore, the vaccine significantly reduces the risk of developing liver cancer [12].

Vaccination coverage data are collected by WHO and UNICEF on an annual basis. Among 25 countries with available data, only nine had met the 2025 WHO target of 95% coverage or more as of 2024, while 12 countries were within 10% of the target (including eight that were within 5%), and four countries reported vaccination coverage of $\leq$ 85% (Figure 6).

When comparing vaccination coverage data from 2024 with data from previous years, some countries reported a decline in coverage of the three doses of HBV vaccine given during infancy between 2019 to 2024. Two countries, (Estonia and Romania) saw a major fall in coverage during this period. Estonia's coverage dropped from 91% in 2019 to 81% in 2024. In Romania, coverage fell from 90% to 66% during the same period. Some of this fall in coverage could be an after-effect of the COVID-19 pandemic, where reductions in vaccination coverage were reported for many pathogens from several European countries due to disruptions in services [13]. However, decreased parental acceptance of vaccination due to misinformation may also have had a further negative impact on vaccination rates in recent years [13].

Figure 6. Coverage (%) with three doses of hepatitis B vaccine (HB3) in EU/EEA countries that implement universal HBV childhood vaccination (n=25), 2024*



** No data available for: Denmark, Finland, and Iceland (no universal HBV childhood vaccination programme); Hungary (has a universal vaccination programme targeting school-age children but coverage data for the three doses of the vaccine are not available); and Liechtenstein (data are included within the data from Switzerland and are therefore not shown separately).*

Source: WHO/UNICEF Estimates of National Immunization Coverage (WUENIC) (as of 6 February 2026) [14].

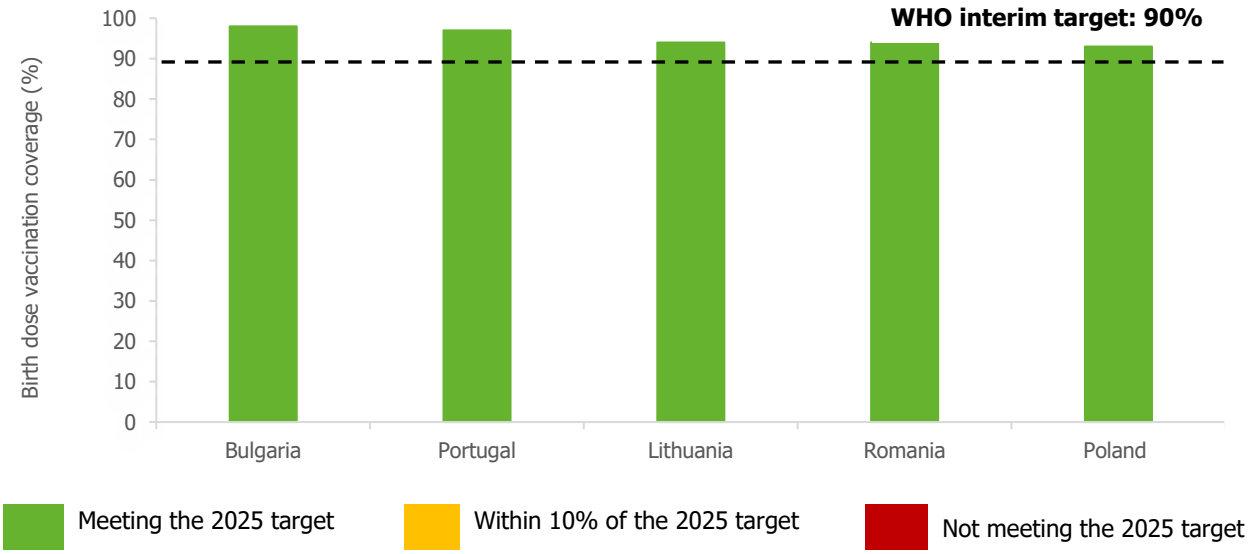
HBV birth dose vaccination

WHO interim 2025 Target: 90% coverage with timely (within 24 hours of birth) HBV birth dose vaccination.

WHO recommends timely (within 24 hours) universal birth dose vaccination of newborns, regardless of the HBsAg status of the pregnant mother. It is recommended that the birth dose is followed by two or three additional doses given at least four weeks apart to complete the primary immunisation series [11].

In the EU/EEA five countries have implemented HBV birth dose vaccination as a universal strategy (Bulgaria, Lithuania, Poland, Portugal and Romania). All countries have achieved the 2025 interim target, with timely (within 24 hours of birth) vaccination coverage ranging from 93% to 98% (Figure 7).

Figure 7. Coverage (%) of HBV birth dose vaccine in EU/EEA countries implementing universal birth dose vaccination (n=5), 2024



Source: WHO/UNICEF Estimates of National Immunization Coverage (WUENIC) (as of 6 February 2026) [14].

Post exposure prophylaxis to children born to HBsAg-positive mothers

All 29 countries in the EU/EEA reporting data (no information from Bulgaria) indicated that their national policies include measures for post-exposure prophylaxis for infants born to HBsAg-positive mothers. All 29 countries provide birth dose vaccination to exposed infants and 27 countries provide hepatitis B immunoglobulin (HBIG) in combination with HBV birth dose vaccination.

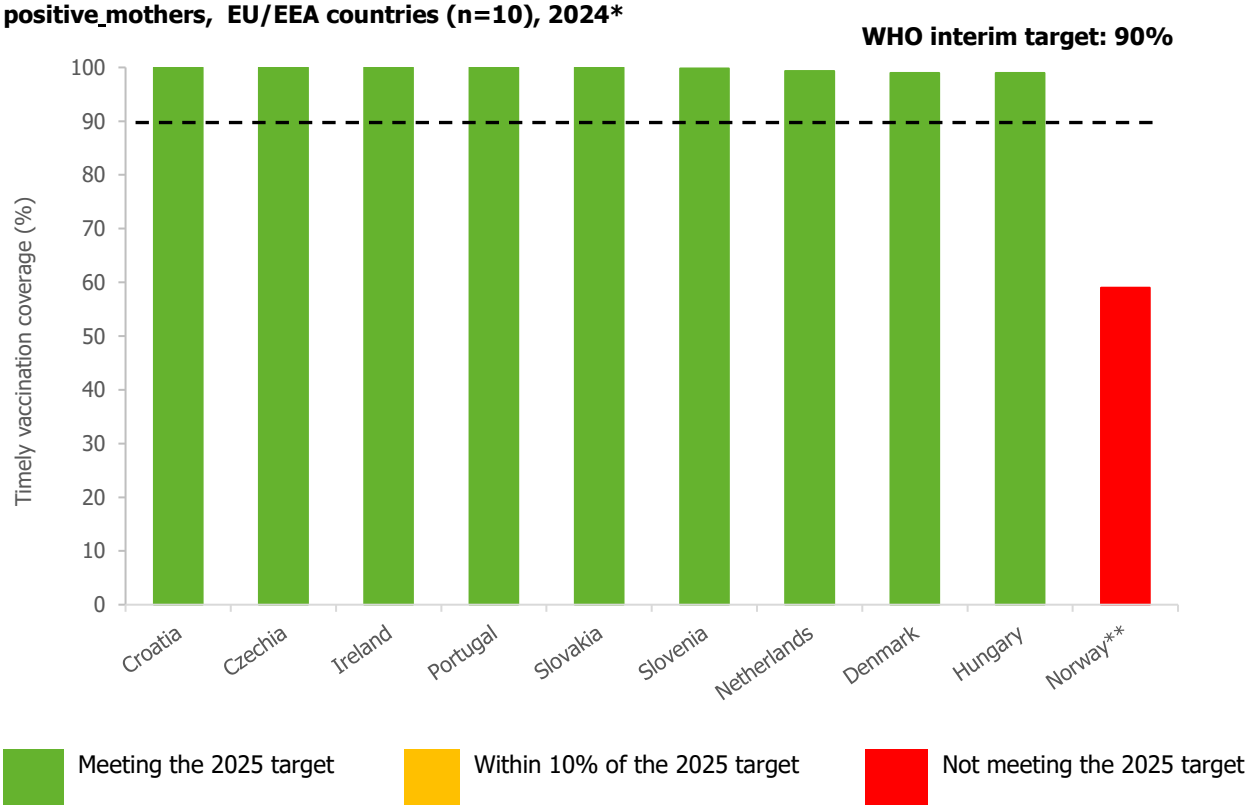
Targeted HBV birth dose vaccination

WHO interim 2025 target: 90% coverage with timely (within 24 hours of birth) HBV birth dose vaccination

Of the 30 EU/EEA countries, five recommend a universal HBV birth dose (Figure 7) and all the others have targeted recommendations to provide an HBV birth dose to exposed infants as a measure of post-exposure prophylaxis for infants born to HBsAg-positive mothers. Ten countries reported on timely administration (within 24 hours of birth) (Figure 8). Nine of the 10 countries with data on timely birth dose vaccination had reached the WHO 2025 interim target of 90% coverage.

In Norway, only 59% of children born to HBsAg-positive mothers (approximately 100–150 annually) were registered as having received the first HBV dose within 24 hours of birth. These figures are based on linked national registry data, which depend on accurate recording of birth doses in the national vaccination registry, and the reported 59% coverage is considered to be an underestimate of the true coverage *[personal correspondence with country representative, 8 November 2025].*

Figure 8. Coverage (%) of timely administration of hepatitis B birth dose for infants born to HBsAg-positive mothers, EU/EEA countries (n=10), 2024*



** 2024 or most recent year with available data: 2023 (Ireland and Norway); 2022 (Slovenia).*

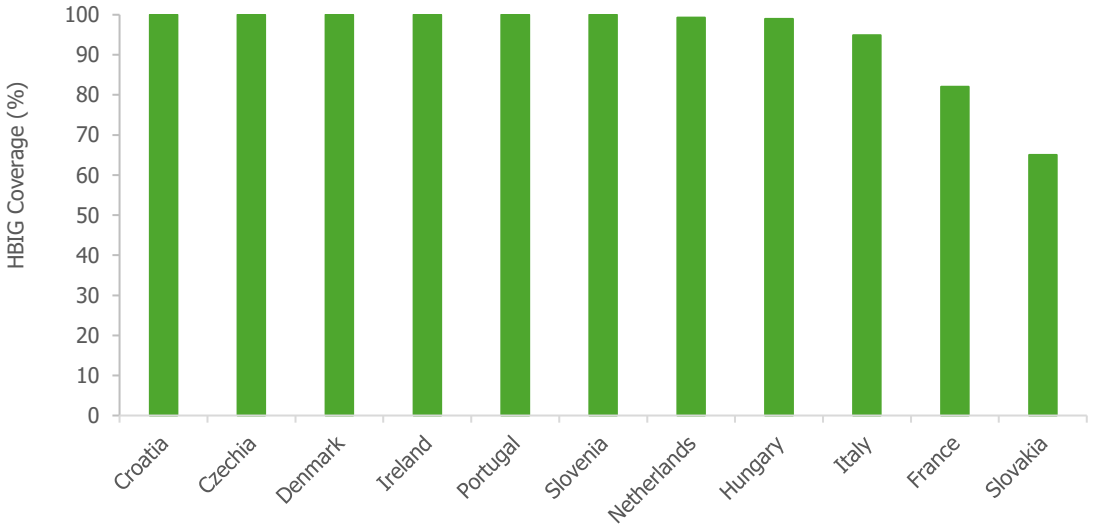
*** This figure is based on linked national registry data, which depend on accurate recording in the national vaccination registry and is therefore probably underestimated.*

Hepatitis B immunoglobulin

In addition to timely administration of a birth dose of HBV vaccine for infants born to HBsAg-positive mothers, the provision of hepatitis B immunoglobin (HBIG) shortly after birth provides additional protection [11]. This is particularly indicated for babies of mothers with a high viral load (HBV DNA ≥ 5.3 log10 IU/ml (≥ 200 000 IU/ml2)) or who are HBeAg-positive, as the risk of transmission is higher in these cases.

A total of 27 countries reported that they provide HBIG as post-exposure prophylaxis for infants born to HBsAg-positive mothers. Of these, 11 countries provided estimates of the proportion of eligible infants receiving HBIG, with coverage ranging from 65% to 100%, and nine countries reporting coverage of 95% or above (Figure 9).

Figure 9. Coverage (%) of timely administration of HBIG for infants born to HBsAg positive mothers, EU/EEA countries (n=11), 2024*



** 2024 or most recent year with available data.*

Impact targets

WHO interim 2025 target:

≤ 2% vertical transmission rate (for countries using targeted timely birth dose)
≤ 0.1% HBsAg prevalence among children aged ≤5 years.

Data on the rate of vertical transmission for HBV were only available from seven EU/EEA countries (Table 1), with reported rates all below the WHO target of 2%, ranging from 0% to 1.8%.

Table 1. National-level rates of vertical transmission of hepatitis B virus, EU/EEA countries, 2024*

Country	Infants born to HBsAg-positive mothers	HBsAg positive infants	MTCT rate (%)**	Year
Czechia	66	1	1.5	2023
Denmark	77	0	0	2024
Finland	No data	0	0	2024
Greece			0	2020
Hungary	48	0	0	2024
Netherlands	319	1	0.3	2023
Slovakia			1.8	2021

** 2024 or most recent year with available data.*

*** Number of HBsAg-positive infants per 100 HBsAg-positive mothers.*

No data available from (or data older than 2020): Austria, Belgium, Bulgaria, Croatia, Cyprus, Estonia, France, Germany, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Norway, Poland, Portugal, Romania, Slovenia, Spain and Sweden.

Data were available on HBsAg prevalence among children aged ≤5 years from four countries, with reported prevalence of 0% in Czechia and Germany and <0.1% in Belgium and Italy.

Conclusions and priorities for action

Overall progress

Vertical transmission of HBV remains very low in the EU/EEA, reflecting the success of preventive measures implemented across the region over many years. Among all countries reporting data, the vertical-transmission rate was below the WHO target of 2% and the HBsAg prevalence among children aged ≤5 years was below the WHO impact target of <0.1%.

National policies across the region are well aligned with WHO recommendations, underscoring a shared commitment to best practices and the global goal of eliminating vertical HBV transmission. Universal HBV screening of pregnant women, as recommended by WHO, is now standard practice in all EU/EEA countries. Reporting on screening coverage has improved in 2025 compared to previous data collections, with 18 countries now providing data, and 14 of these having achieved the 90% coverage target.

Most EU/EEA countries have universal hepatitis B childhood vaccination programmes that have now been in place for decades. However, only around one third of countries reporting coverage data meet the 2025 target of 95% coverage for the three-dose schedule. A few countries have experienced recent declines in coverage, potentially linked to decreasing vaccine acceptance [15]. Sub-optimal childhood vaccination coverage represents a risk, as in the absence of high vaccination coverage, particularly in the context of population dynamics, gains achieved in preventing vertical transmission may not be maintained. Multi-stakeholder strategies, informed by local assessments of barriers and population needs, are important to strengthen vaccination uptake.

All countries reported they have post-exposure prophylaxis policies for babies born to HBsAg-positive women. In fact, all countries in the EU/EEA provide birth-dose vaccine, with five providing this as a universal birth dose to all newborns, and a high vaccination coverage for the birth dose reported across countries. Among the 10 countries reporting data on timely administration of targeted birth dose, coverage is high, with eight countries reaching the target of 90%. In addition, 27 countries also offer HBIG as post-exposure prophylaxis, reflecting strong regional commitment to preventing vertical transmission.

Although data on coverage of antivirals for eligible HBsAg-positive pregnant women were limited, available data indicated that coverage was high in most of the reporting countries.

Trends

Although significant variation persists across countries in both progress and data availability, several countries have shown steady improvement across multiple key indicators. Reporting on universal HBV screening coverage for pregnant women has improved markedly since 2017, alongside improvements in reported coverage of timely HBV birth dose vaccination coverage among infants born to HBV-positive mothers. Progress is also seen in reporting on vaccination coverage among exposed infants. In 2021, six countries reported data on the timely administration of targeted birth dose vaccination, with five of them meeting the 90% target. However, ten countries reported data for 2024, with eight reaching the 95% target, reflecting an upward trend in reporting and the number of countries reaching the target. These gains are particularly important in the current epidemiological context for HBV, with many countries in the region affected by migration from countries with higher endemicity and suboptimal vaccination coverage [15, 16, 17]. Maintaining high coverage and ensuring timely interventions remain essential in order to sustain progress towards HBV elimination and minimise any vertical transmission.

Improving data for action

Sustaining progress towards elimination not only requires countries to maintain high coverage of effective interventions, but also to strengthen monitoring systems to ensure that gaps can be identified early. The lack of robust and reliable data remains a major barrier to accurately assessing progress toward the elimination targets. Although most EU/EEA countries have adopted and implemented the necessary guidelines to prevent vertical transmission, data on coverage across key interventions are often outdated, or incomplete and the quality of data is highly variable across countries, with sources ranging from systematic programmatic data to expert opinion. National monitoring systems need to be strengthened to effectively evaluate programme performance, identify service gaps, and support evidence-based decision-making.

ECDC is currently working on developing new standards of care for antenatal screening, in collaboration with the European AIDS Clinical Society (EACS). This new guidance is expected to be published in 2026. The aim is to establish a framework for auditing and quality improvement that will support EU/EEA countries in strengthening their screening programmes and advancing progress towards achieving the Sustainable Development Goals.

Priorities for action

Strengthen and standardise monitoring systems

- Monitoring for all components of vertical HBV prevention programmes should be established at the national level in line with the WHO elimination indicators.
- Improvements are needed around the completeness, timeliness and quality of national data to enable accurate and timely assessment of progress toward hepatitis elimination targets.

Maintain high coverage of birth dose vaccination and HBIG

- Ensure continued high coverage of timely birth dose vaccination and HBIG administration for children born to HBV-positive mothers.
- Strengthen the reporting of data on targeted birth dose and HBIG coverage to identify any gaps in access.

Increase childhood HBV vaccination coverage

- Countries with sub-optimal HBV vaccination coverage should explore the factors that may affect this low coverage, such as public perception toward vaccination, local vaccination policies and costs to the individual. The results of this assessment should be used to develop tailored, multi-stakeholder communication and vaccination strategies.
- Adapting vaccination services to the needs of different population groups (e.g. migrant populations) requires continuous efforts to understand their needs and identify any barriers that may impede uptake, such as discrimination, financial costs or administrative issues.
- During the COVID-19 pandemic, confidence in vaccination fell among the general public [18]. An evidence-based approach to communication on vaccinations is needed to strengthen local efforts to improve vaccine acceptance through tailored strategies. This approach should address any barriers, engage with communities and promote active communication and education campaigns to address misinformation [18].

Ensure access to antiviral treatment

- Ensure that eligible HBsAg-positive pregnant women have access to timely antiviral treatment in line with WHO guidance and improve the monitoring of treatment uptake and outcomes to evaluate programme effectiveness and identify gaps in access.

Addressing equity and sustaining progress

- Identify and address barriers to antenatal care and vaccination among vulnerable populations, including migrants and those with limited access to healthcare. Promote equitable, person-centred approaches to care across all stages of the vertical transmission prevention cascade.
- Maintain political commitment and investment in vertical transmission prevention programmes to ensure continued high coverage of interventions.
- Align national monitoring frameworks with WHO validation requirements to support verification of elimination.

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Annex A. National immunisation schedules related to hepatitis B for EU/EEA countries, 2025

Country	Universal birth dose of HBV vaccine (delivered to babies within 24 hours of birth)	Targeted birth dose of HBV vaccine (babies born to HBV-positive mothers)	Universal HBV vaccination (delivered to infants)	Universal HBV vaccination (delivered to adolescents)
Austria				
Belgium				
Bulgaria				
Croatia				
Cyprus				
Czechia				
Denmark				
Estonia				
Finland				
France				
Germany				
Greece				
Hungary				
Iceland				
Ireland				
Italy				
Latvia				
Liechtenstein				
Lithuania				
Luxembourg				
Malta				
Netherlands				
Norway				
Poland				
Portugal				
Romania				
Slovakia				
Slovenia				
Spain				
Sweden				

Source: ECDC vaccine scheduler [19] as of 24 June 2026.

Vaccine included in national schedule

Vaccine not included in national schedule

Annex B. Country progress toward the WHO targets

Progress towards the WHO 2025 interim targets related to the prevention of vertical transmission of HBV, by EU/EEA country, 2024

	95% coverage with three doses of childhood HBV vaccination	90% coverage with timely HBV birth dose vaccine (*universal*)	90% coverage with timely HBV birth dose vaccine to babies born to mothers with HBV (*targeted*)	90% coverage of screening for HBV in pregnant women	≤2% HBV vertical transmission rate	0.1% HBsAg prevalence among children aged ≤5 years
Austria	85%			100%		
Belgium	97%					<0.1%
Bulgaria	94%	98%		57%		
Croatia	91%		100%			
Cyprus	94%					
Czechia	86%		100%	99%	1.5%	0%
Denmark*			100%	100%	0%	
Estonia	81%			95%		
Finland*				100%	0%	
France	96%			97%		
Germany	85%			85%		0%
Greece	92%			97%	0%	
Hungary			100%	96%	0%	
Iceland*						
Ireland	92%		100%	100%	0%	
Italy	94%					<0.1%
Latvia	99%					
Liechtenstein						
Lithuania	87%	94%		88%		
Luxembourg	98%					
Malta	97%					
Netherlands	89%		99%	99%	0.3%	
Norway	96%		59%			
Poland	87%	93%		96%		
Portugal	99%	97%		79%		
Romania	66%	94%				
Slovakia	96%		100%	97%	1.8%	
Slovenia	90%		100%	100%		
Spain	94%					
Sweden	95%					

**Denmark, Finland and Iceland do not have a national policy for universal childhood vaccination against hepatitis B.*

Meeting the 2025 target | Within 10% of the 2025 target | Not meeting the 2025 target