

Key Findings and Actionable Policy Recommendations from VH-COMSAVAC

Migrants and refugees in Europe are disproportionately affected by viral hepatitis and face a persistent equity gap in the prevention and care of HBV and HCV. VH-COMSAVAC offers a model for bridging this divide through targeted, community-based care.

However, its full impact and potential scale-up depends on policy-level changes in many countries. National and EU-level stakeholders must now take the steps to translate the strategies, action plans and evidence-based guidelines into action to ensure viral hepatitis elimination efforts leave no one behind.

Background

Despite the progress made in the European Union (EU) towards the World Health Organization's (WHO) goal to eliminate viral hepatitis as a major public health threat by the year 2030, migrant populations from medium- and high-prevalence countries living in the EU continue to face disproportionate risk and inequitable access to testing, care, and prevention for the hepatitis B (HBV) and hepatitis C viruses (HCV). As migration policy is debated and health systems struggle to adapt to the growing needs of a more diverse population, the public health risk of viral hepatitis continues to be imminent for those most vulnerable, resulting in preventable morbidity and mortality.

The Multi-country Viral Hepatitis Community-based Screening, Vaccination and Care (VH-COMSAVAC study) implemented culturally appropriate decentralised models of care in the European countries receiving the largest volume of migrants from outside the EU: Greece, Italy, and Spain to reduce these disparities^{1,2}. This knowledge translation policy brief summarises key findings and proposes actionable policy recommendations to help health systems become more inclusive, equitable, and responsive to the viral hepatitis needs of migrant communities.



Context and Challenge

HBV and HCV infections have declined in Europe as a result of the implementation of national and regional action plans that include universal childhood vaccination programmes, routine screening in antenatal care, harm reduction services for people who use drugs and access to effective treatment, among others. However, these successes have not reached all communities equally. According to the WHO Global Hepatitis Report 2024, there were an estimated 254 million prevalent hepatitis B infections and 50 million prevalent hepatitis C infections worldwide in 2022³. Although the estimated number of people newly infected by viral hepatitis declined from 3 million in 2019 to 2.2 million in 2022, the number of viral hepatitis-related deaths increased from 1.1 million to 1.3 million in the same period, suggesting that the number of hepatitis-related cancer cases and deaths are increasing as well³. In the EU/European Economic Area (EEA), despite limited data being available on the continuum of care for viral hepatitis infections, overall, data indicate that a high proportion of HBV and HCV chronic cases remain undiagnosed, corresponding on average to 55% of people living with chronic HBV undiagnosed and 79% of those living with chronic HCV⁴.

The viral hepatitis burden disproportionately affects certain WHO regions. While in the WHO European region the prevalence of chronic HBV and HCV among the general population is 1.2%, and 0.9%, respectively, the HBV prevalence can reach nearly 6% in the African region, for example³. The African region accounts for 63% of new hepatitis B infections, however only 18% of new-borns in the region receive the hepatitis B birth-dose vaccination³. As the EU/EEA has the highest number of migrants globally, health systems must be prepared to respond to the unique needs of migrants, particularly those coming from regions where hepatitis B and C are endemic.

In 2024, approximately 208,909 migrants arrived to Europe¹, with 68.6% of those arriving by sea or land through Greece, Italy, and Spain⁵. Over 50% of migrants in the EU/EEA originate from HBV-endemic areas and nearly 80% from HCV-endemic countries⁶.

In 2022, an estimated 10.6 million people were living with hepatitis B and 8.6 million with hepatitis C in the WHO European Region³. According to the last European Centre for Disease Control (ECDC) report, migrants represented around 25% of chronic hepatitis B and 14% of chronic hepatitis C cases in the EU/EAA—amounting to roughly 2 million chronic HBV and 900,000 chronic HCV infections⁶. These figures highlight a clear equity gap in prevention, diagnosis, and care.

Migrants, particularly those from countries or regions that are disproportionately affected by viral hepatitis, often arrive without medical and vaccination records⁷ and face cultural and language barriers that make a correct and comprehensive medical assessment more challenging, particularly when intercultural mediators and interpreters may not be readily available, or are non-existent, within healthcare settings⁸. Their health risks are compounded by restrictive healthcare access, cultural and legal barriers, and inadequate system preparedness.

Missed diagnoses and late-stage care result in avoidable morbidity, mortality, and long-term healthcare costs. When, and if, migrants are diagnosed, it may be too late to provide adequate care for these individuals, leading to a high economic burden on the healthcare system. As a priority population, providing migrants with care regardless of their migratory status is crucial for achieving by 2030 the WHO goal of eliminating viral hepatitis as major public health challenge and tackling the Sustainable Development Goal (SDG) 3.3 to end the spread of communicable diseases. Europe's commitment to the Universal Declaration of Human Rights⁹ needs to lead policy into implementation to guarantee the right to health by facilitating the access to healthcare for all individuals within its borders regardless of their migratory status¹⁰. Addressing viral hepatitis in migrant populations is therefore not only a public health priority but also a matter of health equity and social justice.



VH-COMSAVAC: Culturally Tailored Community-based Models of Care

The VH-COMSAVAC project implemented decentralised HBV and HCV testing, HBV vaccination, and linkage-to-care interventions targeting migrants and refugees in Greece, Italy and Spain¹¹. While the models share common principles, each country tailored the model of care to the local migrant population and in accordance with their legal, operational, and health system feasibility.

Screening activities were decentralised and conducted in community spaces, which could include faith-based venues, NGOs, community centres, and prisons¹². Central to the activities, which were community-based in nature, was the use of rapid diagnostic tools to facilitate access to viral hepatitis testing. Educational components were integrated to increase

health literacy regarding viral hepatitis, liver cancer, and its prevention. Communication strategies were tailored to the cultural and linguistic context of the target populations. To ensure timely access to specialist care, expedited referral pathways were established with collaborating tertiary level hospitals, enabling direct linkage to specialist care and reducing potential loss to follow-up.

Outreach efforts were further strengthened through the engagement of community health workers, intercultural mediators, and/or peer navigators who played a key role in supporting engagement across the entire viral hepatitis care cascade for migrant and refugees participating in the project.

1 Universal healthcare makes a difference

VH-COMSAVAC screened 2,043 migrants using rapid diagnostic tests (RDTs) to detect HBV surface antigen (HBsAg+) and HCV antibodies (anti-HCV+). Of the 86 who had an active viral hepatitis infection (70 HBV and 16 HCV), 65.1% were able to be linked to specialist care. 30 (34.9%) were not linked to care, primarily due to a lack of access to the healthcare system (16/30, 53.3%), while others were lost to follow up. **In Catalonia, where there is universal healthcare to those with proof of residency, the linkage to care rate was 84.2%.** Similarly, **in Athens**, migrants were primarily screened in prison settings **where temporary access to care was provided among certain groups, the linkage to care rate was 72.7%.** However, **in Madrid and Milan where the legal barriers were significant, the linkage to care rate was 62.5% and 50.0%, respectively.** These gaps were also observed for HCV-RNA confirmation among those anti-HCV+, where in Catalonia 100% of those needing confirmatory testing (n=4/4) were able to receive it versus only 57.5% (n=27/47) and 22.2% (n=2/9), respectively, having it performed in the Athens and Milan setting.

2 Access to care is necessary but not sufficient

Of the 70 migrants who tested positive for HBV, 77.3% reported not having been tested for HBV before or were unsure; and 46.6% of the 60 HCV antibody positive participants reported not having been tested for HBV before or were unsure of it. In Catalonia, 76.2% of the positive cases had visited their primary care centre in the past year and 47.6% had undergone blood tests, however they had not been diagnosed. Therefore, these **individuals had gone undiagnosed despite being in contact with the health system**, suggesting there are additional needs and challenges the health system must address in order to provide adequate and equitable care to migrants.

3 Missed opportunities for prevention

Of those testing HBV negative, **91.1% reported incomplete or uncertain vaccination status.** Among those undergoing further testing, 78.5% were eligible for HBV vaccination, yet the majority reported not having received the HBV vaccine. In the interventions where **HBV vaccination was offered onsite** (in Catalonia **during some instances**), **89.6% accepted the vaccine**, demonstrating the acceptability of decentralised vaccination models.

4 Legal barriers to access care

In all the intervention settings, **migrants without social security numbers or residency permits faced substantial barriers to access care**. In some settings, efforts were strategically redirected to migrants who had access to care or received temporary access by fulfilling specific criteria, such as being someone who is incarcerated and with a job within the prison, in order to ensure diagnoses went hand in hand with referrals to care. Although **irregular migration status** and legal and administrative proceedings limiting healthcare access **did not hinder who could be screened through VH-COMSAVAC, it did hamper access to vaccination and linkage to care of positive cases**, and therefore some of the most vulnerable, and those who could benefit the most, were excluded from the programme.

5 Language and cultural barriers

Migrant participants originated from **97 countries and reported 103 different mother tongues**. This demonstrates a diversity that is not reflected in the health system. In the **absence of trained intercultural mediators or community health workers (CHWs)**, these barriers **can contribute to misinformation, stigma, and loss to follow up**.

6 High trust and uptake with CHW-led models

Sites using community engagement and CHWs or cultural mediators observed a high level of trust among participants. According to the value-based assessment tool developed to evaluate the VH-COMSAVAC intervention, overall **participants were satisfied with its cultural sensitivity and community health impact, and reported being very satisfied with the provider empathy demonstrated in the programme**.

Actionable Policy Recommendations



Expand HBV vaccination eligibility to adult migrants

Explicitly include HBV vaccine in the public health vaccination programmes for adult migrants from intermediate/high-prevalence countries who lack prior immunity, regardless of age, with financial protection mechanisms.



Train, pay, and integrate CHWs and mediators

Integrate CHWs and mediators into primary, secondary, and tertiary healthcare systems with formal roles, stable funding, and training in health promotion and health system navigation. This will support the delivery of culturally and linguistically appropriate care, improve health equity, and enable health systems to adequately address the needs of diverse populations in a timely manner.



Facilitate the use of simplified diagnostic tools for screening in the community

Deploy rapid diagnostic tests (RDTs) and simplified sample collection methods in community settings to identify HBV/HCV infections earlier and reduce potential loss to follow-up. These tools bring accessible, quick, and confidential testing to settings that adapt to their availability, work schedules, and daily lives, helping to overcome barriers to healthcare and support early diagnosis.



Establish clear referral and care pathways

Migrants have greater difficulty navigating the health system in comparison to their host communities creating inequities in the use of available healthcare services among users. In order to reduce the equity gap and safeguard people are not lost along the care cascade, ensure simplified referral pathways exist to streamline linkage to care.



Enable multidisciplinary collaboration

Establish processes and resources to facilitate collaborations between primary, secondary, tertiary care, and social services, such as housing and immigration services, which address complex health and social issues often faced by migrant communities.



Strengthen migrant-inclusive data systems for monitoring & evaluation

Implement standardised data collection on migrant health indicators, particularly around HBV/HCV testing, vaccination, and care linkage, to track disparities and improve elimination efforts.



Build capacity in primary care for migrant-inclusive hepatitis care

Train primary healthcare providers to understand migration-linked risks, improve targeted screening, and integrate equity into service planning.



Guarantee universal access to viral hepatitis care, regardless of migratory status

Health is a right. Remove all legal barriers for migrants of any migratory status to access viral hepatitis care, including prevention tools like vaccination. Migrants are a priority population for the EU in achieving the SDGs and the WHO goal of eliminating viral hepatitis by 2030.

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