Abstract ID: AS-CISTM17-2021-00013

Making Every Contact Count – Utilising the Travel Consultation to Increase Hepatitis A Vaccine Coverage Amongst the MSM Community

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BACKGROUND

- Recent years have seen hepatitis A outbreaks within the men who have sex with men (MSM) community.[1]
- Both Public Health England (PHE) and the British Association for Sexual Health and HIV (BASHH) identify MSM as an at-risk group and recommend that vaccination for hepatitis A is offered.[2,3]
- Travelling to non-endemic countries was implicated in a recent hepatitis A outbreak in the MSM community.
- Between mid-2016 to early-2018, a hepatitis A outbreak affecting the MSM population was reported in the UK and Europe.[4]
- Whilst hepatitis A infection is not usually life-threatening, hospitalisation and complications can occur.
- Symptoms are generally more common and of greater severity in older people.

OBSERVATION

- In non-endemic countries, the risk of hepatitis A from contaminated food is low.
- However, faecal-oral transmission is still possible and remains a risk, especially in certain cohorts, dependent on behaviours. One at-risk cohort is MSM.
- Three hepatitis A virus genotype IA strains relating to the 2016-2018 outbreak were identified:
  - VRD_521_2016 (first reported in Netherlands, October 2016).
  - RIVM-HAV16-090 (first reported in England, December 2016).
  - V16-25801 (first reported in Germany, January 2017).
- In October 2016, the European Union Early Warning and Response System reported two MSM cases with a specific strain of hepatitis A virus.[5,6]
  - The initial infections were traced back to EuroPride in Amsterdam in July/August 2016.
  - By 26th June 2017, thirteen EU Member States had reported 509 cases with a matching strain and, of the cases with documented information, 80% identified themselves as MSM.
  - This strain, whilst newly seen in Europe, had previously been reported in Asia and linked to an outbreak of hepatitis A in MSM in Taiwan.[7]
  - As of 7th September 2018, a total of 4,475 outbreak-confirmed cases had been reported in 22 EU/EEA countries since 1st June 2016. Of cases where information on gender was available (4,411), the male-to-female (M/F) ratio was 6.8:1.
  - Peak M/F ratio was 11.8:1, observed after May 2017.
  - The most frequently reported strain was VRD_521_2016 followed by RIMV-HAV16-090 and V16-25801.
- Plunkett et al described the outbreak of hepatitis A in England between July 2016 and January 2018 (Table 1).[4]
  - 71% of identified cases were in those identifying as MSM, potentially started with newly infected individuals returning to the UK after travel to European countries.
  - Of the 1243 hepatitis A cases identified during this period, 168 (25%) were Strain 1, 287 (43%) were Strain 2 and 215 (32%) were Strain 3.
  - Outbreak-associated healthcare costs were estimated to be approximately £1,500,000.

Figure 1: Strains identified from the 2016-2018 outbreak

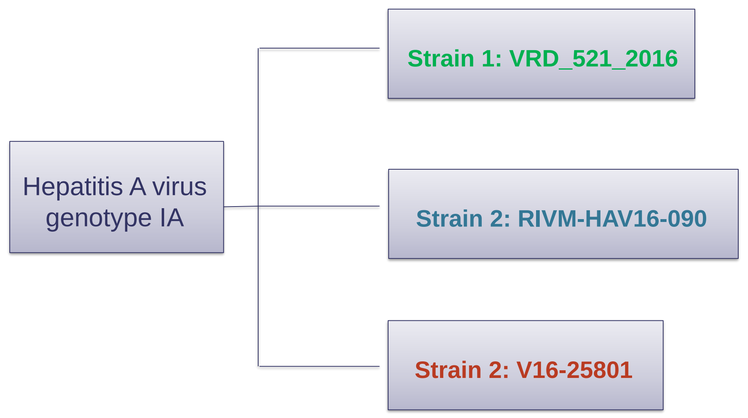

Table 1: Outbreak cases in England July 2016 to January 2018

	Strain 1	Strain 2	Strain 3	Probable	Total
Median age	36	33	38	31	34
Male	144 (88%)	260 (91%)	198 (92%)	93 (100%)	699 (92%)
MSM	100 (68%)	185 (71%)	118 (60%)	93 (100%)	496 (71%)
Travel within 8 weeks of onset of symptoms	83 (49%)	109 (38%)	85 (40%)	59 (63%)	336 (44%)
GP attendance					395 (52%)
Hospital admission					435 (57%)

OBSERVATION

- Sexual activity whilst abroad in the MSM cohort was assessed in a survey by the European Centre for Disease Prevention and Control in 2010:[8]
  - The median proportion of MSM reporting sexual activity whilst abroad in the last 12 months was 26%.
  - The highest reported rates were in the West (Belgium, France, Republic of Ireland, Netherlands, United Kingdom) and North-West (Denmark, Finland, Norway, Sweden) regions.
- Similarly in a study at a genitourinary medicine clinic in the UK, 44% of MSM reported a new sexual partner during their most recent trip abroad.[9]

LIMITATIONS

- Outbreak-confirmed cases may underestimate the actual number due to several reasons:
  - Sequencing information is only available for a proportion of hepatitis A cases.
  - The approach to detection varies between countries and may change depending on the different phases of the outbreak.
  - Asymptomatic cases less likely to present for testing.
- Background hepatitis A immunity is not known.

CONCLUSIONS

- **MSM are already identified as an at-risk group and recommendations in the UK are for MSM to be routinely offered vaccination against hepatitis A.**
- **As well as the prospective destination, travel health consultations routinely contain questions about planned activities and behaviours.**
- **In the context of hepatitis A risk in non-endemic countries, high risk sexual behaviour presents one of the most likely routes of infection.**
- **During an outbreak, there is a risk that the infection spreads from the MSM cohort to the wider population.**
- **A travel health consultation may be a useful point for opportunistic recommendation of hepatitis A vaccination in MSM in the UK, even when travel is to a non-endemic country.**
- **Additionally, the travel health consultation can provide a platform to discuss other preventative measures such as barrier methods during sex, personal hygiene and testing.**
- **Providing travel health practitioners with appropriate training and support may empower them to incorporate sexual health questions into their standard consultation.**

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CONFLICT OF INTEREST

This abstract was conducted and funded by Sanofi Pasteur. All authors are employees of Sanofi Pasteur, UK and may hold shares and/or stock options in the company.

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