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No Elimination Without Trust: Hepatitis B, Stigma and Liver Cancer in Europe

With four years to the WHO elimination goal, is Europe on track?

An ECO Policy Action Report



Acknowledgements

This paper draws on input from experts across Europe and beyond. It was developed through the contributions, evidence and recommendations shared by members of the European Cancer Organisation (ECO) HPV and Hepatitis B Action Network, and through targeted consultation with specialists in viral hepatitis, hepatology, oncology, public health and patient advocacy.

We thank all those who contributed their perspectives and expertise to illuminate the role stigma plays across the hepatitis B care continuum, and to identify the policy responses capable of addressing it. We are grateful in particular to the patient organisations whose members' experience informed this analysis. Finally, we express our gratitude to all those who took the time to review and comment on this report and its recommendations during its wider review, as part of ECO's Policy Approval Pathway process.[a]

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Executive summary

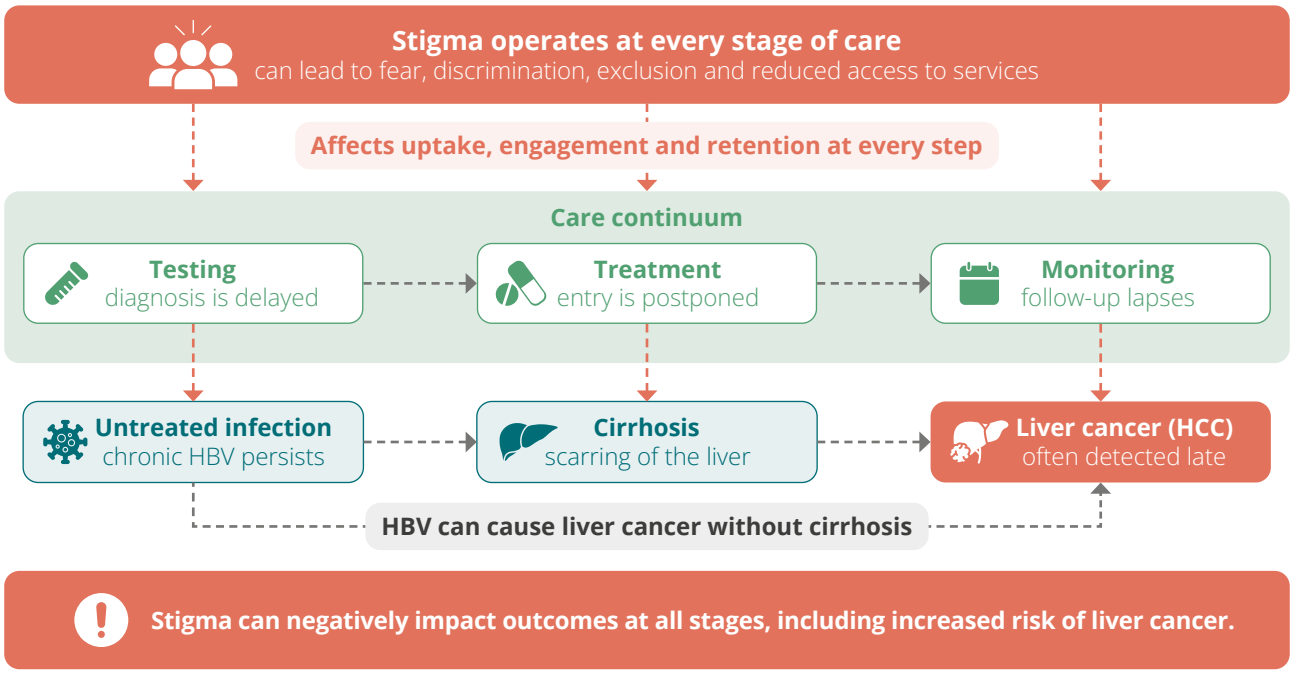
Hepatitis B virus (HBV) remains a leading cause of cirrhosis and hepatocellular carcinoma, the dominant form of primary liver cancer. In the European Union, liver cancer is the sixth leading cause of cancer death.[1] An estimated 3.2 million people live with chronic hepatitis B in the EU and European Economic Area (EEA).[2] In the WHO European Region, according to the Global Hepatitis Report 2026, there are 9.7 million people living with hepatitis B.[3]

Member States of the WHO European Region have committed to the WHO global goal of eliminating viral hepatitis as a public health threat by 2030.[4, 5] Further, Europe's Beating Cancer Plan and the UN Political Declaration on Noncommunicable Diseases (NCDs) set out a framework for cutting liver cancer through that elimination effort. That commitment is now at risk. On World Hepatitis Day, 28 July 2026, the European Centre for Disease Prevention and Control (ECDC) reported that uneven implementation of testing, vaccination, treatment and harm-reduction measures leaves the region set to miss the 2030 target.[6] The WHO Regional Office for Europe reached the same conclusion, noting that the principal remaining obstacle is no longer prevention but finding the people already living with hepatitis B and ensuring they reach care.[7]

Stigma is a significant, and often under-recognised, barrier to reaching and retaining people across the HBV care continuum. It can discourage individuals from seeking testing, delay treatment initiation, and undermine sustained engagement with care, thereby limiting the contribution of HBV prevention and treatment to reducing liver cancer. In a survey conducted by ECDC and the World Hepatitis Alliance across nine European countries, 46% of respondents living with hepatitis B said they found it difficult to tell others about living with hepatitis B, and 15% had avoided healthcare they needed because they expected to be treated differently.[8]

This paper examines how hepatitis B-related stigma manifests across Europe and what it costs for liver cancer prevention, and sets out policy recommendations for European and national decision-makers. Ending HBV-related stigma must therefore be part of ending HBV. Elimination will not be achieved, nor will its liver cancer prevention benefits be fully realised, unless stigma is addressed directly.

Figure 1. Stigma across the HBV care continuum: From delayed testing to late-detected liver cancer



Recommendations

Please note that the full set of recommendations and their rationale can be found at the end of the report.

To Members of the European Parliament

- Press for full implementation of Europe's Beating Cancer Plan, the 2025 UN Political Declaration on NCDs and the WHO Regional action plans for ending AIDS and the epidemics of viral hepatitis and sexually transmitted infections 2022–2030, with stigma recognised as an implementation barrier.
- Ensure national public health agencies report timely and comprehensive hepatitis and liver cancer data to the European Centre for Disease Prevention and Control (ECDC), the European Cancer Information System (ECIS) and WHO Europe.
- Use written questions, hearings and national debates to keep stigma on the political agenda.
- Secure health funding in the 2028–2034 Multiannual Financial Framework that reaches and strengthens community-based services.

To the European Union and European Centre for Disease Prevention and Control (ECDC)

- Measure stigma through monitoring systems that already exist, by extending the ECDC and World Hepatitis Alliance's pilot stigma survey to all Member States on a fixed cycle.
- Report stigma-related barriers and care avoidance alongside liver cancer inequities in the European Cancer Inequalities Registry.
- Ensure that European health funding supports community organisations and peer workers in implementing anti-stigma interventions.

To Member States

- Embed viral hepatitis in national cancer control plans, aligned with Europe's Beating Cancer Plan, and name stigma among the barriers to be addressed.
- Strengthen national reporting to ECDC, ECIS and WHO Europe, and adopt a funded national hepatitis plan where none exists.
- Review national policies for provisions that exclude or deter, including treatment restrictions based on documentation status.
- Strengthen hepatitis B testing in routine settings such as primary care, offering it as a normal part of care rather than only to key populations, with clear, non-stigmatising information on why the test is being offered.
- Enable hepatitis B testing in community-based settings and through community-based organisations, to reach people who are less well served by routine services.
- Make non-discrimination and communication training standard for healthcare professionals, developed in partnership with people with lived experience.









Foreword

I write this as Co-Chair of a Network that brings together two vaccine-preventable, cancer-causing infections shaped by a common obstacle: stigma rooted in misconceptions about transmission and in the association of both viruses with specific populations. In both cases, that stigma discourages engagement at every stage, from vaccination and screening to testing and treatment, undermining the cancer prevention gains that elimination would deliver.

On 28 July 2026, World Hepatitis Day, the European Centre for Disease Prevention and Control confirmed what many of us working in this field had come to expect. Despite genuine progress, Europe is set to miss the 2030 target of eliminating viral hepatitis as a public health threat.

The progress is real and should not be understated. The prevalence of hepatitis B among children under five is now close to zero across the EU and EEA, antenatal screening is established in all thirty EU and EEA countries, vertical transmission has fallen below 2%, and acute cases have declined steadily for two decades. The prevention tools work. They are simply not reaching everyone who needs them.

That is the question the European elimination debate has been slow to confront. If we know how to vaccinate, test and treat, and what remains is a problem of reach, then what is it that keeps people from coming forward?

Part of the answer is structural: services that are not funded, not accessible, or not offered. Another part, I would argue, is that a hepatitis B diagnosis still carries a social cost. It can invite assumptions about how the infection was acquired, and about the person who acquired it. In a pilot survey conducted by the World Hepatitis Alliance with ECDC across nine European countries, nearly half of respondents living with hepatitis B reported finding it difficult to tell others about hepatitis B, and around one in seven had avoided healthcare they needed because they expected to be treated differently. The survey was a pilot, and its sample cannot tell us the full scale of the problem. What it does establish is that the problem is real and that it can be measured.

Stigma is part of the HBV epidemic. It appears in elimination strategies as a barrier to be acknowledged, and rarely as something to be measured. It has no place in routine European surveillance, cascade analysis, or, so far, in cancer inequalities monitoring. We have built an evidence architecture that can tell us with some precision where people are lost along the care continuum, but much less about why.

This paper is an attempt to close part of that gap. It sets out what is currently known about hepatitis B-related stigma in Europe, where the evidence remains thin, and what could realistically be done at national and European level. The recommendations that follow are deliberately modest in ambition and concrete in form: most ask for stigma to be added to instruments, plans and funding streams that already exist, rather than for new machinery to be built. With four years remaining until the 2030 deadline, that is the kind of action still available to us.

Patrizia Carrieri,
Co-Chair, ECO HPV and Hepatitis B Action Network



Hepatitis B and liver cancer: A preventable cause of cancer

Chronic HBV is a leading cause of cirrhosis and hepatocellular carcinoma (HCC), the dominant form of primary liver cancer.[9, 10] An estimated 9.7 million people live with chronic HBV in the WHO European Region, where it causes some 39,000 deaths each year.[3, 11]

The proportion of hepatitis B cases that go undiagnosed varies dramatically across the EU, from close to zero in Denmark to an estimated 95% in Hungary, with the highest-burden countries generally reporting the highest undiagnosed proportions.[2] Only around 27% of people living with chronic HBV are aware of their status, and 4.3% receive treatment[3] coverage in the European Region, while higher, remains far short of what elimination requires.

Prevention measures, such as hepatitis B virus (HBV) vaccination at birth, are implemented across most EU countries. However, for people already living with HBV, gaps remain along the continuum of care, from screening and diagnosis to treatment initiation. Stigma negatively affects this continuum: it can discourage testing, delay people from seeking care, and erode retention in long-term care.[11–13]

The consequences of late diagnosis are measurable. Among the five EU/EEA countries able to report on disease stage at the point of diagnosis, between 1.6% and 17% of people newly diagnosed with chronic hepatitis B already had decompensated cirrhosis or hepatocellular carcinoma.[14] Every one of those diagnoses represents a person the system had opportunities to reach earlier and did not.

Hepatitis B and liver cancer: the burden

- 9.7 million people live with chronic hepatitis B in the WHO European Region, where it causes around 39,000 deaths each year.[3]
- Only around 27% of people living with chronic HBV worldwide are aware of their status, and 4.3% receive treatment.[3]
- Liver cancer is the sixth leading cause of cancer death in the European Union.

The mandate for action

Global: In 2016, the World Health Assembly committed all Member States to eliminating viral hepatitis as a public health threat by 2030. The commitment was reaffirmed in the Global Health Sector Strategies 2022–2030 and is anchored in SDG target 3.3. The UN Political Declaration on NCDs (2025) went further, committing governments to prevent liver cancer by scaling up hepatitis B and C prevention, diagnosis, treatment and vaccination.

Regional: The WHO Regional Action Plans 2022–2030 apply the global strategy across the 53 countries of the WHO European Region.

European Union: Europe's Beating Cancer Plan (2021) commits to improving access to hepatitis B vaccination as liver cancer prevention. The Council Recommendation on vaccine-preventable cancers (2024) adds measures on vaccination coverage, antenatal screening, and integrating immunisation into national cancer plans. The European Code Against Cancer, 5th edition (2025), extends this to hepatitis B and C testing and treatment.

What stigma is, and where it acts

What is stigma and what are the types of stigma?

Stigma arises when labelling, stereotyping, separation, status loss and discrimination occur together, and it is enacted against people, anticipated by them, and internalised as shame.[11, 15] People living with hepatitis B often experience stigma due to misunderstandings about how it is transmitted. Stereotypes also shape who is thought to be at risk. Where the real risk factors are poorly understood, people who do not fit the stereotype may assume the virus is not relevant to them, and health professionals may not think to offer them a test. Those who do recognise their risk may avoid testing, conceal a diagnosis, and disengage from the care that would prevent liver cancer, even where health systems do not discriminate.

- Enacted stigma: actual experiences of prejudice, stereotyping or discrimination because of one's hepatitis B status.
- Anticipated stigma: the expectation of prejudice, stereotyping or discrimination from others, for example if a diagnosis were disclosed.
- Internalised stigma: accepting the negative views of hepatitis B held in society and turning them against oneself, often as shame or self-blame.

Hepatitis B-related stigma is not confined to a single point in time or a specific stage of care. Rather, it operates dynamically across the entire care continuum, shaping behaviours, decisions, and interactions from initial testing through to long-term monitoring for liver disease and hepatocellular carcinoma prevention.[12, 13]



How does stigma manifest in Europe?

Until recently, evidence on hepatitis B stigma in Europe was largely qualitative and confined to individual countries. In 2024, ECDC and the World Hepatitis Alliance conducted a pilot survey of stigma experienced by people living with hepatitis B and C across nine European countries, providing the first comparable European measurements.[8]

Among respondents living with hepatitis B, 46% reported finding it difficult to tell others that they were living with hepatitis B, and 18% reported low self-esteem as a result of their status. Fifteen per cent had avoided going to healthcare services when they needed them because they expected to be treated differently, and a further 15% had experienced a delay in treatment or a medical procedure because of stigma encountered in healthcare settings.[8]

One feature of these findings deserves emphasis. The healthcare figures capture both anticipated and enacted stigma: people stayed away from services because of what they expected would happen, not only because of previous experiences of discriminatory treatment. This means that addressing discrimination after it occurs is not enough: building trust, and ensuring that services are visibly non-stigmatising, are part of the response. The survey was a pilot, covering nine countries and a self-selected sample recruited largely online over a short fieldwork period; it establishes that the problem is measurable in Europe, not the full scale of it.

The effects of stigma (From ECDC and World Hepatitis Alliance pilot survey)

- 46% of European respondents living with hepatitis B find it difficult to tell others about their diagnosis.
- 15% have avoided healthcare they needed because they expected to be treated differently.
- 15% have experienced a delay in treatment or a procedure because of stigma in healthcare settings.

Table 1. Stigma across the Hepatitis B care cascade

Stage	How stigma operates	Consequences for liver cancer prevention
Testing	Concerns about discrimination in healthcare or social settings; confidentiality concerns; people who may be at risk are not offered or able to access testing.	Reduced uptake of HBV testing and delayed or missed diagnosis, increasing their risk of developing liver cancer.
Diagnosis	Fear of disclosure to family, employers, or insurers; internalised stigma and identity-related concerns following a positive result; fear of being 'labelled'.	Non-disclosure of status, psychological distress, and delayed or no engagement with care.
Linkage to care	Anticipated stigma within healthcare settings, including fear of judgement or poor treatment by providers.	Delayed or incomplete linkage to specialist care; early drop-out from the care pathway, increasing liver cancer risk.
Treatment initiation	Moral judgement attached to hepatitis B; anticipated blame and self-blame; stigma at linkage to care.	Delay or refusal of antiviral treatment despite clinical eligibility, increasing risk of advanced liver disease and liver cancer.
Long-term monitoring	Persistent stigma combined with care fatigue and normalisation of symptoms; fear of repeated exposure to healthcare settings; negative previous healthcare experiences.	Reduced adherence to follow-up and loss to long-term monitoring programmes; missed or irregular HCC surveillance, leading to diagnosis at more advanced stages.
Prevention of vertical transmission	Non-disclosure of hepatitis B status during pregnancy due to fear of discrimination. As antenatal HBsAg screening is universal across the EU/EEA, stigma surrounding testing and a positive result can also affect engagement with follow-up care.	Vertical transmission is not prevented, increasing infants' risk for developing liver cancer later in life. Missed opportunities to offer treatment to mothers living with hepatitis B and family testing, reducing their risk of developing liver cancer.

Across the cascade, stigma does not act alone. It compounds structural and health system barriers, widening inequalities in access and outcomes. Its cumulative effect is a progressive disengagement from care, often occurring silently and outside formal health system indicators.

Stigma is not a secondary concern but a social and structural barrier to early detection and timely intervention on which hepatocellular carcinoma (HCC) prevention depends.[13, 16] The consequences are avoidable: HBV-related liver cancer is largely preventable through vaccination, early diagnosis, antiviral treatment, and regular surveillance.

Why may people living with hepatitis B experience stigma?

Stigma related to hepatitis B is multifaceted and operates at multiple levels: individual, interpersonal, institutional, and structural.[13] It is shaped by social norms, health system practices, and broader political and economic contexts. Hepatitis B-related stigma is not produced by a single source but emerges from a combination of misconceptions, moral judgements, and systemic factors that interact and reinforce one another.

Misunderstandings regarding hepatitis B transmission

A distinct dimension of HBV stigma arises from the fact that communicable disease transmission itself often becomes morally coded. Across societies, perceived transmission routes are associated with different moral judgements:[13] with sexually transmitted and drug use-related acquisition attracting more blame, and therefore more stigma, than perinatal or transfusion-related acquisition. While most global HBV cases occur through vertical transmission (mother-to-child) or early childhood exposure, persisting misconceptions link HBV with behaviours framed as morally culpable. This process transforms a biological event (viral transmission) into a social and moral statement about the individual living with hepatitis B and reinforces stigma. Understanding this mechanism is essential: campaigns that only explain transmission routes may fail to reduce stigma, and can reinforce it if their language or imagery implies that some routes are more 'acceptable' than others. The route of transmission should never determine how a person is perceived, treated or supported.



Key drivers of HBV-related stigma

HBV-related stigma is sustained by interconnected drivers at individual, social, structural, and institutional levels. Misconceptions about transmission, such as through casual contact, shared meals, or social interaction, persist among both the public and healthcare workers despite decades of awareness raising, and poor knowledge of prevention, treatment and prognosis leaves room for stigmatising narratives to spread.[17] Hepatitis B has also become socially associated with migrants and ethnic minorities from high-prevalence regions, reinforcing stereotyping and '**othering**' in which people living with hepatitis B are viewed as a risk to others instead of as people with a treatable condition. This is exacerbated where migration is politically sensitive. The drivers of stigma intersect and reinforce one another, compounding barriers across the cascade of care.[13]

What is 'othering'?

Othering refers to the social process through which individuals or groups are constructed as fundamentally different from, and separate from, a perceived social norm, often reinforcing stigma, stereotyping, and exclusion.[18]

How have these drivers become entrenched?

Structural stigma

Structural stigma refers to the ways in which laws, policies, and institutional practices systematically disadvantage people living with hepatitis B.[13] In some settings, individuals with HBV may face restrictions in employment, education, or migration, either through explicit policies or through informal practices. Financial and organisational barriers within health systems may also contribute to structural stigma. Limited insurance coverage, out-of-pocket costs for diagnostic tests or treatment, and fragmented care pathways can disproportionately affect already vulnerable populations. While these barriers are not always explicitly discriminatory, they can interact with stigma to create cumulative disadvantages.

European monitoring data show how these barriers operate in practice. In 2023,[11] EU/EEA countries reported restrictions on access to hepatitis treatment, mostly affecting undocumented migrants, and 80% of countries required that hepatitis testing be performed by healthcare workers, with only a third reporting that testing was available from peer testers in community and harm-reduction settings.[14]

Healthcare-related stigma

Healthcare settings, which should provide safe and supportive environments, can sometimes reproduce or amplify stigma.[1] Negative attitudes among healthcare providers, including fear of transmission, moral judgement, or inadequate knowledge of HBV transmission, may result in discriminatory behaviours or suboptimal care. Examples include breaches of confidentiality, reluctance to provide care, or differential treatment of patients perceived to be at risk. These experiences can erode trust in health systems and discourage individuals from seeking or continuing care. Given the importance of healthcare providers in hepatitis B care, addressing stigma within clinical settings is a critical priority.

Intersectional stigma

Hepatitis B-related stigma often intersects with other types of discrimination, leading to compounded effects for some populations. Factors such as migration status, socioeconomic position, gender, sexual orientation, and ethnicity can shape both exposure to stigma and its consequences. This is particularly relevant for migrants, people who inject drugs, men who have sex with men, and people in prisons and other closed settings, who may already face stigma unrelated to hepatitis B. These forms of stigma reinforce one another, creating context-specific barriers to care. Policies and interventions therefore need to address them together.



The blind spot: What we cannot currently see

Effective responses to HBV-related stigma and its consequences for liver cancer prevention require robust health system data. However, stigma and its relationship with care avoidance remain insufficiently measured and rarely integrated into routine surveillance systems. **This lack of visibility limits the ability of policymakers and health systems to identify inequities, monitor progress, and evaluate interventions.**

What Europe currently measures

Stigma is also absent from the systems used to monitor progress on hepatitis. At global level, WHO collects data from all regions on implementation of the global health sector strategies. In Europe, ECDC operates a system for tracking progress towards the WHO European Region 2025 interim targets, collecting data on testing policies, diagnosis, linkage to care, treatment and viral suppression.

In 2023, all 30 EU/EEA countries responded to the monitoring questionnaire, yet only 25 could provide national data for even one stage of the hepatitis B continuum of care, and no country could provide data across all stages.[14]

The structural picture is comparable. Eight of the 30 countries reported no national action plan or strategy for viral hepatitis at all, and only two-thirds of those with a plan reported national funding for its implementation.[14] Where data do exist, they point towards the populations most exposed to stigma without measuring it: gaps were reported in testing policies for migrant populations, men who have sex with men, healthcare workers and people in prison.[14]

None of the four countries with sufficient data are meeting the 2025 interim target of 60% of people with chronic hepatitis B diagnosed.[14] Even limited monitoring shows that people are being lost along the care continuum, with these gaps in follow-up contributing to missed opportunities to prevent liver cancer.

Stigma is absent from routine surveillance

Stigma-related indicators should be built into existing surveillance platforms for HBV and liver disease. People living with hepatitis B and patient organisations should be involved in the development and validation of stigma indicators, not only as respondents. Patient involvement is important to ensure that the indicators capture experiences that are meaningful in real life, including anticipated stigma, discrimination, avoidance of care and loss of trust in healthcare services.

This could take the form of periodic population-based surveys, or integration of stigma modules into communicable disease monitoring systems. Standardisation across countries would further enable benchmarking and reveal structural inequalities at the European level.

Cascade analysis shows where people are lost, not why

Stigma is a significant but under-measured driver of attrition along this cascade. Integrating stigma metrics into cascade monitoring would allow a more explanatory model of care gaps. Combining clinical indicators with patient-reported stigma measures could help distinguish between structural access barriers and psychosocial barriers to care engagement.

The research base is thin, and thinner still in cancer

While stigma associated with other communicable diseases, particularly HIV and tuberculosis, has been extensively documented and measured, HBV stigma remains markedly under-researched.[12] Most existing research relies on cross-sectional designs, capturing stigma at a single point in time; very few studies prospectively examine how stigma at diagnosis affects subsequent treatment initiation or surveillance adherence, and fewer still evaluate stigma reduction interventions in HBV contexts. Stigma is also notably absent from liver cancer prevention research. Cancer registries and HCC surveillance systems do not routinely collect data on stigma-related barriers, making it difficult to distinguish access-related from stigma-related reasons for gaps in the prevention cascade.[17] Interventions promoting screening or treatment uptake may therefore fail without accounting for stigma as an underlying determinant.



What works: Frameworks and evidence

Reducing hepatitis B virus (HBV)-related stigma requires action at several levels at once: social norms, clinical practice, and the structural environment. Evidence from communicable disease and chronic disease fields shows that information alone does not reduce stigma. What works is sustained, system-wide effort combining community engagement, changes to how services are delivered, and supportive legal frameworks.

Community-level and community-led interventions

At community level, stigma reduction is most effective when interventions are participatory, sustained, and delivered by trusted actors.

The available evidence demonstrates that successful HBV campaigns address misconceptions and target specific populations, though direct evidence specifically addressing 'immoral behaviour' misconceptions is limited.[19]

Peer-led and community-based models have proven to be particularly effective. Social contact interventions, which facilitate meaningful interaction between people living with HBV and members of the wider community, including healthcare professionals, can help challenge stereotypes, correct misconceptions, and reduce stigmatising attitudes.[20] Ensuring that people living with hepatitis B and their communities are meaningfully involved in the design and delivery of interventions reframes narratives around lived experience, resilience and treatment success.[21, 22] Peer educators can act as trusted intermediaries, make health systems more accessible and address language barriers.

Health system interventions

Healthcare settings are critical for both stigma production and stigma reduction.

Specific training interventions named 'social contact interventions' have been shown to be effective in reducing stigma in healthcare settings.[21, 22] Studies across communicable diseases consistently show that stigma in HBV care is often driven by inadequate knowledge, outdated beliefs about how HBV is transmitted, and implicit moral judgements. Training should therefore combine clinical updates with reflective components addressing attitudes, communication practices, and unconscious bias.

Integration of HBV services into primary care is another key lever for stigma reduction. Embedding HBV screening, vaccination, and long-term management into routine primary care normalises HBV prevention and care and helps position HBV alongside other chronic conditions. This normalisation can significantly reduce experiences of 'othering' and improve continuity of care.

A 'liver health' framing offers an additional strategic shift. Moving from disease-specific silos towards an integrated 'liver health' approach[23] can reduce stigma by decoupling HBV from identity-based or behavioural labels. This framing supports a more inclusive model of care that emphasises shared risk factors, prevention, and overall liver health across populations.

Policy and legal frameworks

Structural stigma requires structural responses. Legal and policy frameworks play a central role in ensuring protection from discrimination and safeguarding patient rights.[24]

Anti-discrimination policies should explicitly include chronic communicable diseases such as HBV in employment, insurance, education, and migration-related contexts. Enforcement mechanisms are crucial; legal protections alone are insufficient if individuals are unaware of their rights or if reporting mechanisms are weak.

Data protection and confidentiality are also central to stigma reduction. Fear of disclosure remains a major barrier to testing and engagement in care. Strengthening confidentiality safeguards in healthcare, occupational health, and insurance systems can reduce perceived risks associated with diagnosis.

Addressing HBV-related stigma and its consequences for liver cancer prevention requires systematic integration into existing frameworks rather than the creation of parallel structures, recognising patient and community organisations as implementation partners within these existing frameworks, particularly in the design, delivery and evaluation of stigma-reduction measures. National hepatitis strategies, cancer control plans, and universal health coverage (UHC) frameworks already provide strong entry points for action.[23]

What the EU has already agreed: the Council Recommendation on vaccine-preventable cancers

Adopted on 21 June 2024, the Council Recommendation sets out 19 measures for Member States on HPV and hepatitis B vaccination as cancer prevention. On hepatitis B, it calls on Member States to:

- Remove structural barriers to vaccination for disadvantaged and high-risk groups, and adapt hepatitis B vaccination services to different target groups, recognising how disadvantages intersect.
- Strengthen efforts towards the WHO 2030 targets of 95% third-dose childhood vaccination coverage, 95% of pregnant women screened for HBsAg, and 95% of newborns receiving a timely birth dose within 24 hours, and to reinforce monitoring of progress towards them.
- Make vaccination free of charge or fully reimbursable.
- Integrate immunisation against vaccine-preventable cancers into national cancer plans.
- Improve communication and counter mis- and disinformation, including on social media and digital platforms.
- Improve monitoring of coverage rates, with ECDC support.



Table 2. Entry points for stigma reduction in existing frameworks

Framework	What to include	Expected impact
National hepatitis elimination plans	Stigma indicators and monitoring frameworks within national HBV strategies.	Improved visibility of stigma, enabling systematic monitoring and accountability.
National cancer control plans	HBV screening, linkage to care, and surveillance into liver cancer prevention pathways, with stigma named as a barrier to be addressed.	Earlier diagnosis of chronic HBV and improved hepatocellular carcinoma prevention.
Health workforce policies	Training modules on HBV, stigma, and communication for healthcare providers.	Reduced discrimination and improved quality of interactions within healthcare settings.
Community funding mechanisms	Peer-led and community-based programmes targeting key populations.	Increased trust in health systems, improved testing uptake, and stronger linkage to care.
Anti-discrimination law and data protection	Explicit coverage of chronic communicable diseases such as HBV in employment, insurance, education and migration contexts; strengthened confidentiality safeguards.	Reduced fear of disclosure and improved uptake of testing and long-term care.
EU surveillance instruments	A standardised stigma module within ECDC's annual hepatitis monitoring questionnaire; stigma-related access barriers within European Cancer Inequalities Registry reporting.	Comparable European data on hepatitis B-related stigma, allowing levels to be compared across Member States and progress to be tracked over time.

Conclusions and recommendations

HBV-related stigma is not a peripheral social issue but a determinant of inequity in liver cancer prevention across Europe. It operates at every step of the care continuum, from prevention and screening to long-term monitoring and cancer surveillance, ultimately contributing to avoidable morbidity and mortality.

Addressing stigma is therefore a condition for meeting both hepatitis elimination and liver cancer prevention targets. To translate evidence into action, European cancer policy needs to move from acknowledging stigma to measuring, monitoring and reducing it across health systems.

The recommendations below are deliberately concrete. With four years remaining before the 2030 deadline, the realistic route to action is to add stigma to instruments, plans and funding mechanisms that already exist and already function, rather than creating parallel systems. Each recommendation therefore names the vehicle, not only the objective.

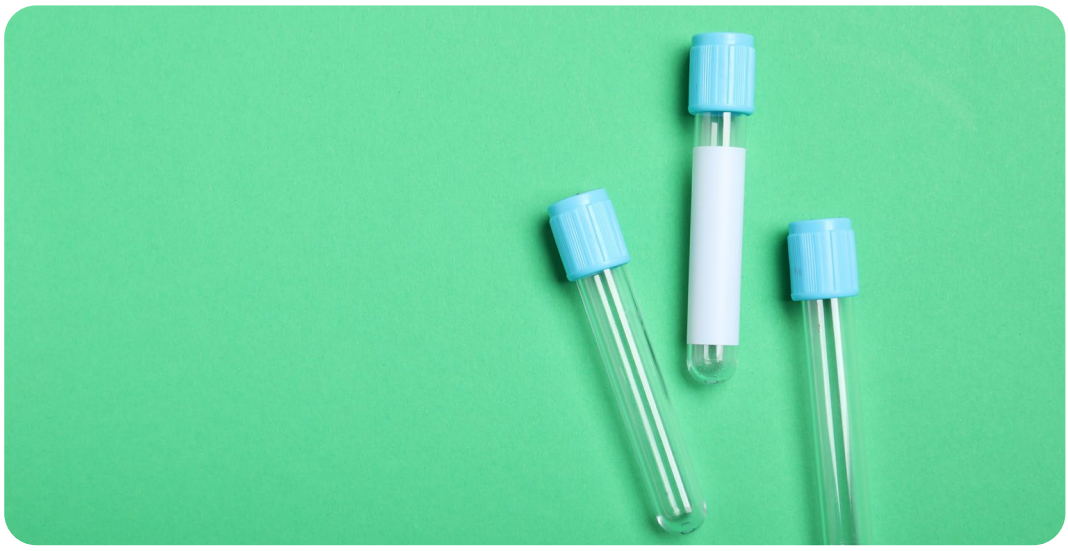
Recommendations to Members of the European Parliament

1. Press for full implementation of Europe's Beating Cancer Plan, the 2025 UN Political Declaration on NCDs and the WHO Regional Action Plans to End AIDS and Elimination of Viral Hepatitis and STIs 2022–2030, with stigma recognised as an implementation barrier

These commitments already exist and already cover hepatitis B vaccination, testing and treatment. Parliamentary advocacy should press for stigma to be treated as an implementation barrier in its own right, rather than as a communications afterthought.

2. Ensure national public health agencies report timely and comprehensive hepatitis and liver cancer data to ECDC, European Cancer Information System (ECIS) and WHO Europe

In 2023, no EU/EEA country was able to report across all stages of the hepatitis B continuum of care.[14] Without complete national reporting, Europe cannot identify where people are lost to care, still less why. MEPs are well placed to raise this with their own governments and health agencies.



3. Use written questions, hearings and national debates to keep stigma on the political agenda

Written questions, committee hearings and national parliamentary debates are the tools available to parliamentarians between legislative cycles, and they cost nothing. Stigma has never been the subject of sustained parliamentary attention at European level despite appearing in almost every elimination strategy.

4. Secure health funding in the 2028–2034 Multiannual Financial Framework that reaches and strengthens community-based services

Peer and community delivery is the approach with the clearest evidence of reaching people who avoid clinical settings, and the least reliable funding. The MFF negotiation is a defined window in which to secure it.

Recommendations to European Union and European Centre for Disease Prevention and Control (ECDC)

5. Measure stigma through monitoring systems that already exist, by extending ECDC's and World Hepatitis Alliance's pilot stigma survey to all Member States on a fixed cycle

ECDC operates an annual hepatitis monitoring questionnaire to which all 30 EU/EEA countries respond,[14] and has already piloted stigma measurement with the World Hepatitis Alliance across nine countries.[8] Extending that pilot to all Member States and repeating it on a fixed cycle would produce comparable European data without building new machinery.

6. Report stigma-related barriers and care avoidance alongside liver cancer inequities in the European Cancer Inequalities Registry

The European Cancer Inequalities Registry already shows that the countries with the highest hepatitis burden generally have the highest proportions of undiagnosed cases.[2] The Commission should extend this monitoring to include stigma-related barriers to testing and care, including care avoidance, alongside existing indicators. Measuring these barriers would help explain inequalities in prevention and diagnosis and provide policymakers with actionable information to improve access to care.

7. Ensure that European health funding supports community organisations and peer workers in implementing anti-stigma interventions

The Commission and co-legislators should ensure EU funding instruments explicitly name patient and community organisations, and the peer workers they support, as eligible recipients and delivery partners in hepatitis and liver cancer prevention, not only as consultees.

Recommendations to Member States

8. Embed viral hepatitis in national cancer control plans, aligned with Europe's Beating Cancer Plan, and name stigma among the barriers to be addressed

Hepatitis is frequently absent from national cancer plans altogether, despite being a leading preventable cause of liver cancer. Where plans are revised, hepatitis should be embedded as a cancer prevention priority, with stigma named among the barriers to be addressed and an accountable owner attached.

9. Strengthen national reporting to ECDC, ECIS and WHO Europe, and adopt a funded national hepatitis plan where none exists

Eight EU/EEA countries have no national hepatitis plan at all, and only two-thirds of those with a plan report funding for its implementation.[14]

10. Review national policies for provisions that exclude or deter, including treatment restrictions based on documentation status

Eleven countries reported restrictions on access to hepatitis treatment in 2023, mostly affecting undocumented migrants, and most require that testing be delivered by healthcare workers rather than trained peers.[14] Legal restrictions of this kind prevent key populations from accessing hepatitis services and their deterrent effect extends well beyond those formally excluded.

11. Strengthen hepatitis B testing in routine settings such as primary care, offering it as a normal part of care rather than only to key populations, with clear, non-stigmatising information on why the test is being offered

A test offered to everyone carries no information about the person who accepts it. A test offered only to those identified as at risk requires accepting a risk label in order to accept the test. Routine offers in primary care and other everyday settings remove that signal.

12. Enable hepatitis B testing in community-based settings and through community-based organisations, to reach people who are less well served by routine services

People who avoid clinical settings, or feel unsafe in them, are more easily reached by organisations and peers they already trust. Enabling trained peers and community organisations to offer testing, with clear pathways into care, extends reach without building new services.

13. Make non-discrimination and communication training standard for healthcare professionals, that is developed in partnership with people with lived experience

Fifteen per cent of European respondents living with hepatitis B reported a delay in treatment or a procedure because of stigma encountered in healthcare settings.[8] Such training should involve people with lived experience, not only as participants, but also in the development and delivery of this training. This would help ensure that training reflects real experiences of stigma and discrimination within healthcare settings.[16, 17]



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