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POLICY STATEMENT

Ending stigma and discrimination - everyone deserves dignity and care for liver health

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A CALL TO ACTION

Stigma and discrimination fuel health disparities and worsen outcomes for individuals with liver disease. To address these challenges, we must shift the focus from individual blame to the broader social determinants of health. Learning from successful approaches in HIV, mental health, diabetes, and cancer, we must implement targeted interventions that reduce stigma, expand healthcare access, and promote equity.

Collaboration is key. Healthcare providers, policymakers, community organisations, and individuals with lived experience must work together to foster awareness, use respectful language, and advocate for equitable policies. By uniting efforts, we can break stigma and improve European liver health outcomes.

INTRODUCTION

Stigma and discrimination severely affect individuals with liver disease, particularly those with viral hepatitis, alcohol-related liver disease (ArLD), metabolic dysfunction-associated steatotic liver disease (MASLD), and those having MASLD and simultaneous moderate alcohol consumption (MetALD). Misconceptions linking liver disease to personal choices reinforce stereotypes and moral blame, leading to emotional distress, social exclusion, and workplace discrimination. These factors discourage healthcare-seeking, delay diagnoses, and worsen health outcomes.[1–4].

CORE OBJECTIVE: ADDRESSING STIGMA AND DISCRIMINATION IN LIVER DISEASE

This policy statement reflects EASL's commitment to dignity, respect, and comprehensive care for individuals with liver disease. It presents key strategies to combat stigma, promote equitable healthcare access, and enhance patient outcomes across European healthcare systems.

KEY POLICY PRINCIPLES

1.Recognising Stigma's Multifaceted Nature and Discrimination in Liver Disease

Self-stigma is common among individuals with viral hepatitis, ArLD, and MASLD. It often stems from experiences of stigma and discrimination, and significantly contributes to care avoidance, engagement in riskier behaviours, progression of liver disease, and reduced employment opportunities.

Public and moral stigma surrounding liver disease often stems from the misconception that it results solely from personal lifestyle choices. This stigma is compounded by the fact that people living with liver disease frequently belong to already marginalised groups, such as migrants, people who use drugs, individuals with obesity, and those with unhealthy alcohol use. Chronic viral hepatitis, for instance, is frequently associated with injecting drug use and perceived sexual promiscuity, while ArLD is heavily stigmatised as self-inflicted [5,6]. MASLD is commonly linked to obesity, poor diet, and physical inactivity, which leads to damaging stereotypes of affected individuals as "lazy" or "non-compliant." These perceptions diminish quality of life and reinforce moral blame [7–10]. Overt stigma in social media discussions around MASLD is less frequent; however, negative attitudes toward obesity remain widespread [11]. Poor liver health literacy further exacerbates these issues, as liver cirrhosis continues to carry significant social judgment and misunderstanding [12].

Viral hepatitis remains a major global health concern, with millions of people unknowingly living with chronic hepatitis B and C. Early detection through screening is vital to reduce morbidity and mortality, prevent transmission, and meet the World Health Organisation's (WHO) targets for hepatitis elimination by 2030. Screening facilitates timely access to effective treatment, improves individual health outcomes, and helps curb the spread of infection within communities. However, fear of public and moral stigma continues to pose substantial barriers to screening and care, driven in large part by persistent misconceptions linking liver disease solely to poor lifestyle choices[13–16].

Structural stigma, driven by inequitable healthcare policies, legal frameworks, and social norms, disproportionately affects marginalised populations, exacerbating health disparities and restricting access to care [3]. Food insecurity, a key social determinant of health, further amplifies moral stigma by limiting access to nutritious food, particularly in underserved communities and among individuals with ArLD, MASLD, or MetALD [17].

Discrimination reinforces stigma, further isolating individuals, delaying care, restricting job opportunities, and worsening quality of life while creating barriers to diagnosis and treatment[1,4].

2. Understanding the Impact of Stigma in Liver Disease

Stigma profoundly affects individuals with liver disease, leading to worse health outcomes. Key consequences include:

Increased Psychological Distress, Self-Stigma, and Risk Behaviours

Internalised stigma in liver disease heightens emotional and psychosocial risks, contributing to depression, anxiety, social isolation, increased risk behaviours, and marginalisation, care avoidance driven by fear of judgment and discrimination. At the public health level, this results in an increased number of people with severe liver disease, and consequently, a higher liver-related burden[1,7,18–22] .

Delayed Healthcare Seeking and Poor Treatment Adherence

Stigma surrounding viral hepatitis, ArLD, and obesity (the main cause of MASLD) discourages individuals from seeking timely care due to fears of being deemed "undeserving" [5,23–28].

[1] A migrant term is used for displaced populations, asylum seekers, refugees, migrants in irregular situations and undocumented migrants, as well as migrants, who at their destination, are marginalized and facing vulnerabilities, such as language barriers, difficulties integrating and xenophobia (4,5).

- People with viral hepatitis – in particular, migrant people (documented and especially undocumented) or people who use drugs - may avoid medical care due to fear of legal consequences, including arrest or imprisonment under criminalisation laws [24] .
- Weight-related stigma increases stress and calorie intake, raising the risk of transitioning from overweight to obesity in both children and adults [9,22,29].
- Bias in healthcare settings, particularly regarding obesity and lifestyle choices, leads to underdiagnosis and undertreatment of obesity-related liver disease [30,31] .
- Perceived moral blame contributes to late-stage liver disease diagnoses, delaying treatment and worsening health outcomes and quality of life [3,7,12,19,20].

Unequal Access to Care, Discrimination in Healthcare and Employment

- Patients living with liver disease often feel dismissed by healthcare providers, who may offer fewer treatment options to those perceived as responsible for their condition, reducing treatment adherence [32].
- In many European countries, the limited availability of harm reduction services reinforces stigma by framing viral hepatitis as a self-inflicted condition, increasing the risk of transmission of infection or reinfections [33].
- Restrictive liver transplant policies for patients with ArLD create systemic barriers to equitable treatment [5,34].
- Stigmatising language in healthcare, such as "recidivism" or "alcohol relapse," reinforces moral blame instead of acknowledging the chronic nature of substance use disorders [5].
- Food insecurity exacerbates healthcare inequities, worsening liver disease risks and negatively affecting health from childhood through adulthood [17,35] .
- In employment, misconceptions about productivity and disease transmission further limit job opportunities and financial stability for individuals with liver disease, which may worsen food insecurity, stress, and substance use disorders [1,12,36].

RECOMMENDATIONS FOR ADDRESSING STIGMA AND DISCRIMINATION

Public Awareness and Education

- Address misconceptions about liver disease through public education and evidence-based anti-stigma interventions.
- Engage media and implement liver health literacy programs to reduce stigma and encourage early diagnosis and treatment.
- Develop culturally tailored education initiatives and provide social support to reduce self-stigma among diverse populations, including migrants, people who inject drugs (PWID), and socioeconomically disadvantaged groups.

Healthcare Provider Training

- Integrate stigma reduction training into healthcare provider education to improve provider awareness of its impact on liver disease outcomes.
- Foster non-judgmental clinical environments through trauma-informed care training, addressing factors such as addiction, food insecurity, and adverse childhood experiences.
- Incorporate patient perspectives into healthcare provider training, using testimonials from individuals with MASLD, ArLD, and viral hepatitis to humanise their experiences.
- Promote person-first language (e.g., “a person/patient/individual living with liver disease” instead of “alcoholic” or “obese patient”).
- Replace blame-oriented language (e.g., “self-inflicted disease,” “non-compliant,” “alcohol relapse”) with terminology acknowledging liver disease as a complex medical condition.
- Reduce weight bias in liver disease care, ensuring equitable treatment for patients with MASLD.

Community Engagement

- Co-design liver health services with affected populations to ensure patient-centred care.
- Strengthen peer support networks and advocacy partnerships to provide psychosocial support and reduce self-stigma.
- Conduct targeted outreach for high-risk groups, including individuals with substance use disorders, PWID, migrants, and those with obesity-related liver conditions.
- Expand community-based liver health education programs, particularly in underserved areas, to promote early screening and encourage healthcare-seeking behaviours.

Legal Protections, Access to Care and Social Inclusion

- Strengthen legal protections against discrimination in healthcare, employment, and social services for individuals with liver disease.
- Remove policy barriers that delay or deny liver transplants for individuals with ArLD based on moralised eligibility criteria.
- Integrate liver disease care into national public health programs to ensure equitable access to treatments for viral hepatitis, MASLD and ArLD.
- Promote inclusive workplace policies supporting individuals with liver disease by addressing productivity, disease infectivity, and management misconceptions.

Research on Stigma Reduction

- Prioritise research on stigma reduction interventions in liver disease, incorporating findings into policy reforms and healthcare provider training.
- Expand research on and evaluation of harm reduction services to improve access to viral hepatitis treatment, particularly for PWID, reducing stigma-related barriers to care.
- Evaluate and address stigma in food equity programs to ensure nutritional interventions consider social biases affecting liver health.

Addressing Structural Barriers to Care

- Tackle financial constraints, transportation issues, and stigma-related fears that prevent timely access to treatment.
- Develop interventions addressing food insecurity as a structural determinant of health, to mitigate its impact on liver disease progression.

Stigmatising / blaming negative language	Suggested alternative positive language
Obese / overweight	A person/patient/individual living with obesity/overweight (use a person's first language)
Liver disease patient	A person/patient/individual with liver disease (in clinical trials, a participant with liver disease can be used)
Cirrhotic patient	A person/patient/individual with cirrhosis
Viral hepatitis patient/ infected with viral hepatitis/ hepatitis positive patient/ Hepatitis carrier	A person/patient/individual living with/ diagnosed with viral hepatitis
Drug user with hepatitis C	A person/patient/individual living with hepatitis C who uses substances
Promiscuous behavior	Multiple sexual partners
High-risk group	Group disproportionately affected by hepatitis

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Drug addicts and people with risky sexual behaviors should get tested for hepatitis to prevent spreading the disease	People who inject drugs or have multiple sexual partners may benefit from hepatitis testing, which can help prevent transmission and lead to early treatment
Let's discuss your obesity problem/ You are seriously overweight	Is it okay if we talk about your health and weight? If not, respond with: ‘I understand this is difficult for you, we'll let it rest’
Obesity/ liver disease is caused by increased calorie intake and decreased physical activity	Obesity is caused by many factors, including genetics, medications, life stressors, lifestyle, and the environment we live in
Self-inflicted disease	The condition is influenced by multiple factors/reasons. There are risk factors we can’t control, such as family history, but others we can control
You need to act now regarding the excess weight/ liver disease	I understand that your obesity/ liver disease is not simple to solve. Can we work together to see how we can help you?
Do you eat unhealthily? Do you drink alcohol regularly? Fail to exercise?	May I assume you have already tried many things to lose weight or live healthier? What worked for you and for how long?
Alcoholic liver disease	Alcohol-related liver disease
Alcohol abuse/ smoking/ drug addicted patient	A person/patient/individual having problems with consuming too much....
Alcoholic patient	A person/patient/individual living with alcohol dependence
Alcohol misuse	A person/patient/individual living with harmful alcohol consumption
Non-adherent/ non-compliant	A person/patient/individual facing challenges with the treatment plan/finding it difficult to take medication regularly

Patients with risk factors	People at risk
Failed treatment	The treatment didn't achieve the desired outcome / A patient whose treatment didn’t succeed as expected / A patient requiring alternative treatment options
You must…	The main thing you can do for your liver is… How can we help you look after your liver / take medication regularly…? What else can we do to help you…?
You are going to kill yourself	I am worried about you and your liver

To read

- Vaz J, Willemse J, Jepsen P. Addressing the impact of stigma in liver diseases: A call for proper language and responsibility allocation. J Hepatol 2024;81:e221-e222.
- European Association for the Study of the Liver, American Association for the Study of Liver Disease, Latin American Association for the Study of the Liver, Asian Pacific Association for the Study of the Liver. Ending stigmatizing language in alcohol and liver disease: A liver societies' statement. J Hepatol. 2023;79(6):1347-1348.

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