Anti-Stigma Program

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2.0	20/10/2026	Antonio Martin	Final Version
2.0	26/10/2026	Steering Committee	Approval

List of Abbreviations

D2.1	Deliverable 2.1 “Research Methodology & Tools”
D3.2	Deliverable 3.2 “Anti-Stigma Program Implementation Report”
D3.5	Deliverable 3.5 “Final Stigma and Dignity Report”
ECDC	European Centre for Disease Prevention and Control
ES	Spanish language
EU	European Union
GDPR	General Data Protection Regulation (Regulation (EU) 2016/679)
HBV / HCV	Hepatitis B Virus / Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HR	Croatian language
KPI(s)	Key Performance Indicator(s)
M1 – 36	Month 1 – 36 from project start
MS3.2	Milestone 3.2 “Anti-Stigma Interventions Deployed”
NGO	Non-governmental organisation
PDF	Portable document formant
PT	Portuguese language
QR	Quick response code
REDCap	Research Electronic Data Capture
STIs	Sexually transmitted infections
WP1 – 5	Work Package 1 – 5

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Executive Summary

Populations in situations of vulnerability – including people who use drugs, sex workers, people deprived of liberty, migrants in an irregular administrative situation and people experiencing homelessness – face a disproportionate burden of hepatitis, human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs). Structural and social stigma remain major barriers to accessing screening, healthcare and continuity of care, both at first contact with mobile units and throughout subsequent referral pathways.

This document presents the D3.2 Stigma-Reduction Programme for the mobile units of the MOBHOPE project. The programme is conceived as a cross-cutting component integrated into activities already underway, particularly Work Package 1 (Communication and Health Promotion), Work Package 3 (Stigma and Discrimination) and Work Package 4 (Standardisation), rather than as a parallel workstream. It aims to strengthen stigma-sensitive, accessible and person-centred care while building on existing project activities and avoiding duplication of deliverables.

The programme brings together four complementary strands: (1) information, education and awareness-raising on stigma for service users and health and social care professionals; (2) assessment of stigma among people with hepatitis attending mobile units, using the validated questionnaire; (3) communication, dissemination and awareness-raising through estigma.info and MOBHOPE communication channels; and (4) contributions to the development of a standardised European protocol for mobile healthcare. Mobile units offer an opportunity to establish trusted points of contact where people can receive clear information, understand their rights, express their concerns and access appropriate support and referral pathways.

Implementation status as of 20 October 2026. The table below summarises outputs developed and published to date. However, country-level implementation and outcomes have not yet been verified; therefore, publication alone cannot confirm achievement of the corresponding milestones, including MS3.2. The following sections distinguish completed activities from ongoing or proposed actions, providing a transparent basis for monitoring progress and guiding next steps.

Table 1. Anti-Stigma Program Implementation Status

Component	Completed Work	Reporting status and limitations
Platform and navigation	https://estigma.info/en/ published in ES, EN, PT and HR, with separate participant and professional entry points and links from MOBHOPE activities / WP3	Country-level use and local review have not been verified for this report
Professional training	Ten initial cases, targeted feedback and ten new reassessment cases; 0–100 scores, ≥80 reassessment pass threshold, PDF certificate and dignity badge	Verified staff totals, session records and learning outcomes are not yet available for reporting
Professional data	Initial and reassessment answers and scores saved in the same record in separate REDCap project; optional name and role, anonymous option; four-language learning dashboard	Aggregate results are subject to verification of non-test records
Participant pathway	Country stigma-questionnaire links and unscored information and support	The implemented questionnaire version and completion totals have not been verified for this report. The users' survey is separate from the professional learning assessment
Materials	28 PDFs: seven themes in four languages, published on both websites; language-organised ZIP prepared for mobile units	Content and language review, printed distribution and stakeholder feedback have not been verified for this report

1. Introduction and Rationale

1.1 The context of vulnerability and public health

Mobile units represent the front line of public health where conventional healthcare does not reach or does not generate sufficient trust. However, geographic proximity alone is not enough if psychosocial barriers persist. Stigma does not affect only the person who needs the service: it also permeates receiving services (hospitals, primary and specialist care), generating a cycle of exclusion in which a person may prefer not to know their serological status rather than face discriminatory treatment.

1.2 The role of mobile units as agents of change

Mobile units are not merely screening points: they are spaces of trust, harm reduction and health education. To maximise their impact, they should be reinforced as community-intervention nodes capable of engaging both the target population and the network of contacts – social work, NGOs, prison staff, primary care – that interacts with people before and after their contact with the unit.

1.3 Fit within MOBHOPE

MOBHOPE already includes stigma as a specific project objective (Objective 4 of the Description of the Action) through its WP3, which includes the application of a validated tool adapted from the ECDC / World Hepatitis Alliance pilot, with a consortium-level target of at least 600 baseline assessments and an exploratory target of a 20% reduction in stigma scores after the training package delivered to socio-healthcare providers. This programme does not replace that activity; rather, it provides the framework through which the interventions to reduce stigma will be developed and implemented in mobile units, alongside the definition of the indicators and measurement approach that will be used to assess the expected reduction in stigma.

2. Programme Objectives

2.1 General objective

To inform and educate mobile-unit users and health and social care professionals about stigma, discrimination and dignity, strengthening trust and supporting equitable access to hepatitis, HIV and STI services.

2.2 Specific objectives

- Equip health and social care professionals with practical knowledge to recognise stigma, communicate respectfully and support referral.
- Describe stigma and barriers reported by people living with hepatitis B or living with or previously treated for hepatitis C who attend mobile units, using the agreed WHA/ECDC questionnaire.
- Provide users with understandable information, relevant leaflets and support, reinforcing their rights, confidence and trust in the mobile unit.
- Contribute the stigma and dignity module to the future standardised European mobile-unit protocol.

- Use the data collected to feed into the policy recommendations already foreseen as a project deliverable.

3. Strategic Lines of Action

The four lines below cover activities the team is already developing. They are presented here in structured form, noting in each case their relationship to existing Work Packages and deliverables, to ensure coherence and avoid duplication.

Line 1 – Targeted training and awareness-raising on stigma reduction in the socio-healthcare environment

Target audience: Socio-healthcare workers, educators, prison staff, NGO professionals and hospital reception staff who may come into contact with people in situations of vulnerability.

Objectives by M24: (1) Staff trained in dignity and anti-stigma practices: 50 staff members (no M24 deadline is specified in this KPI row); (2) Information and education sessions on stigma for staff and users: 18 sessions conducted by M24.

Rationale and approach

Training modules have already been developed under WP1, covering the core knowledge and operational aspects needed to support the work of the mobile units. Complementing this wider training framework, WP3 has developed a set of stigma-reduction resources, including the estigma.info website, anti-stigma leaflets and the *Without Stigma* interactive app. Available in Spanish, English, Portuguese and Croatian, these resources provide separate pathways for health and social care professionals and mobile-unit users.

Building on these existing resources, this line of action focuses on integrating practical stigma-reduction content into the training and awareness-raising activities of the mobile units. The professional pathway within *Without Stigma* uses ten initial fictional cases and ten new reassessment cases to explore issues such as stigma, confidentiality, patients' rights and access to care. These materials can support reflection on how stigma and discrimination shape people's experiences, behaviour and access to healthcare, while helping professionals identify and address barriers in their everyday interactions. The user pathway provides accessible information, anti-stigma leaflets and support without scoring or assessing individuals' experiences.

Together, the WP1 training framework and the WP3 resources offer complementary approaches to strengthening stigma-sensitive, person-centred care. The focus is therefore on making effective use of the tools already developed and integrating them into relevant training, communication and mobile-unit activities, rather than duplicating existing materials or creating a parallel training programme.

The *Without Stigma* resources are publicly accessible at: https://estigma.info/formacion/sin-estigma/?lang=en.

Key content

- **Understanding stigma and barriers to care:** Raising awareness of the forms of stigma and discrimination experienced by vulnerable populations, and how these translate into barriers to screening, healthcare access, follow-up and engagement with support services, to be informed by the project's documented baseline findings.
- **Practical strategies for stigma reduction:** Promoting inclusive, non-judgemental language, active listening, respectful communication and approaches that avoid assumptions or discriminatory practices.
- **Building trust across care settings:** Strengthening professionals' ability to create safe, welcoming and supportive environments in which people feel heard, respected and confident that their needs will be taken seriously. The module will emphasise the importance of continuity and coordination across services, helping users perceive the mobile units, hospitals and other care settings as interconnected parts of a system that cares about them and is ready to respond to their needs.
- **Referral, navigation and accompaniment:** Providing clear recommendations on how to facilitate access to appropriate services, support referrals and, where needed, accompany individuals through their first contact with other healthcare settings.
- **Access to specialist support:** Providing direct contact details for the MOBHOPE project teams, enabling professionals to seek guidance and draw on their experience when addressing specific needs, barriers or contextual challenges.

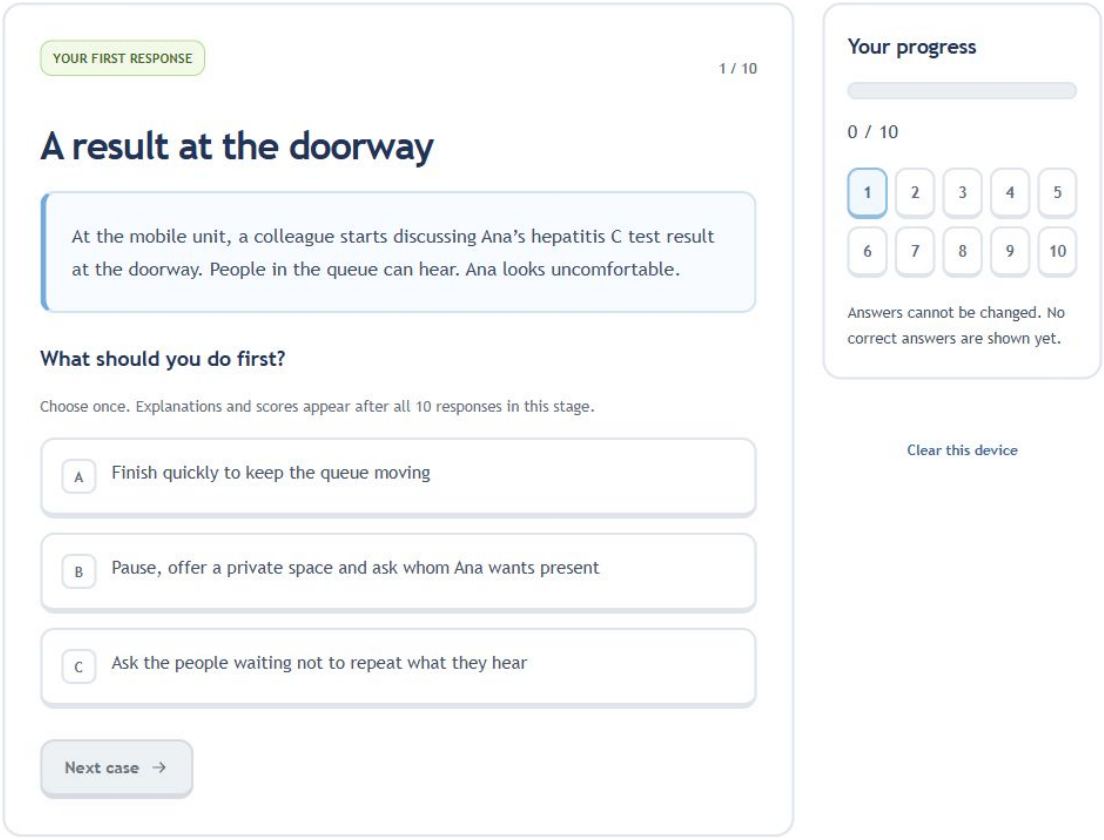
Format and certification

The module is available online in Spanish, English, Portuguese and Croatian. Documented sessions and unique eligible staff trained will be recorded separately; individual app attempts and retries do not automatically count as sessions or distinct professionals. Validated participation totals are not yet reported.

Completion is recognised by a separate educational certificate and dignity badge after both assessment stages, a reassessment score of at least 80/100 and confirmed saving. This is not professional accreditation. Integration with WP1 certification has not been confirmed.

Professional assessment: the app saves all ten initial answers before feedback. Explanations and leaflet or guidance links address incorrect answers, followed by an optional reassessment using ten new cases on the same topics. Both stages are saved in the same professional REDCap record, separate from user stigma questionnaires. An optional name requires explicit consent; anonymous participation and an optional professional role are available. The cases draw principally on the Spanish Social Pact for Non-Discrimination and Equal Treatment Associated with HIV and the estigma.info resources. This immediate, uncontrolled comparison evaluates professional learning; it does not establish stigma reduction or a causal effect.

Figure 1. *Without Stigma* App Training Example Case



Note: A fictional confidentiality case in the WP3 professional app (initial assessment, English, 18 October 2026). Explanations and scores follow all ten initial answers. This interface screenshot does not report participant outcomes.

Expected contribution

By equipping professionals with practical tools and access to specialist guidance, this action aims to increase awareness on stigma while reducing discriminatory practices, strengthen trust between vulnerable populations and service providers, and foster a more connected, person-centred care environment across mobile units and other healthcare and support settings.

Line 2 – Continued application and use of the stigma survey

The primary objective of this line is to describe stigma, discrimination and barriers to care among people with hepatitis attending the mobile units. It uses the European Region Survey to Explore the Experiences of Living with Hepatitis B and/or Hepatitis C, developed by WHA with ECDC. Country questionnaire links have been configured; the implemented versions and completion totals require verification for reporting.

Purpose and interpretation

The user questionnaire documents experiences and needs to guide information, education and support. It is not treated here as a validated scale for measuring the effect of the brief intervention. The published pilot documentation reviewed does not establish a composite hepatitis-stigma score or its responsiveness to intervention-related change. Historical experience items cannot demonstrate that past discrimination has disappeared. Stigma may change over time, but that does not make this questionnaire an appropriate

immediate pre/post test. Any longitudinal comparison requires suitable items, consistent recall periods and an agreed protocol. The professional app questionnaire assesses learning separately.

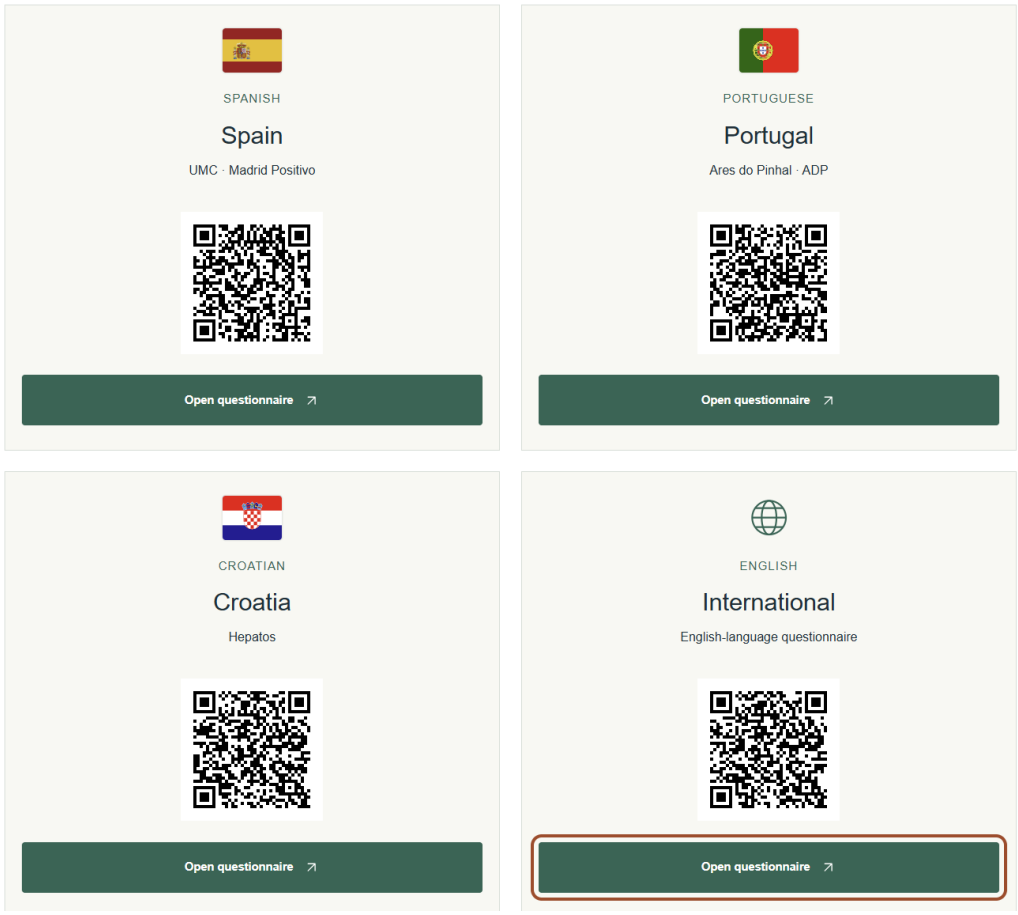
Findings will help mobile-unit teams identify barriers, adapt explanations and leaflets, strengthen referral and respond to users' concerns. These assessments support service improvement and the WP3 evaluation reports; they are distinct from evidence of professional learning.

Implementation and data use

Staff should offer the questionnaire privately and voluntarily, using the agreed country version and protocol. Information and care remain available whether or not a person participates. Respectful listening and a clear explanation of confidentiality are central to maintaining trust.

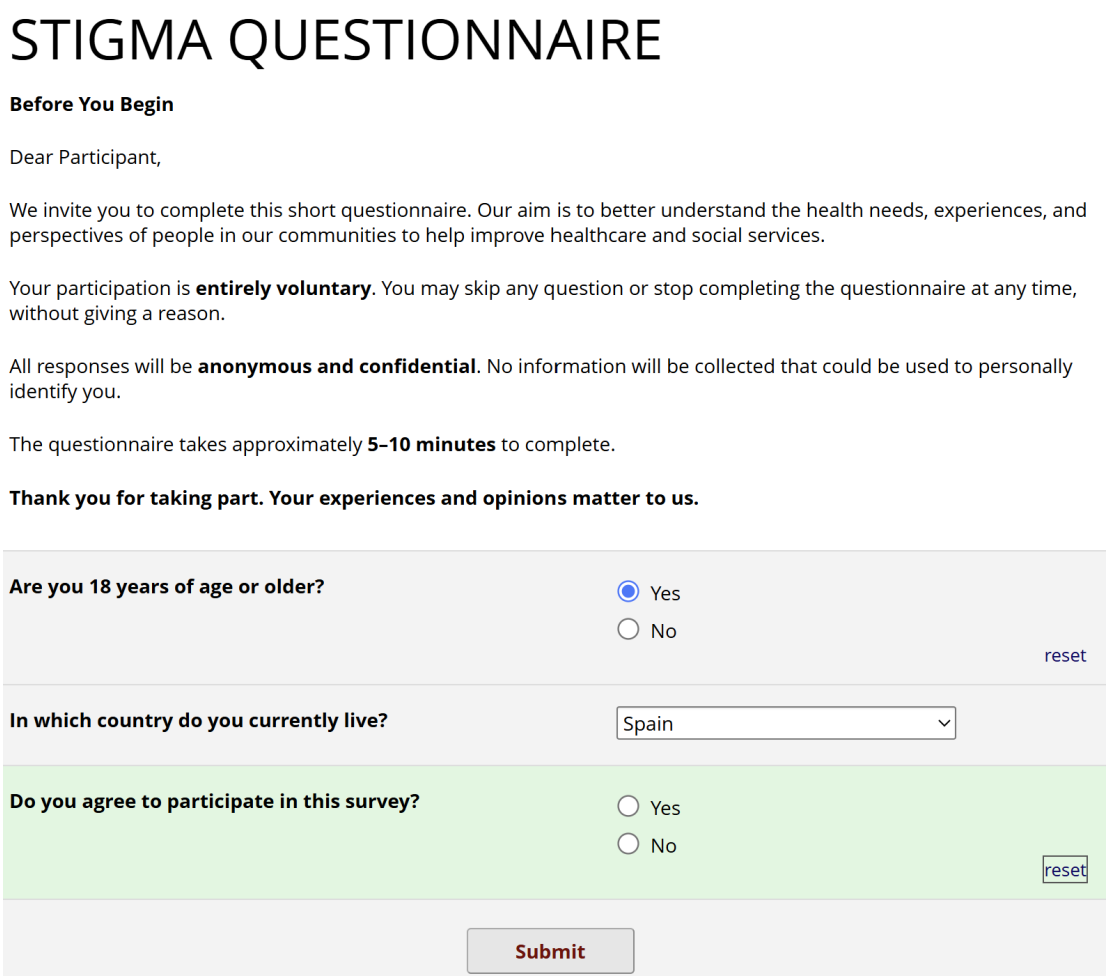
The user intervention combines a brief conversation about stigma, rights and access to care with the relevant estigma.info leaflet and a support contact. There is no game score or pass/fail outcome. Questionnaire completion totals and user and staff feedback have not yet been consolidated for this report.

Figure 2. Access Points to Mobile-Unit User Stigma Questionnaire



Note: Access options and QR codes for mobile-unit user stigma questionnaires in Spanish, Portuguese, Croatian and English. These questionnaires are separate from the professional learning assessment.

Figure 3. Stigma Questionnaire Consent Screen



Note: Participant information and consent screen for the English user stigma questionnaire, illustrating voluntary participation. This interface screenshot does not report questionnaire completions or outcomes.

Line 3 – Communication, dissemination and user empowerment

Rationale and approach

An essential component of any anti-stigma programme is to ensure that its implementation, findings and effectiveness are visible and accessible to the professionals, institutions and communities concerned. This line of action will therefore focus on the communication, dissemination and exploitation of the activities and results generated through the MOBHOPE anti-stigma programme, ensuring that evidence gathered through its different action lines translates into greater awareness, improved service delivery and sustainable institutional change.

Communication activities will be coordinated with MOBHOPE's existing dissemination, communication and exploitation plan and will address three complementary audiences: professionals working with vulnerable populations, mobile-unit users and the general public, and the institutions and policymakers responsible for shaping healthcare services and policies.

Dissemination of training and professional engagement (linked to Action 1)

Dissemination will highlight the WP3 outputs already published—estigma.info, the interactive professional app and the anti-stigma leaflets—alongside the broader WP1 training resources. Documented training experiences and feedback will inform improvements and wider use.

Activities will include:

- Share the WP3 website, professional app and leaflet collection through MOBHOPE and partner channels.
- Providing contact details for the mobile-unit teams and relevant project professionals, enabling external organisations to request information, guidance or support in adapting good practices to their own settings.
- Publishing information about the programme's implementation, upcoming deliverables and relevant results on the project website.
- Distribute the existing WP3 leaflets and accessible digital information through mobile units, partner organisations and project channels, adapting delivery to local needs.

Presentations and awareness-raising activities will also be offered to organisations working with these populations, with a particular focus on building trust, promoting non-judgemental interactions and strengthening connections between community-based services and the wider healthcare system.

Communicating findings and empowering mobile-unit users (linked to Action 2)

Communication with mobile-unit users and the general public will be informed by the findings of the stigma survey described in Action 2. Key findings and emerging insights will be regularly communicated through MOBHOPE's social media channels and other appropriate communication formats, raising awareness of the barriers experienced by target populations and demonstrating the programme's commitment to addressing them.

This approach aims to strengthen trust between mobile-unit users and service providers by showing that users' experiences are being heard, their needs are being taken seriously and the programme is working to improve services in response to the barriers identified. Where appropriate, communication will also highlight how findings are informing dialogue and action with relevant healthcare institutions and stakeholders.

The published WP3 collection consists of seven anti-stigma leaflet themes, each available in Spanish, English, Portuguese and Croatian: 28 PDFs in total. These are the materials prepared for use by mobile-unit teams:

- Understanding stigma: a general introduction for users and the wider community.
- Stigma affecting people who use drugs; gay and bisexual men and other men who have sex with men; and trans people.
- Stigma affecting people in prison; migrants in an irregular administrative situation; and people who do sex work.

The leaflets provide accessible information for discussion with users and can also support professional awareness. They are published on estigma.info and mobhope.eu, with a ZIP organised by language prepared for mobile units. It is aimed for a printed

circulation target of 10,000 copies by M24; published files and downloads are counted separately.

Publication does not demonstrate printing, distribution or effectiveness. Content and language review and distribution by country still require documented evidence. Contact our team at info@mobhope.eu.

Dissemination of evidence, good practices and policy recommendations (linked to Action 4)

The programme will use the findings and implementation experience generated through its different action lines to support the identification and dissemination of good practices in stigma reduction and mobile-unit service delivery.

This will include contributions to the project's planned reports and deliverables, documenting lessons learned and identifying practical improvements in service organisation, accessibility, user engagement, referral pathways and coordination with other healthcare settings. Findings will be communicated through the project website, social media, stakeholder networks and presentations to relevant professional and institutional audiences.

Building on MOBHOPE's stakeholder network, the programme will also support engagement with key organisations, healthcare institutions and policymakers who can contribute to the wider adoption of effective practices. In particular, the standardised protocol for mobile-unit services that MOBHOPE aims to develop for use across Europe will be disseminated to relevant institutional and political leaders, supporting discussion on its applicability, transferability and potential integration into service delivery frameworks.

Expected contribution

Through these activities, Line 3 will ensure that the programme's interventions and findings are not only implemented and evaluated, but also communicated, understood and used by the people and institutions best placed to act on them. By connecting professional training, user-facing communication, evidence dissemination and stakeholder engagement, this action will help strengthen trust, challenge misconceptions, improve the responsiveness of services and support the longer-term uptake of good practices beyond the immediate scope of MOBHOPE.

Line 4 – European standardisation and contribution to public policy

The development of a standardised European mobile-unit protocol (standard service package) is already a planned MOBHOPE deliverable. The specific contribution of this anti-stigma programme will be to ensure that the protocol incorporates a dedicated component on stigma reduction, dignity and non-discriminatory care, complementing its existing technical and operational procedures. This will help ensure that countries and mobile units adopting the protocol are equipped not only to deliver screening services, but also to provide respectful, inclusive and person-centred care to vulnerable populations.

Integration of stigma-reduction practices into the European protocol

Building on the activities implemented through Lines 1–3, this action will identify and consolidate practical procedures and recommendations for integration into the standard service package, including:

- **Staff competencies and professional practice:** Recommendations on inclusive, non-judgemental communication, active listening, trust-building and the prevention of discriminatory practices, building on the training resources developed under Line 1.
- **Routine monitoring and service improvement:** Guidance on using stigma-related findings and feedback from service users to identify barriers, monitor changes over time and inform improvements to mobile-unit practices and referral pathways, building on Line 2.
- **User engagement and access to information:** Recommendations for communicating services and referral options clearly, strengthening trust and ensuring that users understand how to access support throughout their care journey, building on Line 3.
- **Coordination and referral across care settings:** Practical guidance to support continuity of care and strengthen connections between mobile units, hospitals, primary care, community organisations and other relevant services.

The recommendations will draw on baseline and follow-up stigma assessments, implementation experience and lessons learned across the participating countries. This will help ensure that the protocol reflects barriers encountered in practice and provides actionable guidance that can be adapted to different national and institutional contexts.

Policy engagement and dissemination

Findings from the stigma assessments, implementation activities and good-practice reports will be presented to relevant health and social-service authorities, institutional stakeholders and policymakers through the advocacy and dissemination activities already planned within MOBHOPE. These activities will reinforce existing project messages and support evidence-informed discussions on how stigma reduction and dignified treatment can be embedded in mobile-unit services and wider healthcare pathways.

MOBHOPE's stakeholder network will be used to identify and reach relevant organisations and decision-makers, present the proposed recommendations and encourage their consideration in the development or improvement of healthcare policies, service standards and referral pathways. The standardised protocol, including its stigma-reduction component, will be shared with relevant institutional and political leaders to promote awareness, facilitate discussion and explore opportunities for its future adoption.

Where appropriate, feedback from stakeholders will inform the refinement and contextual adaptation of the recommendations. While formal endorsement and implementation will remain the responsibility of the relevant authorities and institutions, MOBHOPE will actively promote the relevance, feasibility and transferability of the proposed practices.

Specific outputs and expected contribution

This action will deliver the following outputs:

1. **A stigma-reduction and dignified-treatment component** developed for integration into MOBHOPE's European standard mobile-unit protocol, incorporating practical recommendations on staff competencies, user engagement, stigma monitoring, referral and continuity of care.
2. **A set of evidence-informed recommendations and good practices** based on findings and implementation experience across the three participating countries, designed to support the adaptation of stigma-sensitive approaches to different national and institutional contexts.
3. **Dissemination and policy engagement activities** through which the protocol and recommendations will be presented to relevant health and social-service authorities, institutional stakeholders and policymakers, encouraging their consideration and potential uptake.

Through these activities, MOBHOPE will help translate the programme's evidence and practical experience into a transferable European framework for stigma-sensitive mobile-unit services. By embedding dignity, non-discrimination and person-centred care within the standard service package and actively promoting its use among decision-makers, this action will support the wider dissemination of good practices, strengthen the sustainability of the programme's results and contribute to more equitable access to screening, referral and healthcare for vulnerable populations.

4. Proposed Complementary Strategies

These options may complement the core programme, subject to feasibility, partner agreement and the approved scope; they are not reported as implemented.

4.1 Peer navigators

A supervised pilot could involve trained people with relevant lived experience in building trust and supporting referral, with clear roles, confidentiality safeguards and appropriate compensation.

4.2 Dignified waiting spaces

Feasible adjustments to existing mobile-unit spaces could improve visual and acoustic privacy and provide a welcoming environment for consultations and results.

4.3 Harm-reduction materials as part of the service

Where consistent with local needs, requirements and resources, hygiene and harm-reduction materials could be offered without making access conditional on testing or questionnaire participation.

4.4 Collaborative assessment of care following referral

With receiving services' prior agreement, a brief dignity checklist and voluntary user feedback could identify referral barriers and support service improvement while protecting confidentiality.

4.6 Train-the-trainer approach

Designated focal points could use WP1 training and WP3 estigma.info resources to train colleagues, supported by shared guidance, quality review and participation records.

Implementation and prioritisation

Partners will prioritise feasible measures within existing resources and record any pilot delivery and feedback.

5. Implementation Plan and Timeline

The implementation of the anti-stigma program will follow a phased approach, moving from the development and coordination of interventions to their deployment, integration into the standardised European mobile-unit service package, and final evaluation.

Table 2. Anti-Stigma Program Implementation Timeline

Phase	Period	Main Activities
Phase 1	By M12	Develop and publish the WP3 estigma.info website, professional app and anti-stigma leaflet package, complementing WP1 training; coordinate implementation through mobile units; analyse and report the agreed stigma assessment.
Phase 2	By M18	Deliver the mid-term stigma evaluation review, based on available baseline findings and relevant monitoring data; review identified barriers and discrimination experiences; use the findings to refine the planned interventions, communication materials and implementation approach during implementation.
Phase 3	Initial deployment by M12; continued rollout to M24	Implement the stigma-reduction training module for socio-healthcare professionals; deploy the communication and awareness-raising activities; distribute human dignity promotion materials and user-facing leaflets; continue application of the stigma questionnaire and collection of feedback; document implementation experience and emerging good practices.
Phase 4	Draft by M18; pilot by M24; final by M30	Incorporate the stigma-reduction and dignified-treatment component into the standardised European mobile-unit service package under WP4; consolidate practical recommendations on staff competencies, user engagement, monitoring, referral and continuity of care; share the proposed package with relevant stakeholders and authorities for consideration.
Phase 5	Data and analysis by M30; report by M36	Continue stigma assessment and review reported barriers, intervention delivery, professional learning and user feedback; consolidate lessons learned and good practices; prepare the final stigma and dignity report. The evaluation approach remains subject to the methodological clarification described in section 1.3.

6. Monitoring, evaluation and indicators

The indicators proposed for this programme complement, rather than replace, those already defined under MOBHOPE's Research Framework (D2.1). Existing monitoring tools and data sources will be used wherever possible to minimise duplication and ensure consistency across work packages.

Table 3. Anti-Stigma Program KPI

Area	Indicator	Source / Reference
Training	Number of staff trained in dignity and anti-stigma practices (target: 50 unique eligible staff)	Training register and separate professional REDCap records

Awareness-raising	Number of information and education sessions on stigma delivered to staff and users (target: 18 by M24)	Training and dissemination records
Stigma assessment	Number of users completing the stigma questionnaire (target: 600 participants)	REDCap stigma module (WP3)
Professional learning and evaluation	Changes in professional scores and incorrect responses between baseline assessment and post-intervention reassessment; exploratory target of at least 20% relative reduction in incorrect responses	*Without Stigma* application and paired professional REDCap records
Communication	Number of social media posts and leaflets distributed across the three participating countries (printed circulation target: 10,000 copies by M24; digital metrics separate)	Dissemination register
Dissemination	Communication of training resources, findings and good practices through project channels	Website, social media and dissemination records
User experience and dignity	Reported experiences of respectful treatment, trust and barriers to care	Stigma questionnaire and available user feedback
Service uptake	Number of people accessing mobile-unit services over time	Mobile-unit encounter register
Referral and continuity of care	Referral completion rate and time to specialist evaluation, where available	Care-cascade tracking (WP2)
Standardisation	Integration of stigma-reduction and dignified-treatment procedures into the European mobile-unit service package	Standard service package (WP4)
Final evaluation	Assessment of stigma-reduction interventions and human dignity promotion effectiveness (D3.5: one report by M36)	WP3 assessment data and implementation records; final stigma and dignity report

6.1 Evaluation of professional learning and stigma-related decision-making

The MOBHOPE anti-stigma programme uses the *Without Stigma* application, available in multiple languages, as a case-based educational intervention for health and social care professionals. The intervention is designed to improve professionals' recognition of and responses to potentially stigmatising or discriminatory situations.

The intervention follows a three-stage process:

1. **Baseline assessment.** Participants respond to ten fictional scenarios addressing potentially stigmatising or discriminatory situations in healthcare and social care settings. Responses are recorded before corrective feedback is provided, establishing a baseline measure of stigma-related knowledge and decision-making.
2. **Educational intervention.** Participants receive explanations of incorrect or potentially stigmatising responses, supported by educational infographics, recommendations and links to additional resources available through https://estigma.info/en/.
3. **Post-intervention reassessment.** Participants respond to ten new scenarios addressing comparable competencies. This enables changes in responses to be assessed without simply repeating the original questions.

Baseline and reassessment responses, individual scores and relevant optional participant information are recorded in the same professional-training REDCap record. These records are kept separate from the stigma questionnaires administered to mobile-unit users, allowing professional learning and service-user experiences to be evaluated as distinct outcomes.

Evaluation Indicators

The immediate educational outcomes will be assessed using the following indicators:

- Mean baseline and post-intervention scores, expressed on a 0–100 scale.
- Absolute change in individual scores, expressed in percentage points.
- Number and proportion of participants whose scores improve between assessments.
- Number and proportion of initial incorrect responses corrected at reassessment.
- Relative reduction in incorrect responses across completed assessment pairs.
- Number and proportion of participants achieving a post-intervention score of at least 80/100.
- Number of professionals completing both assessments.

The exploratory 20% target will be operationalised as a relative reduction of at least 20% in incorrect responses between baseline assessment and post-intervention reassessment. The calculation will use the aggregate number of incorrect responses across valid paired assessments:

$$\text{Relative reduction (\%)} = [(\text{Baseline incorrect responses} - \text{Post-intervention incorrect responses}) / \text{Baseline incorrect responses}] \times 100$$

The denominator is the total number of incorrect responses at baseline across the included assessment pairs. The indicator is not applicable when there are no baseline incorrect responses. Results will therefore be reported alongside the baseline and reassessment totals and the number of valid paired assessments. Individual score changes and the number of initial errors corrected will be reported separately to provide additional context.

Data quality and interpretation

The analysis will include eligible professionals with valid, completed baseline and reassessment records. Technical test records will be excluded, incomplete assessment pairs will be excluded from paired comparisons, and records of uncertain provenance will be verified before inclusion. The comparability of the two sets of scenarios will be considered when interpreting changes in scores and incorrect responses.

This approach provides a quantitative measure of immediate changes in professionals' responses to simulated stigma-related situations. However, improved assessment scores do not, by themselves, demonstrate an equivalent reduction in underlying stigmatising attitudes or discriminatory behaviour in clinical practice. The proposed 20% indicator should therefore be interpreted as an exploratory educational outcome, not as direct evidence of a 20% reduction in experienced stigma or real-world discrimination.

The professional-learning assessment is distinct from the questionnaires administered to people living with or previously treated for viral hepatitis. These questionnaires provide complementary information on experienced stigma, dignity and barriers to healthcare access. Findings from professional assessments and service-user questionnaires will be

interpreted separately and, where appropriate, considered together in the overall programme evaluation. Further longitudinal follow-up and assessment of real-world professional practices would be required to establish whether educational improvements translate into sustained changes in professional behaviour and service-user experiences.

6.2 Monitoring, reporting and use of findings

Monitoring findings will inform implementation adjustments and the mid-term assessment (by M18). The final evaluation will combine documented programme delivery, professional learning, user experiences and stigma findings, interpreted within the agreed methodology.

App scores and satisfaction responses are not substitutes for a validated measure of changes in experienced stigma. In particular, professional assessment scores will not be used as a proxy for patient stigma reduction.

For completed non-test professional assessment pairs, learning indicators will include initial and reassessment scores (0–100), signed score change in percentage points, and the number and percentage of initial errors corrected. The percentage of initial errors corrected is not applicable when there are no initial errors. Initial-only attempts will be counted separately for monitoring purposes but excluded from paired outcome calculations.

Current results and reporting status. Verified country totals for survey completions, unique staff trained, documented sessions, printed circulation and professional-learning outcomes are not yet available for reporting. The professional-learning methodology and REDCap data structure provide a basis for the planned analysis; however, aggregate results should be reported only after data extraction, quality checks and analysis have been completed. Technical test records are excluded from programme results, and records of uncertain provenance require verification before inclusion. The target of 600 survey participants does not imply a requirement to complete 600 baseline surveys by M6. Professional assessment scores do not measure patient stigma reduction. No conclusions on stakeholder experience, access to care or quality of life will be drawn without supporting analysed data.

7. Ethical and Data-Protection Considerations

All activities under this programme will comply with applicable EU and national legislation, institutional requirements and the ethical and data-management frameworks already established within MOBHOPE. Particular attention will be paid to protecting the dignity, autonomy, privacy and rights of vulnerable populations.

- **Informed consent and voluntary participation:** All data-collection activities, including the stigma questionnaire and complementary questions, will follow the project's established informed-consent, voluntariness and confidentiality procedures. Participation in data collection will never be a condition for accessing mobile-unit services, screening or support.
- **Non-conditional provision of support:** Harm-reduction materials and other support will be offered according to users' needs and the service's scope, without conditioning their provision on accepting a test or participating in research or data collection.

- **Confidentiality and data protection:** Stigma-questionnaire data and any complementary information, including self-reported HBV vaccination status, will be processed in accordance with the General Data Protection Regulation (GDPR), applicable national legislation and MOBHOPE's existing data-management framework. Any changes to data collection or processing arrangements will be reviewed through the appropriate project procedures before implementation.
- **Sensitive and non-stigmatising data collection:** Staff administering questionnaires and collecting feedback will be guided to use respectful, non-judgemental language, minimise unnecessary personal questions and avoid practices that could cause distress or reinforce stigma. Participants will be able to decline to answer individual questions, in accordance with the applicable consent and data-collection procedures.
- **External service assessment:** Any structured assessment of care provided by external services will require prior agreement with the institutions concerned and, where applicable, review by the competent ethics committee and other relevant authorities.
- **Peer navigation and telemedicine:** Any pilot involving peer navigators or remote specialist consultations will be subject to prior feasibility assessment and appropriate safeguards, including confidentiality, clear role definitions, informed consent where required, clinical governance and secure handling of information.
- **Data minimisation and responsible reporting:** Only information necessary for the programme's monitoring and evaluation objectives will be collected. Reporting and dissemination will use aggregated or appropriately anonymised information wherever possible, minimising the risk of identifying individuals or reinforcing stereotypes about vulnerable populations.

These safeguards will ensure that stigma reduction is pursued in a manner consistent with the programme's core principles of dignity, non-discrimination, trust and equitable access to healthcare.

8. Conclusion

The technology and vehicles of MOBHOPE's mobile units provide the technical means to bring screening and healthcare services closer to vulnerable populations. Training, active listening, dignified treatment and the reduction of stigma and discrimination provide the human dimension that helps ensure these services are accessible, trusted and responsive to the needs of those who face the greatest barriers to care.

This programme does not seek to create a parallel structure within MOBHOPE, but to translate the project's existing commitment to stigma reduction into practical, measurable and sustainable action. By combining targeted training, systematic monitoring of stigma and experienced barriers, accessible communication and the integration of good practices into a standardised European mobile-unit service package, it aims to strengthen the relationship between mobile units, their users and the wider healthcare system.

Ultimately, the programme seeks to ensure that the right to health and treatment, particularly for hepatitis C and HIV, extends beyond the availability of services to include the dignity, trust and support necessary for people to access and benefit from them. By

addressing not only the technical but also the social and institutional barriers to care, MOBHOPE can contribute to a more inclusive, equitable and person-centred approach to healthcare across the participating countries.

The stigma-reduction resources developed through MOBHOPE have been published and are available to support the programme's implementation. However, country-level implementation records, preliminary outcome data and stakeholder feedback have not yet been consolidated and verified for this report. Accordingly, the publication of these resources should not be interpreted as evidence of implementation across all participating countries or of demonstrated reach or impact. These areas remain important priorities for subsequent monitoring and evaluation.