Does EU action against misinformation & disinformation reach those most vulnerable to its influence?

This is a guest blog by Research Intern, Constance Hardenne, whose experience as a practicing nurse adds the extra perspective of a healthcare worker* to *HAI's work on misinformation & disinformation as part of the EU-funded ECHO Project.

As a nurse working across different wards, I often meet patients who have been influenced by health misinformation and disinformation. For example, a mother who had read all vaccines were dangerous after a transplant. I explained why revaccination is essential to rebuild her son's immunity, and she agreed to follow the schedule. This conversation went well, but this is not always the case. Some patients remain convinced, even after several explanations. Of course, patients have the right to make their own decisions about their health. But a decision based on false information is not really a free one.

Health mis- and disinformation both refer to false or misleading health information. The difference lies in intent: misinformation is shared without the intention to mislead, while disinformation is deliberately created or spread to deceive. Both can influence the decisions people make about their health and erode trust in health experts and institutions (Denniss & Lindberg, 2025). For marginalised groups, they may also worsen existing health inequalities (Senteio et al., 2025).

The Digital Services Act (DSA) is the European Union's (EU) main legally binding instrument regulating online platforms. It requires the largest ones to assess and reduce systemic risks, including the spread of mis- and disinformation. It is complemented by the Code of Conduct on Disinformation and, more recently, the European Democracy Shield, which addresses disinformation as part of a wider effort to protect democracy (European Commission, 2026). This article asks whether EU action considers that some groups are less able to recognise false health information and more likely to trust it.

Who is left behind

People can be more vulnerable to health mis- and disinformation for several reasons, including limited health literacy and lower education. Health literacy is also linked to social position: in all 17 countries of the European Health Literacy Population Survey 2019–2021 (HLS19), people who were economically

disadvantaged and had a lower social position had more difficulty finding, understanding and judging health information (HLS19 Consortium of the WHO Action Network M-POHL, 2021).

Limited health literacy matters because it is associated with greater susceptibility to health mis- and disinformation. In Poland, people with inadequate or problematic health literacy were more susceptible to health misinformation than those with sufficient health literacy (Duplaga, 2025). In Germany, belief in COVID-19 misinformation was more common among people with lower education, a migration background and those relying on social media, tabloids or neighbours for information (Leuker et al., 2022). Across 26 European countries, education was linked to lower belief in COVID-19 conspiracy theories, and this protective effect was stronger among people who trusted scientists (Jabkowski et al., 2023). Vulnerability to mis- and disinformation therefore depends on individual skills, but also on trust and the information channels on which people rely.

Access to information and discrimination

Migrants may be more vulnerable to health mis- and disinformation for several reasons, including language barriers and experiences of discrimination. First, official health information is often not available in their languages, so they may rely more on social media and on information shared within their own communities (Tjaden et al., 2022). Second, migrants and refugees in seven EU countries reported discrimination in medical settings, at levels that varied between countries (Gil-Salmerón et al., 2021). In Sweden, having experienced discrimination was the factor most strongly associated with low trust in healthcare (Wemrell et al., 2025). Negative experiences with authorities may lead migrants to distrust health agencies and make less use of the information they provide (Tjaden et al., 2022).

EU responses and opportunities to go further

The EU has several instruments that touch on health mis- and disinformation. This section reviews a few of them and asks whether they address specific vulnerabilities.

The DSA, adopted in 2022, is not a health law. It does not impose a general obligation to remove health mis- and disinformation but focuses on systemic risk management: Article 34 concerns risk assessment and Article 35 risk mitigation. Article 34 lists among the risks that very large online platforms and very large online search engines must assess negative effects on public health, people’s physical and mental well-being, the right to non-discrimination and the protection of minors (Regulation (EU) 2022/2065, 2022). Its recitals add that platforms should, where appropriate, involve representatives of groups potentially affected by their services (Recital 90).

The AI Act, adopted in 2024, is not a health law either. Article 5 prohibits AI systems

that exploit vulnerabilities linked to age, disability or a specific social or economic situation to materially distort people's behaviour in a way that causes or is likely to cause significant harm. Since 2 August 2026, Article 50 requires, under certain conditions, people to be told when they are interacting with an AI system, such as a chatbot. It also requires deepfakes to be disclosed, as well as AI-generated text published to inform the public on matters of public interest, unless the text has undergone human review or editorial control and someone holds editorial responsibility (Regulation (EU) 2024/1689, 2024). These transparency rules may help people judge the health information they find online, but they do not address whether this information is accurate.

Presented on 12 November 2025, the European Democracy Shield is a policy initiative, not a binding legal instrument. It includes a European network of fact-checkers, which should also support fact-checking during health emergencies, as well as support for media and digital literacy (European Commission & High Representative of the Union for Foreign Affairs and Security Policy, 2025). Its media literacy actions target all age groups and socioeconomic backgrounds, with priority for groups facing barriers in engaging in democratic life. However, they are framed around democracy and foreign interference. Its general digital literacy actions may also benefit health, but it includes no targeted health literacy measures.

In its May 2025 response to the consultation on the Democracy Shield, the Health Literacy Section of the European Public Health Association recommended tailored health literacy measures for vulnerable and marginalised groups (European Public Health Association, 2025).

A recent systematic review found that evidence on interventions against health misinformation in marginalised groups remains limited and generally weak. The authors recommend routinely involving representatives of these groups in the design, delivery and evaluation of interventions (Senteio et al., 2025).

The role of healthcare workers

Healthcare workers are well placed to address misinformation and disinformation through their direct relationship with patients but they rarely have time for dialogue and little is known about how much training they receive to discuss it (Kbaier et al., 2024).

My conversation with the concerned mother showed what this can achieve: taking her concern seriously and explaining the evidence was enough for her to follow the schedule. But when a patient shares a questionable belief about their health, I rarely have time to discuss it properly between care and medication rounds. These conversations are often postponed or never happen.

Within the EU-funded ECHO project (Engaging Citizens in Honest Opinion), Health Action International is developing training to help healthcare workers limit the

spread of mis- and disinformation and share evidence-based information with patients (Health Action International, 2026).

So, does EU action reach the people most vulnerable to false health information? So far, only partly. The EU has several instruments that address different sides of the problem, such as platform risks, AI transparency and media literacy. But only a few provisions consider vulnerable groups, and none of the instruments reviewed here includes measures specifically aimed at health literacy. The next step is to make sure its response also reaches those who are most likely to believe what they read and to support the people they turn to for care, including healthcare workers. Projects like ECHO are a first step, and their lessons should be built upon in the long term.

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