
The bi-annual plenary of the BE EBCP Mirror Group highlighted Belgium's engagement in Europe's fight against cancer under the European Commission's Mission on Cancer and the European Beating Cancer Plan (EBCP). The Mirror Group serves as a national coordination platform, aligning Belgian priorities with EU strategies, facilitating stakeholder collaboration, identifying funding opportunities, and translating European initiatives into concrete national action.

The plenary opened with updates from the Belgian Mirror Group, including the presentation of its latest policy recommendations spanning across the whole cancer continuum.

## 1. Mission on Cancer – From European ambition to impact

A dedicated segment on the Mission on Cancer featured contributions from DG RTD and HaDEA, outlining the Mission's ambition, core pillars, governance structure, and implementation mechanisms. The discussion emphasised how the Mission, together with other EU initiatives, addresses the entire cancer continuum from prevention and early detection to treatment, survivorship, and quality of life. The discussion showcased Belgian participation in Horizon Europe across the years as well as a benchmarking with other European countries.

## 2. Mission on Cancer in Action: Projects & Perspective

A central highlight was the panel discussion, "Mission on Cancer in Action: Projects & Perspectives," showcasing five major European initiatives:

- European Cancer Information Portal (EU-CIP) – advancing health literacy through reliable, patient-centred digital information.
- UNCAN-Connect – building decentralised, interoperable cancer data networks to accelerate research.
- PERIFORMANCE – strengthening public and stakeholder engagement in cancer research.
- ECHoS – establishing National Cancer Mission Hubs to improve coordination across Member States.
- FORCE – mobilising cancer charities to drive patient-focused, non-profit research addressing unmet needs.

Through short pitch presentations and interactive discussion, panellists explored key strategic questions. Discussions addressed the long-term sustainability of National Cancer Mission Hubs and how they can be embedded into national cancer plans to avoid remaining project-based structures. The importance of systematically integrating patient, citizen, and professional voices into decision-making processes was strongly emphasised. The role of pragmatic clinical trials in improving real-world cancer care in Belgium was discussed as well as how EU projects could benefit the clinical trials landscape and patient access to innovative treatment in Belgium. Panellists also discussed Belgium's readiness to contribute to decentralised data infrastructures such as UNCAN-Connect through the Belgian Cancer Research Alliance (BeCRA). Practical considerations around user-centred digital design and health literacy were also examined.

The session concluded with reflections on challenges and enablers for implementation in Belgium. Across projects, common themes emerged: sustainability, collaboration, inclusivity, data sharing, system integration, and long-term commitment. Overall, the session reinforced the importance of

strong national coordination to ensure that European cancer initiatives translate into meaningful impact for Belgian patients and healthcare systems.

## 3. Session JA PreventNCD: Can we personalize prevention in Belgium?

Federica Rossetti introduced the Joint Action PreventNCD and its implementation and outputs in Belgium. Sciensano leads Work Package (WP) 10 "Identify individuals at risk – Prevent and treat" on personalised risk-stratified prevention, where a number of different pilot studies are conducted across European countries on four different themes: genetic determinants, tobacco and nicotine cessation, physical activity and a holistic approach to prevention.
After introducing the concepts of risk stratification, personalised prevention and the main objectives of the WP, the presentation focused on the ethical, legal and societal implications of personalised risk-stratified prevention (Task 10.2 of WP10). Milana Trucl provided a brief overview of the citizen engagement activities conducted under this task across different contexts and disease areas. For more information on this task, its activities and recommendations for an ethical personalised risk-stratified prevention, the task report can be consulted[1]. The results of these activities led to the identification of three core ethical dimensions for the implementation of personalised risk-stratified prevention (relational autonomy, empowerment and justice), as well as a set of recommendations, including the need for system preparedness, monitoring of inequalities and sensitive and supportive communication of risk information.

**Group discussion**

Wannes Van Hoof introduced the group discussion. We used *Slido* to engage the participants, including two multiple choice questions and one word cloud.

(Q1) **Do you expect personalised prevention to increased health inequalities in Belgium?** (n = 18)
- 39% responded "Unsure"
- 28% responded "Slightly increase"
- 17% responded "Slightly reduce"
- 11% responded "No effect"
- 6% responded "Strongly increase"

This uncertainty is understandable, as personalised prevention is not yet widely implemented in Belgium. However, a concerning proportion indicated that personalised prevention might increase health inequalities, and this is particularly worrying given that one of the major JA Prevent objectives is to **reduce inequalities**, not exacerbate them.
In the T10.2 report (see footnote 1), it is highlighted that there is a tension between communicating risk and risk in terms of actionability and fairness. If the system is ready, we could be able to prevent the increase in inequalities.

(Q2) **How ready is Belgium to implement personalised prevention at national level?** (n = 18)
- 56% responded "Not ready"
- 28% responded "Unsure"
- 11% responded "Partially ready"
- 6% responded "Mostly ready"

Literacy, infrastructure and budget are key components of readiness. An example discussed was the use of **liquid biopsies** for colorectal cancer. Liquid biopsies could represent a feasible strategy in Belgium for detecting colon cancer in at-risk populations, with the benefits including earlier detection and more targeted screening approaches. Here, personalised prevention may reduce unnecessary screening among low-risk individuals, thus contributing to cost reductions. The overall

[1] The report is currently not publicly available. For further information, please contact Federica Rossetti (Federica.Rossetti@sciensano.be) or Milana Trucl (Milana.Trucl@sciensano.be) for more information.

goal is to maximize benefits while limiting potential harms. However, labelling people too early based on genetic risk profiles can have unintended consequences, particularly for societal perceptions and self-image. For example, being classified as 'at risk' person may shift an individual's self-perception from being healthy to being a patient.

Citizens and patients have, on the one hand, the *right not to know* certain health information. On the other hand, there is an increasing expectation and demand for *full access to all our personal health data*, even when it is **not actionable**, which can create anxiety or misinterpretation. For example, if a person live in an area with bad air quality, they might not be able to move that easily. Data gaps across population groups remain a concern, and personalised prevention risks widening inequalities if vulnerable groups are underrepresented in the evidence base.

(Word cloud) **What is needed to implement personalised prevention in Belgium?** (n = 17)

This is the result of the word cloud:


An error to avoid when we say **education** is failing to ask citizens what they want or need to be educated about, and initiatives are often top-down. **Trust** is also often cited as essential, but this should be built through engagement and transparency, to ensure our health care systems are prepared.

In personalised prevention, **clinical utility** is one of the main recommendations. Individuals classified as low risk must truly be at low risk, based on robust evidence and comparison with standards of care (e.g., eligibility for general screening). In practice, risk stratification is inherently uncertain: some low-risk individuals will develop disease, while high risk individuals will not.

There is also a perceived tension between personalised prevention and population based screening. Screening does not aim to detect all cancers, as this would generate excessive false positives. A **balance is needed between population and individual benefits.** Low risks does not necessarily mean risk-free, but offering screening to everyone may lead to over-testing, and exposing low-risk individuals to consequences, such as side effects, unnecessary procedures, or psychological burden. There is a need for careful risk stratification and balanced decision-making.

Communicating low risk is often more challenging than communicating high risk. More information is not always better; communication must be clear, tailored, and focused on actionable points. Risk communication should be iterative and adapted to audience needs. While patients have the right to full information, effective communication prioritises clarity and relevance.

**These reflections suggest that societal readiness for personalised prevention may lag behind clinical or technological readiness. We need more input from citizens.**