

ORIGINAL ARTICLE

Hepatitis B-related stigma among Chinese immigrants living with hepatitis B virus in Australia: A qualitative study

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Abstract

Chinese immigrants in Australia are overrepresented among people with chronic hepatitis B virus (PWCHB) but experience poor access to healthcare. Given the historical discriminatory policies against PWCHB in mainland China, this study aimed to explore the lived experiences of stigma and discrimination surrounding hepatitis B virus (HBV) among Chinese immigrants originally from mainland China. Semi-structured in-depth interviews were conducted by a researcher with a Chinese background in 2019–2020. Sixteen Chinese immigrants living with HBV were recruited across Sydney and Melbourne through advocacy and support groups. This study is positioned in social constructionism. Data analysis was informed by the Health Stigma and Discrimination Framework that highlights the interaction between layered stigmas. This study revealed the historical, social and cultural construction of HBV-related stigma among PWCHB and demonstrated how this stigma was manifested across socioecological levels in China and Australia. Findings show that HBV-related stigma has mostly been driven by knowledge deficits about HBV and fear of HBV infection. HBV-related stigma was mostly demonstrated around social isolation including isolation imposed by family and the community and employment restrictions in the Chinese workplace. In the Australian context, HBV-related stigma was related to the ethnic and cultural background of PWCHB, and primarily occurred as anticipated stigma in the community and in employment. The findings provide significant insights for crosscutting research and policy endeavours to develop and test cross-disciplinary initiatives that more broadly address the complex lived realities of Chinese immigrants living with hepatitis B virus.

KEYWORDS

Australia, Chinese immigrants, chronic hepatitis B, discrimination, hepatitis B-related stigma, hepatitis B virus

1 | INTRODUCTION

Hepatitis B is a potentially life-threatening liver infection caused by the hepatitis B virus (HBV) and can place people at a high

risk of death from cirrhosis and liver cancer (World Health Organization, 2017). HBV is transmitted through exposure to infectious blood, semen and other body fluids. It can be prevented by

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approved vaccinations and treated by suppressive antiviral therapy (World Health Organization, 2017).

Chronic hepatitis B (CHB) is often described within a medical or preventative framework. Currently, there are few studies which have investigated the lived experiences of people with CHB (PWCHB) (Tu et al., 2020; Wallace et al., 2007). This small body of research highlights the social implications of living with HBV among the affected populations (Adjei et al., 2020; Freeland et al., 2021; Stanton et al., 2007; Tu et al., 2020; Wallace et al., 2017; Yu et al., 2016). Moreover, inadequate HBV knowledge among PWCHB, healthcare workers and the general public also hinders diagnosis and treatment (Cohen et al., 2016; Wallace et al., 2011). The challenges faced by PWCHB are compounded by social stigma and discrimination associated with HBV infection (Adjei et al., 2019; Brener et al., 2021; Vedio et al., 2017; Wallace et al., 2007).

As with other infectious diseases, stigma is associated with HBV because of the notion of peril related to fear of contagion (Jones, 1984; Tu et al., 2020; Yang & Wu, 2011). This fear is predominately underpinned by a lack of awareness about HBV (Ellard & Wallace, 2013; Lee et al., 2016). Stigma associated with HBV has detrimental impacts on the health outcomes and well-being of affected population, presenting a barrier to screening, diagnosis and treatment (Cotler et al., 2012; Guirgis et al., 2012).

Epidemiological research and surveillance data show that Chinese immigrants residing in western countries are overrepresented in the groups with CHB but have poor access to healthcare services for CHB (MacLachlan et al., 2020; Vedio et al., 2017). Despite increased research focusing on these population groups (Coronado et al., 2007; Cotler et al., 2012; Li et al., 2012; Vedio et al., 2017), there are few qualitative studies on HBV-related stigma that include Australian Chinese people (Hopwood et al., 2019; Le Gautier et al., 2020; Tu et al., 2020; Wallace et al., 2011).

A key factor to incorporate in studies with Chinese immigrants is the effects of historical structural discrimination against PWCHB prior to 2010 in China. Investigation of government regulations that supported discriminating against people with viral hepatitis showed that regulations introduced between 1987 and 1996 did not define hepatitis A, B, C and D. Yet, restrictions were imposed on people with all types of viral hepatitis in employment and education (Lei et al., 2013). Although the Chinese government initiated steps to eradicate discrimination against PWCHB in employment and education in 2005, discrimination against PWCHB remains a concern (Huang et al., 2016; Leng et al., 2016).

Additionally, for Chinese people in a new country, those living with CHB may be particularly vulnerable to different layers of stigma and discrimination as a result of their migrant status, past trauma, race or lower socioeconomic status (Ellard & Wallace, 2013; Wallace et al., 2007). Given the increased migration of Chinese people to Australia and the high prevalence of CHB in China, a more culturally inclusive response to HBV is needed among this population to improve rates of diagnosis, links to treatment and ongoing care.

Stigma is defined as a 'deeply discrediting attribute' (Goffman, 1963, p. 3). This deviant attribute negatively impacts the self-identity and

What is known about this topic

- HBV-related stigma and discrimination were prevalent during the two decades prior to 2010 in China and were mostly associated with misunderstanding about the transmission of HBV.
- HBV-related stigma has a detrimental impact on the quality of life of people living with HBV including limited employment.

What this paper adds

- HBV-related stigma is mainly demonstrated in social isolation among the Chinese community and discriminatory restrictions in employment in China.
- Chinese immigrants living with HBV expect to be discriminated against when seeking work in Australia.
- Stigmas related to socio-cultural factors such as occupation and socioeconomic status interact with HBV-related stigma among the Chinese community in Australia.

social identity of the possessors, resulting in them being rejected and devalued as 'other'. Goffman theorises that the nature of stigma 'is a special kind of relationship between attribute and stereotype' (p. 4). In this case, the attribute is the primary condition, and the stereotype is the social construction associated with this condition.

The Health Stigma and Discrimination Framework was employed to analyse the data in this study (Stangl et al., 2019). This framework articulates the stigmatisation process in the context of health, including four domains, namely, factors that drive or facilitate health-related stigma, stigma 'marking', stigma manifestations and outcomes of stigmatisation among affected populations, organisations and institutions. This framework addresses pathways leading to stigma at five socio-ecological levels, including individual, interpersonal, community, organisational and public policy. The framework also recognises issues of disempowerment and marginalisation associated with other socioeconomic factors, and how this intersects with health-related stigmas. This framework allowed the current study to explore the complexity of stigma experienced and anticipated, including stigmas related to race, class and occupation that intersected with HBV-related stigma, and illustrated factors that facilitate and mediate the stigma towards PWCHB at different levels (Stangl et al., 2019).

In the light of the paucity of HBV-specific studies, the current study focuses on the lived experiences of HBV-related stigma among the Chinese community residing in Australia. Findings from this study are intended to illicit a wider understanding of the significance and impact of stigma attached to HBV among this community in the Australian context. Ultimately, the study aims to inform multilevel public health responses to improve health outcomes of this population and reduce the burden of HBV within Australia and in other parts of the world.

2 | METHOD

2.1 | Study design and data collection

This study formed part of PhD research exploring HBV-related knowledge and stigma around HBV among the Chinese community living in Sydney and Melbourne, Australia. This study is positioned in social constructionism (Schwandt, 1994). The meaning of the data gathered was built by the perceptions of the researcher, the study participants and the social context. Data collection was conducted between February 2019 and March 2020 and guided by a pilot-tested interview schedule. The semi-structured interview protocol was informed by an extensive scoping review of publications on HBV-related stigma and discrimination in China and a review of literature on HBV-related stigma and discrimination among Chinese immigrants living in other countries (Jin et al., 2021). Key questions were formulated around how participants were diagnosed, their views and understanding about HBV and health and lived experiences related to stigma associated with HBV in family, workplace, community and healthcare settings, experienced or perceived stigma and discrimination in relation to their socioeconomic characteristics in family, workplace, community and healthcare settings (Table 1).

Recruitment criteria included: (1) Chinese immigrants who have an Australian permanent resident visa or Australian citizenship; (2) aged 18 years or over; (3) have resided in Australia for at least six continuous months; (4) came from mainland China or have ancestors from mainland China; (5) lived in Sydney or Melbourne where the largest proportions of Chinese Australians resided (Australian Bureau of Statistics, 2014); (6) could speak Mandarin or English; (7) were living with CHB.

Purposive sampling including snowballing sampling was employed. A total of 16 PWCHB were recruited through advocacy and support groups hosted by two organisations, Hepatitis NSW and Hepatitis Victoria (now LiverWELL). The interviews were conducted over the phone or face to face depending on the preference and location of the participant. Face-to-face interviews occurred in easy-to-access locations, such as community libraries. Individual interviews ranged from 45 to 70 minutes were conducted in Mandarin and English by the first author who was a female bilingual PhD candidate in social science. Written informed consent was obtained from participants prior to each interview and participants were reimbursed with a \$20 voucher for their time. Interview recordings were transcribed into Chinese by a transcription service. The transcriptions were translated into English where necessary by the first author who was an accredited translator. A summary of key findings was returned to participants, giving them the opportunity to respond if any of the information and knowledge was not appropriate to be shared. Field notes and reflections were taken throughout the data collection process. Ethics approval was obtained from the Human Research Ethics Committee, University of New South Wales.

TABLE 1 Interview guide

Understanding of HBV

- a. How do you describe your health in general?
- b. Tell me anything you know about hepatitis B.

Experiences of diagnose

- a. How did you know that you were infected by hepatitis B?
- b. How did you feel about the diagnose?
- c. How would you describe the medical services received at the point of diagnose?

Experiences of HBV-related stigma and discrimination in communities

- a. How do people around you think about your hepatitis B status? (family, friends, colleagues... from the Chinese community and other communities)
- b. What do you think about their understanding of your hepatitis B status?
- c. What's their attitudes towards you as a person living with hepatitis B?
- d. What's their greatest concern in thinking about people around them living with hepatitis B?
- e. What's your greatest concern in relation to hepatitis B when interact with people around you?
- f. What is it like to be a Chinese person living with hepatitis B in Australia?

Experiences of HBV-related stigma and discrimination in healthcare settings

- a. What kind of healthcare have you used? (if no, why not)?
- b. Why did you choose this type of service?
- c. (If used the Western medical service) What is it like to be a Chinese person living with hepatitis B in this medical service?

Responses to HBV-related stigma and discrimination

- a. How do you make the decision when to disclose (or not disclose) your HBV status to your family, friends or colleagues?
- b. (If disclosed) Did any of your relationships change as a result of the disclosure? How did it (they) change?
- c. How did you deal with this change?

2.2 | Data analysis

The transcriptions were imported into NVivo 12 software (QRS International). Data coding was guided by the principles of reflexive thematic analysis (Braun & Clarke, 2019). Utilising the Health Stigma and Discrimination Framework, data were examined as relevant to each of the four dimensions of the framework (drivers and facilitators, stigma 'marking', manifestations and outcomes) at five socio-ecological levels (individual, interpersonal, community, organisational and public policy). Stigmas related to race, class and occupation that intersected with HBV-related stigma were also explored (see Figure S1 for coding tree). The three authors collaboratively examined conceptual consistencies, identified patterns in the data, coded and reflected on the analysis through regular meetings.

3 | RESULTS

All individuals who had signed the consent form participated in interviews, none dropped out. The sample consisted of 16 participants

(12 from Sydney and four from Melbourne) ranging in age from 40 to 75 (the majority were in their 50s and 60s). Participants were predominantly women (11 of 16). Over half (nine) had obtained post-secondary education. All participants were diagnosed with HBV in mainland China or Hong Kong and the time since diagnosis ranged from 5 to 47 years. Fourteen participants were engaged in health-care at the time of being interviewed.

3.1 | Drivers and facilitators of HBV-related stigma

3.1.1 | Knowledge deficit

Participants revealed that they perceived the greatest driver of HBV-related stigma was fear of contagion through contact within family, communities and organisations. This fear was underpinned by a lack of knowledge about HBV, particularly the transmission routes of HBV and the health outcomes of living with HBV, among individuals, family and community members. Participants described similarities between fears associated with HIV/AIDS and HBV due to a similar incurable nature, transmission modes, chronicity and the potentially fatal consequences of these two diseases.

I found that many Chinese people believed that the virus could be transmitted through saliva. And I was afraid of disclosing the disease to my colleagues or friends. If I did so, they would be scared. Many friends have already run away because of this. (P1, female, 69 years, 35 years since diagnosis)

At that time, people felt that hepatitis B was very scary. It was similar to the feeling people had surrounding AIDS. I sensed the fear. That was true. (P6, female, 48 years, 23 years since diagnosis)

3.1.2 | Food customs that value sharing food

Chinese social norms, particularly food traditions, were revealed to be a facilitator of HBV-related stigma. Even decades after migration, most Chinese immigrants still maintain traditional customs associated with Chinese food. In Chinese culture, a meal provides a platform for meaningful interaction among family and the community. Sharing food can bring harmony and closeness to friends, families and relationships (Tian et al., 2018). Hence, being excluded from meals with family or friends leads to feelings of shame and loss of connection. Exclusion from family and social meals was the most frequent form of stigma experienced by participants.

If you tell others [about your HBV status], they might avoid eating with you. This avoidance would be the most critical change in the relationship. The other

aspects [of the relationship] would continue as usual. (P13, female, 59 years, 39 years since diagnosis)

3.1.3 | Discriminatory policies

A history of blatant employment discrimination in China was represented in a number of participants' accounts. A female participant expressed her despair in trying to find employment in the 1990s. She was denied a job as a factory worker because she was found to be HBV positive in the mandatory health examination as part of the recruitment process.

Yes. I wanted to apply for a job, to give it a go. But I was rejected immediately because of this. I felt like a nobody. You understand, don't you? ... This rejection was a strike for me. It was... It occurred at the start of entering the employment market. (P6, female, 48 years, 31 years since diagnosis)

3.2 | Manifestations and outcomes of HBV-related stigma

3.2.1 | Separate self from family

Being 'an HBV carrier' was considered a life-long label, some participants internalised social stereotypes and developed a stigmatised identity (i.e. being inferior, being unhealthy, being different). As a result, low self-esteem and social withdrawal were evident in the accounts of some participants.

I found out that... Why it was me? I was like... I became a member of this category [HBV carriers]. (P6, female, 48 years, 31 years since diagnosis)

With the disease, I always felt that I was inferior to others. Though I often encouraged myself, I thought that I was very unlucky. (P9, female, 61 years, 30 years since diagnosis)

As evidenced by participants' accounts, they perceived the expectation from their family and the community to be cautious and mitigate the risk of passing HBV onto others. In line with this expectation, most participants separated their food and utensils at home even though they were aware that HBV cannot be transmitted this way. These participants expressed concerns about being blamed for putting others at risk. For instance, a participant, who had considerable education about HBV via a community organisation, described her cautious behaviour at home:

Having hepatitis B, definitely, I have been separated from all other family members. You know, I have a

stainless cup, as I mentioned. I use it at home. We can't avoid essential contact in the family. But this cup has not been used by anyone else. (P1, female, 69 years, 35 years since diagnosis)

3.2.2 | Separation by family

The most frequently reported response to HBV diagnosis from participants' family was separating their cutlery to mitigate HBV transmission. A female participant illustrated her feeling of 'being struck' by the reaction of her relatives when she visited.

What struck me the hardest was the experience of visiting my relative and had dinner at her home (in China). My mum (mother's cousin) gave every other guest the same [utensils and food]. She only gave me separate chopsticks and a separate bowl. I had a separate serve for everything I ate. I thought she was like [disrespectful]...to me because she was a nurse [who knew how HBV could be transmitted]. (P9, female, 61 years, 30 years since diagnosis)

While most stigma against participants with CHB in family was represented by separating food and utensils, strict isolation from family occurred for one participant shortly after diagnosis in the 1980s in China.

She [My sister-in-law] said, 'oh, aunt, please don't live with us nor sit next to us. You'd better have a separate dish.' I remember that at that time, my mum asked me to live in a small room. I stayed in that room. Food was delivered to me. That happened many years ago. (P9, female, 61 years, 35 years since diagnosis)

3.2.3 | Reduced prospects of a relationship

Living with HBV also adversely affected new dating opportunities and romantic relationships. Some participants viewed themselves as poor prospects for romantic relationship. A female participant experienced disruption in her relationship and decreased marital satisfaction, which, in the end, led to being rejected by her spouse.

When we got married, I told him that I was HBV positive. I didn't know our baby would carry this [disease]. I didn't know that. I had no idea about that. If I had known, perhaps I would have considered not getting married. Believe me, I really knew nothing about it. (P16, female, 62 years, 40 years since diagnosis)

In the beginning, when our relationship was good, he didn't mind. Later on, he started to care about this [my HBV status]. For example, [he] required me

to use a separate bowl and reduced the frequency of sex because he concerned about catching hepatitis B through it or something like that. (P13, female, 59 years, 39 years since diagnosis)

3.2.4 | Associated with sexual promiscuity

While stigma at the interpersonal level was mainly endorsed by the belief that HBV is contagious and driven by fear of contagion, there was a link between infection and perceived sexual promiscuity. Community members negatively judged individuals with CHB as having casual sexual relationships, which was considered immoral, particularly among the older generation.

People might think that you got the disease because you had casual [sexual] relationships. They would be suspicious; 'How did you get the disease?' If your job is a kind of hostess, they will suspect that you have done something... (P9, female, 61 years, 30 years since diagnosis)

3.2.5 | Reduced employment opportunities

As noted, living with HBV was reported to be an obstacle to employment in China. The most frequently shared stories involving fear of being rejected were around seeking employment in the hospitality industry in China. A participant told of feeling hopeless when she found out about restrictions on employment for PWCHB. As a result, she gave up pursuing her ideal career.

I knew that there was no chance for me. You see, I knew what would happen and I stopped. Didn't apply for jobs in hotels. I was protecting myself. (P9, female, 61 years, 30 years since diagnosis)

Although none of the participants in this study reported experiencing enacted stigma against CHB in an Australian workplace, some participants anticipated rejection when navigating the employment system. This anticipation and corresponding anxiety primarily stemmed from previous experiences of or perceived stigma and discrimination in China, resulting in them limiting their employment choice in Australia.

Once before, I was too worried to apply for a job. That position was a part-time job at a childcare centre [in Sydney]. After several interviews, I was accepted and required to take a medical examination. But I was so scared that I didn't go for it. I gave up the application [for that job]. (P2, female, 55 years, 40 years since diagnosis)

When I considered building a business in Australia, at first, I wanted to open a restaurant. I have experience

running a restaurant for many years in China. But I changed my idea because I was concerned about my health condition. I thought that I might be rejected if a health examination was a must for application [for opening a restaurant business]. Hence, I gave up and bought a cleaning business. (P8, female, 61 years, 35 years since diagnosis)

3.3 | Intersecting stigmas

In the Chinese context, stigmas that interact with HBV-related stigma included those associated with occupation and socioeconomic status. Positions in the hospitality industry, including waiter, chef and people who sell food, were associated with anticipated stigma against PWCHB. Most participants held the belief that these positions involved risk of passing on HBV.

They said that to work in some industries, for example, in hotels or restaurants, people with HBV positive would not be allowed. Even if you were the best candidate, you wouldn't get the chance. I was devastated by these words. (P9, female, 61 years, 30 years since diagnosis)

Participants noted that employees of higher socioeconomic status were unlikely to be discriminated against by their colleagues and friends as severely as people of lower socioeconomic status in the Chinese workplace. A person living with HBV who was a 'team leader' or 'had expertise' was considered less likely to be discriminated against due to their HBV status. A 'super smart' person living with HBV was also described as being rarely rejected from the community. These perceptions demonstrated that the extent of discrimination towards PWCHB was entangled with broader socioeconomic factors.

Interviewer: Did having hepatitis B affect your promotion [in China]? Participant: No, not at all. I think because I was older and had long work experience. I somehow had prestige in the hospital. But now, if it happens to a young guy, he might be heavily discriminated against by the public. They would say, 'Look, that guy has hepatitis B. We should stay away from him. Don't eat with him, don't be close to him.' They all hold these beliefs. (P3, female, 75 years, 29 years since diagnosis)

In the Australian community and healthcare encounters, participants also suffered multilayered stigma including racism due to their migrant status and ethnic background. One participant who had been residing in Australia for over 20 years and had a full-time job revealed her sufferings from the prejudice around her poor English proficiency and Chinese appearance. She felt angry and reluctant to disclose her HBV status to people who

were not family members because of the extreme fear of being stigmatised.

I could not stand it if we were being discriminated against only because we've told others [that we had Hepatitis B]. Therefore, I was reluctant to tell anyone [about this]. Do you understand? I already have a Chinese appearance, and I can't speak perfect English. If I were further discriminated against because of this, it would be too much! (P2, female, 55 years, 40 years since diagnosis)

At Australian public policy level, a key component driving the stigma towards PWCHB perceived by participants included insufficient health resources allocated to prevention and treatment of HBV, low quality of healthcare services and discriminatory regulations against PWCHB in the migration assessment. A participant offered the view that insufficient health resources in Australia had been allocated to tackle HBV because it was considered as a disease with a higher prevalence among the Asian population.

It is reasonable to say that this [hepatitis B] should be given more importance by the government...The prevalence of hepatitis B among local Australians is not too high. It is more common among Asians. There are fewer resources. The service in this regard is also relatively poor. This is my understanding. (P10, male, 53 years, 47 years since diagnosis)

Another participant expressed her anger towards the government's perception that PWCHB pose a burden to public health resources. She insisted that an applicant for permanent residency who might be able to make contributions to the community was devalued because of his HBV status.

I don't think that makes sense. Why? You shouldn't deny people [for permanent resident visa] only because they have this thing [hepatitis B]. You can't dismiss their skills and deny them permanent residency. Do you feel that these people would use your country's resources? If he had money, he would see a doctor and pay from his pocket. (P11, female, 52 years, 20 years since diagnosis)

4 | DISCUSSION

The current study provides a comprehensive understanding of HBV-related stigma across socioecological levels among the Chinese community using the Health Stigma and Discrimination Framework. The study reveals that historical institutional discrimination, Chinese food traditions and eating habits formed a cultural context that

influenced the way Chinese Australians thought about CHB and PWCHB.

In the Australian community, HBV stigma was demonstrated as being related to the ethnic and cultural background of PWCHB. Participants' experience before migration reflected the unique history of legal and economic construction of HBV-related stigma in China. Even though employment and education restrictions for PWCHB have been long repealed in China, historical stigma still had complex impacts on the personal and social life of participants in the host country. A culture of silence around HBV remains in the Chinese Australian community. These findings re-enforced studies on fears and stigma surrounding HBV among Chinese migrants in other western countries (Carabez et al., 2014; Smith-Palmer et al., 2020).

Anticipated stigma was reported more frequently than enacted stigma in the Australian context. As a result, anticipated stigma deterred some participants from disclosing their HBV status and interrupted HBV care. As most CHB is asymptomatic, avoidance of disclosure or selective disclosure (only disclosing to family/close friends) was employed as a strategy to protect themselves from being targeted by stereotyping and rejection. The concealment led to increased stress and anxiety among participants in social interactions.

In this study, stigma related to HBV appears to be mostly driven by knowledge deficits, fear of HBV infection, Chinese social norms and food customs and discriminatory policies rather than moral judgements blaming PWCHB for acquiring and transferring the infection (Jones, 1984). As with previous studies, the Chinese community's concerns were mostly around sharing food and with close daily contact with PWCHB, stigma associated with sexual activity was found to be less common in this study (Hopwood et al., 2019; Lee et al., 2017; Vu et al., 2012; Yoo et al., 2012).

At the community and interpersonal levels, hepatitis B-related stigma was driven by the Chinese social norms and food customs and demonstrated in social exclusion. This stigma led to declining mental health among participants. Sharing a meal is a strategy to establish and strengthen interpersonal bonds in Chinese culture (Li et al., 2012). Chinese culture is family-oriented and family members are expected to take care of each other and provide psychological support (Li et al., 2008). Efforts to protect family from HBV infection considerably increased participants' anxiety and stress. Social bonds are tighter in Chinese social life than in Western culture and a social sharing concept guides most personal interaction among the Chinese community (Kaynak, 2013). Being discredited, the experiences of reduced social status and weakened social ties resulting from HBV-related stigma become inseparable from feelings of overwhelming shame, humiliation and hopelessness (Kaynak, 2013). To avoid social isolation, a number of PWCHB in this sample reported concealing their HBV status and this may lead to a delay in screening and vaccination among their close contacts who were at high risk of HBV (Li et al., 2012).

At the organisational level, concerns related to employment, including disclosure of their HBV status for work purposes and

restrictions on employment opportunities, were raised by participants in both the Chinese and Australian contexts. Employment discrimination experienced in China limited employment choices and caused potential loss of income and poor career advancement. This evidence was consistent with the research conducted in China (Han et al., 2018; Wallace et al., 2015). This current study demonstrated that in the Australian employment environment, stigma was experienced as anticipated discriminatory restrictions for PWCHB. These findings have not been documented elsewhere.

At the public policy level, in the Chinese context, participants experienced rejection and limited choice in employment. Stigmas related to socio-cultural factors interacted with HBV-related stigma and discrimination (i.e. social status, occupation) making PWCHB more vulnerable. In the Australian context, similar to previous findings (Tu et al., 2020; Wallace et al., 2019), participants' perceived stigma around HBV at the public policy level was revealed to be interconnected with their migrant status and cultural background. PWCHB could be denied a permanent visa if they failed the health assessment required by the Department of Home Affairs (Riches et al., 2020). Fear of disclosure, fear of HBV-related stigma and multilayered discrimination (i.e. racism), combined with misconceptions about HBV, limited health literacy and poor English language proficiency reduced engagement in clinical management of CHB among participants. As a result of the stigma related to HBV and its interaction with other layered stigmas, positive health and well-being outcomes, economic opportunities, the prospects of intimate relationships and community engagement of the participants were limited. These findings are consistent with studies conducted in Australia and other countries (Ellard & Wallace, 2013; Le Gautier et al., 2020; Li et al., 2012).

4.1 | Strengths and limitations

This study has numerous strengths. Firstly, the first author who conducted the interviews was of Chinese background. The language and cultural concordance between the interviewer and participants allowed for the establishment of excellent rapport, and also encouraged the participation of people with limited English proficiency. Offering phone interviews as well as face to face allowed participation of geographically distant participants or those who preferred to discuss their experiences over the phone because of concerns of being identified as living with HBV.

Nonetheless, several limitations may have influenced the findings of this study. Partly due to the disruption of COVID-19, it was difficult to recruit PWCHB into the study. All participants were first-generation immigrants above 40 years old and were diagnosed with HBV outside of Australia. Hence, the study failed to capture the experiences of the second-generation and younger immigrants. Two-thirds of participants had moved to Australia when the stigmatisation against PWCHB was rampant in China, and their experiences in China do not reflect the changed social context due to the more recent implementation of anti-discriminatory policies.

4.2 | Implications for future research and HBV response

This study has several implications for future research, public health interventions and building a more comprehensive response to HBV infection. Stigma can be combated through educational messages on HBV infection among PWCHB and the broader community (Mokaya et al., 2018). As illustrated in some participants' accounts, attitudes may change when individuals gain proper knowledge about HBV prevention, testing, treatment and monitoring (Li et al., 2012). It should be noted that only a few participants were aware of the availability of relevant information and support in Australia (i.e., services provided by community-based organisations). Hence, engaging with PWCHB, including using resources and raising the visibility of HBV, is likely to improve treatment uptake and reduce mortality from HBV-related liver cancer. To effectively reach this population, the healthcare workforce could enhance coordination with community organisations that support this population (Wallace et al., 2019; Wallace et al., 2020).

The present study explored interactions between HBV-related stigma and stigmas associated with social status, occupation, migration status, ethnicity and English proficiency. Strategies to address HBV-related stigma should take account of these intersecting stigmas. This approach to stigma reduction requires that sufficient resources are developed to respond to the needs of PWCHB, clinicians, educators and policy makers (Bailey et al., 2011). To change regulatory and policy barriers that affect this populations' health-seeking behaviours and their broader quality of life, the insights of PWCHB should be included in designing interventions and policies targeting this population and aim to reduce the social, health and economic burden of HBV.

AUTHORS CONTRIBUTIONS

The study was designed by Defeng Jin with the supervision from Carla Treloar and Loren Brener. The interview guide was developed by Defeng Jin and agreement was achieved through discussion with Carla Treloar and Loren Brener. Defeng Jin conducted data collection and initial analysis, with Carla Treloar and Loren Brener examining the qualitative coding and Carla Treloar suggesting the framework and concept for analysis. Preparation of the manuscript was undertaken by Defeng Jin, with considerable input from all authors.

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CONFLICT OF INTEREST

No potential conflict of interest was reported by the authors.

DATA AVAILABILITY STATEMENT

The data are not available due to privacy or ethical restrictions.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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