Improving access to health care for chronic hepatitis B among migrant Chinese populations: A systematic mixed methods review of barriers and enablers

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Summary
Migrant Chinese populations in Western countries have a high prevalence of chronic hepatitis B but often experience poor access to health care and late diagnosis. This systematic review aimed to identify obstacles and supports to timely and appropriate health service use among these populations. Systematic searches resulted in 48 relevant studies published between 1996 and 2015. Data extraction and synthesis were informed by models of healthcare access that highlight the interplay of patient, provider and health system factors. There was strong consistent evidence of low levels of knowledge among patients and community members; but interventions that were primarily focused on increasing knowledge had only modest positive effects on testing and/or vaccination. There was strong consistent evidence that Chinese migrants tend to misunderstand the need for health care for hepatitis B and have low satisfaction with services. Stigma was consistently associated with hepatitis B, and there was weak but consistent evidence of stigma acting as a barrier to care. However, available evidence on the effects of providing culturally appropriate services for hepatitis B on increasing uptake is limited. There was strong consistent evidence that health professionals miss opportunities for testing and vaccination. Practitioner education interventions may be important, but evidence of effectiveness is limited. A simple prompt in patient records for primary care physicians improved the uptake of testing, and a dedicated service increased targeted vaccination coverage for newborns. Further development and more rigorous evaluation of more holistic approaches that address patient, provider and system obstacles are needed.

KEYWORDS
access to health care, barriers, Chinese population, hepatitis B

1 | INTRODUCTION

Hepatitis B is a highly transmissible viral infection with global distribution. Epidemiological studies show that a third of the world’s population currently has, or has had, hepatitis B infection. The infection is particularly prevalent in areas of East Asia such as China, Taiwan, Singapore, Malaysia and South-East Asia such as Korea, Vietnam, Cambodia and Laos.1 In recent decades, there has been a considerable increase in global migration including movement of persons of Chinese ethnicity from East Asia to countries with low prevalence for the disease, such as North America, Europe and Australia. Groups of migrants from these countries where hepatitis B is endemic have
similar prevalence to their country of origin.2–4 There is evidence that Chinese persons in the UK experience greater mortality rate than the background population from liver cancer5 and that they endure reduced access to healthcare services for chronic hepatitis B (CHB).6–8 This is a growing public health issue for receiving countries, and there is need for better disease surveillance and testing of high-risk migrant groups as well as effective follow-up to ensure infected persons access appropriate health care and their close contacts are appropriately protected, an issue recognized in national policies.9,10

Poor access to healthcare services among migrant and other marginalized groups is increasingly recognized as a complex, multifaceted issue. Recent frameworks usefully emphasize the interactive and recursive nature of healthcare access, highlighting the need to understand the interplay between patients, providers and the services on offer.11,12 To date, these perspectives have not been used to synthesize the growing body of research that examines hepatitis B among migrant Chinese populations. Several past reviews have addressed particular populations or interventions, but none have employed systematic methods nor provided a comprehensive synthesis that can be applicable in different contexts.13–15 The current study adds to our understanding of the barriers and enablers of access to hepatitis B testing and healthcare access for Chinese migrants in Western societies through a systematic and theory-informed evidence synthesis.

2 | MATERIALS AND METHODS

2.1 | A systematic mixed method review

This review adopted a systematic mixed methods approach to identify and integrate relevant evidence from the widest range of primary studies.16

2.2 | Search strategy

We used a search strategy that aimed to be inclusive by using expanded search terms and by searching both in biomedical databases (Medline, Embase, CINAHL, PsycINFO) and in social sciences databases (ASSIA, Web of Science). We adopted this broad approach to ensure we captured all relevant publications. The search terms were grouped into three areas: the population of interest, healthcare access and experiences, and hepatitis B and are delineated in Table 1.

2.3 | Inclusion/exclusion criteria

An initial screen undertaken by three of the authors (AL, AV and SS) involved a review of the title and/or the abstract, and studies were retained if they focused on (i) individuals identified as Chinese and/or Far East Asian ethnicity living in Europe, North America or Australia/New Zealand and on (ii) health care (including testing and vaccination) for hepatitis B. Publications that took a purely epidemiological or pathological approach, without investigating factors affecting healthcare access, were excluded, and inclusion and exclusion conflicts were discussed and consensus reached. A second sifting stage involved full-text review for “richness” and retained only those studies judged to provide sufficient data on influences on healthcare access. Following an initial recommendation for inclusion/exclusion by a senior reviewer, a team of three reviewers agreed the final set of included studies. A methodological quality checklist that combined both generic indicators16 and indicators of quality for research on ethnicity and health17 was used. However, as the volume of studies was low, we chose not to exclude on the basis of quality, but rather to moderate the contribution of papers that were of low methodological quality to the final conclusions drawn from the synthesis. Reference lists of included papers identified were then scanned and potentially relevant papers subjected to the same sifting process as described above.

2.4 | Data extraction and synthesis

An extraction template was developed and refined iteratively by three members of the research team drawing on access to care frameworks11,12 and initial reading of a subset of included papers. Papers were categorized by methodology for analysis: qualitative papers were examined by an anthropologist (EL); quantitative studies by a physician researcher (AV); and interventional studies by a social scientist (SS). NVivo® was used to code and retrieve material from the qualitative papers, while a template was prepared in a MS Excel® spreadsheet to support the retrieval of relevant information from the quantitative and interventional studies. Extraction codes related to areas influencing individuals’ choice and identification of need for healthcare (ie community and family support, health beliefs), health services accessibility and adjudication of perceived need for care (ie practitioners attitudes, knowledge and practice) and wider determinants (ie socioeconomic barriers, policy, institutional factors). Synthesized memos were prepared initially for each set of studies to correctly classify the studies, their context and the clarity and strength of the evidence of each study. Next, evidence was integrated across the methodologies through discussion and consensus in research meetings. Finally, a series of statements was developed to summarize the available evidence in terms of its strength and consistency (approach adapted from McLean et al.18 as described in Table 2).

| TABLE 1 | Search strategy terms |
|----------|------------------------|
| Criteria | Terms included |
| Population | “Chinese,” “Asian continental ancestry group,” “Asian Ancestry,” “Far East Asian,” “Korean,” “Taiwan or Taiwanese,” “Malaysia or Malaysian,” “Asian,” “East Asian,” “Singapore” |
| Healthcare access | “Barriers,” “Access to Health Care” (or health care), “Health services accessibility,” “Healthcare disparities,” “Patient acceptance of health care,” “Health Knowledge, Attitudes, Practice” or “barrier$ to health,” “Health behaviour” or “Attitude to health” |
| Hepatitis B | “Hepatitis B, Chronic,” “Hepatitis B,” “HBV” or “Hepatitis B Virus” |
TABLE 2 Definitions edited for the evidence statements (Table 4)

| Category                        | Definition                                                                 |
|---------------------------------|---------------------------------------------------------------------------|
| Strong consistent evidence      | Studies pointing in the same direction (for or against) with a pattern of statistical significance |
| Strong equivocal evidence       | Studies with statistical significance shared between for and against positive and negative effects |
| Weak consistent evidence        | Studies pointing towards a general trend without statistical significance |
| Weak equivocal evidence         | Studies divided between for and against without statistical significance  |
| Indicative evidence             | Studies suggesting that a factor may be important (ie result from single study) |
| Confounded evidence             | Studies include factor but have not been designed to isolate its importance |

3 | RESULTS

3.1 | Study characteristics

The initial search found 347 publications of which 111 were deemed relevant after abstract screening, and 48 were selected after richness and methodological appraisal (Figure 1). Table 3 provides an overview of the 48 studies included, together with descriptions of their geographical setting, study design, objectives, populations and sample sizes. Nineteen cross-sectional surveys described knowledge levels and other factors hypothesized to influence healthcare usage and health behaviours related to HBV, as well as reasons for (non-) testing or (non-) vaccination. The different studies employed diverse measurement approaches, reflecting a lack of validated instruments, which made findings difficult to compare. Two recent cross-sectional studies recruited patients with hepatitis B and enquired about rates of contact tracing of relatives and potential factors affecting treatment uptake. Seven qualitative studies explored reasons for (non-) testing, (non-) vaccination or treatment adherence, as well as underlying meanings, processes or values related to the disease. Twenty-two interventional studies sought to either describe, or evaluate the effectiveness of, interventions. Although the evaluations were likely to provide the most robust evidence, their study designs were frequently weak which compromised the strength of the evidence generated.

A few studies took a holistic approach, aiming to examine the interplay between populations and healthcare system actors, but the majority focused solely on patients or members of the public of Chinese or East Asian ethnicity. Among the interventional studies, seven papers referred to multi-component interventions addressing purported obstacles at both the community and healthcare level. Four referred to lay health worker interventions, six referred to lay health worker interventions, and two reported on narrower health education interventions and two reported on interventions that involved modifications to the healthcare delivery alone.

The uptake of HBV testing was the most frequently studied outcome (14 quantitative papers and six interventional papers), Few papers looked at vaccination uptake (one survey and two interventions), or the receipt of care/treatment by HBV-infected individuals (three surveys and one qualitative paper). Several papers examined more than one healthcare outcome, particularly those focused on multi-component interventions and the qualitative papers.

Theoretical frameworks were infrequently used to inform collection or analysis of data in the quantitative studies. The frameworks used in studies included the “Health Belief Model”, “Health Behaviour Framework” and the “Sociocultural Health Behaviour Model” derived by the G. Ma was applied to elucidate factors associated with never having been screened for HBV.

3.2 | Evidence statements (Table 4)

3.2.1 | There is strong consistent evidence of low knowledge and awareness of CHB among Chinese populations

Examination of knowledge levels, awareness and misconceptions held by individuals within the target populations found common misconceptions regarding transmission routes, participants erroneously identifying sharing food and utensils as a route of infection. Transmission by sexual intercourse was correctly identified by 50%-66% of survey respondents and 80% of patients with CHB. Knowledge of hepatitis B mother-to-child transmission at birth was recognized correctly by 70%-91% of respondents and 85% of patients with hepatitis. One-third to two-thirds were unaware that HBV is more common in China or among Chinese immigrants than among other populations. While 89% of Chinese American respondents thought HBV would be harmful if they contracted it, only 33% believed that they were at risk. Respondents were unlikely to perceive themselves as being at risk of infection if they had been resident in the UK for a long period. Misconceptions about causal factors were reported including: harmful food (fried foods or contaminated foods), alcohol, contact with infected individuals, stress and inadequate rest. Among patients with CHB, a third of treated and 40% of untreated patients believed lifestyle changes and diet can be sufficient to manage the infection.

3.2.2 | There is weak equivocal evidence that levels of knowledge are associated with receipt of HBV testing and vaccination

Studies that examined the association between knowledge levels and HBV testing, or with both testing and vaccination, reported a positive association with previous testing for HBV and knowledge scores. The strength of association observed was between OR 1.15 and 4.8 as measured with different instruments.
have HBV” (OR=1.9), “individuals with HBV can be infected for life” (OR=1.7) and “HBV causes liver cancer” (OR=2.0)45—and the answers to two knowledge questions—reporting that the disease was serious (OR=1.3) and that it caused harm (OR=3.9)39—were all positively associated with having been tested. In the latter, there was no significant association with having been vaccinated in the logistic regression analysis.39 A knowledge score (based on 11 statements with possible answers yes/no/unsure) was not significantly higher among China-born respondents who had been tested for HBV, but was significantly higher among those that had been vaccinated, although there was no significant association between current knowledge and prior testing or vaccination among their Vietnam-born respondents.47

3.2.3 There is weak, consistent evidence that interventions focused on improving knowledge about HBV (without action on other barriers) result in only modest increases in uptake of screening and vaccination

Poor knowledge levels about the disease among the target populations have previously been addressed by designing and delivering educational material in linguistically and culturally tailored ways such as lay health workers, using community venues and through mass media and English language classes. Most studies reported an increase in knowledge levels post-intervention, but this was not necessarily sustained over time and some misconceptions appeared difficult to shift.30-32,62 Importantly, several interventions that achieved an increase in knowledge did not achieve similar increases in uptake of testing or vaccination.25,35,69 A study from Texas, USA reported significant increases in knowledge among two intervention arms for raising knowledge and awareness among parents (coupled with improved access to low-cost services). However, despite a significant increase in child vaccination rates, these remained below 40% in both intervention groups.25 A few studies evaluated a Lay Health Worker model involving educational and motivational dimensions in different contexts.29-31,62 They found significant increases in mean knowledge scores and self-reported testing, but concluded that effect sizes on testing were small for the resources needed and that poor knowledge may not be the key factor restricting testing. One randomized trial found self-reported testing at six months was significantly different between control groups (6%) and intervention groups (18%).63 Taylor delivered an educational intervention in ESL classes67,68 and similarly found that increased knowledge was accompanied by a weak effect on testing uptake (with just 6% of intervention participants reporting testing at follow-up).35

3.2.4 There is consistent evidence that stigma around hepatitis B exists, but interventions to address stigma, also addressed other factors thus confounding the evidence on its relevance as a barrier to care

The importance of stigma as an obstacle to HBV healthcare access shows variable results. In a UK study, HBV-related stigma did not show a consistent picture across their ethnically diverse sample of UK respondents and there were no findings specific to Chinese participants.52 Nevertheless, some participants did report a fear of infection among community members and felt that this could lead to anxiety around eating together and the sharing of utensils.

Two non-UK qualitative studies identified stigma and the fear of disclosure as potentially adversely impacting on access to care as it made it more difficult for patients to keep their disease status secret.52,57 Fear of rejection or stigma at a personal and community level also restricted CHB patients from disclosing their status to family and friends as it could lead to exclusion from family and social life in some communities. The stigma seems to arise from a belief that “the way to avoid disease is exclusion.”52

One study addressing stigma found that the “fear of contagion” stigma was most prevalent; 62% of respondents believed that “infected individuals should avoid close contact with others such as kissing and hugging.”48 Stigma associated with the “fear of contagion,” “negative perception” and “workplace/school stigma” was lower and knowledge levels were higher in people who reported having a relative with hepatitis B.48

In one Canadian study, a third of participants with hepatitis B, the majority of whom had secondary education and had resided in Canada for over 10 years, were not ashamed and were willing to inform others of their condition. Persons who had resided in Canada for <10 years were less likely to inform others.52 Markers of stigma were also less common among people with poor knowledge of hepatitis B; for example, “fear of getting a bad test result, embarrassment/shame” was not associated with never having been tested.45 In contrast, a previous study, Ma et al. (2010) reported that “the fear of a bad test” and “embarrassment or shame” were negatively associated with testing status.44

Exploration of the role of social support, and particularly family-level support, found that testing was more common among those who had discussed it with their spouse 39 and among those who reported that a family member had suggested it, but less common among those that had not discussed hepatitis B with a partner or family member.40 However, the direction of the association could not be ascertained and reverse causality could not be excluded from these cross-sectional studies.

Several of the studies of multi-component interventions aimed to address stigma via both individual communication and community-wide efforts, eg mass media, using celebrities, community awareness events held at churches and engagement of community leaders. For example, an intervention for Korean Americans included activity in churches aimed at challenging community-level stigma including messages that emphasized the benefits of being tested for HBV, that such action is the responsible thing to do, and these aimed to challenge the embarrassment or shame associated with HBV infection.24

However, detailed description of how these were implemented was not provided in the publications and none explicitly reported on any shifts in attitudes or behaviours to suggest reductions in levels of stigma. None of these studies attempted to isolate the effect of reducing stigma on uptake of testing, vaccination or treatment for HBV.
3.2.5 | There is consistent evidence that migrant Chinese populations have low engagement and satisfaction with local health systems

Financial barriers to hepatitis care were reported in several of the US-based qualitative studies. The financial barriers included lack of health insurance and difficulty in getting such insurance. Chinese and Korean participants could not afford screening tests and the practitioners reported being somewhat reluctant to test for and diagnose HBV because of anticipated problems with the affordability of care. However, in a survey study of patients with CHB not receiving treatment, affordability of treatment was seen as possible below certain monthly expenditure and this exceeded the actual out-of-pocket expenditure of treated patients. In the survey studies, there were mixed findings in relation to the association between general socioeconomic factors (such as employment, income and education) and screening status. Individuals without health insurance were less likely than those with insurance to have been tested, but household income was not associated with testing status.

Not having a regular family physician was also found to be negatively associated with prior screening. Similarly, a positive correlation (OR: 10.5) was found between prior HBV vaccination and having a primary care physician. A UK study reported that some immigrants do not register with primary health care. In addition, other structural issues identified included limited consultation availability, long working hours, restrictions on the use of some healthcare services by immigrants, potentially affecting their engagement with HBV screening. Chinese participants who reported not having less time or transportation were less likely to have been tested for HBV.

Language and communication difficulties were also identified as barriers to engagement with primary care-based screening and treatment for Chinese patients in the UK. This mirrors similar findings from non-US qualitative studies elsewhere. Some of the survey studies found that those who needed an interpreter during doctor visits were less likely to have been tested, while not speaking the physician’s language was negatively associated with prior HBV vaccination. Some immigrants have low levels of trust and confidence in UK general practice-based care that has been attributed to rushed appointments and delays in receiving treatment. Key informants felt that a screening invitation letter might be ignored by some expecting to be contacted again if the screening was important and others fearing the knock-on implications in terms of further tests or treatment. A lack of preventive healthcare seeking was highlighted, as well as the acceptance of poor health and a lack of familiarity with the healthcare system that contributed to low levels of health service engagement.

The use of complementary and alternative medicine (CAM) by Chinese immigrants was another factor that was identified as undermining positive patient-provider interactions and potentially affecting appropriate HBV care. There was evidence that patients turn to CAM when told that hepatitis B is not curable with biomedicine. In addition, practitioners have mixed attitudes towards CAM and some practitioners suspect their nonacceptance of CAM could turn patients away.

Misunderstandings about HBV-related health care were further potential barriers to uptake. In the UK, healthcare providers identified adherence to treatment among some chronic hepatitis B immigrant patients to be poor and that this was because patients may not fully appreciate the value of monitoring or taking medication if they felt well. Studies from the USA also found misunderstandings regarding testing: Korean groups did not understand the significance of screening prior to vaccination and participants did not understand test results, others were unclear about vaccination including fears of side effects and failed to recognize vaccination as a primary means of prevention. Reasons given by participants for not having been tested in some of the survey studies also suggested a lack of understanding regarding HBV infection and testing. The “lack of knowledge” and “feeling well” were commonly reported reasons for not being screened. Among patients with CHB, many were concerned about the potential side effects of treatment such as kidney damage and bone thinning.

3.2.6 | There is confounded evidence that the provision of free or low-cost services that are culturally appropriate and geographically and temporally accessible is effective in increasing uptake of HBV screening, vaccination and treatment

Some interventional studies recognized structural obstacles and included modifications to the cost, availability and/or cultural appropriateness of HBV healthcare services. The multi-component interventions tended to address several factors at once including: free or low-cost testing and vaccination, provision of additional community-based sites for testing and vaccination, flexible opening times, and the involvement of bilingual or multilingual healthcare practitioners or support staff. It was not possible from these studies to ascertain the individual contribution of each intervention component.

Studies that evaluated these multi-component interventions concluded that the provision of free services was important. For instance, 48% of those tested for HBV through the Jade Ribbon Campaign in San Francisco said that they would not have been tested if it had not been free, and 88% of those newly identified with HBV infection were insured in BeFreeNYC. There were also several studies that evaluated simpler interventions involving training and deployment of Lay Health Workers to help community members navigate the health services, and provide support and education to them in their homes. These studies reported significant increases in self-reported testing, although levels remained low (6% of the intervention group for Chinese in 2009; 22% of the intervention group for Cambodians in 2013; 24% of the intervention group for Hmong in 2013), and the authors concluded that increases were small for the resources expended.
3.2.7 | There is strong, consistent evidence that healthcare providers miss opportunities during routine healthcare encounters to refer Chinese immigrant individuals for screening and follow-up for HBV

The role of healthcare practitioners, particularly family physicians, was explored in several studies as a potential barrier or support to testing, vaccination and treatment access. Several of the US papers noted that physicians in the USA commonly fail to adhere to CDC recommendations that individuals of Chinese/Far East Asian origin should be routinely tested for HBV.

Opportunities for testing and vaccination of Chinese immigrants within routine healthcare encounters are frequently missed in receiving country settings. In one study, only a third of 393 practitioners surveyed reported that they screen all new Asian patients for HBV, regardless of risk factors or symptoms, while two-thirds reported that they would screen some of their new Asian patients for CHB, but that this was dependent on the presence of risk factors in these patients. The reasons given for not testing were primarily the cost of tests, physician considerations and patient resistance. In an Australian study, 70% of the Chinese respondents who had been vaccinated had received it in their country of origin. Similarly, those who had lived a shorter proportion of their life in North America were significantly more likely to have had HBV testing which may reflect greater HBV prevention efforts in Asia than in North America.

A common theme in focus group discussions was adherence to the doctors’ recommendations, both in relation to other medical matters and in relation to HBV testing and vaccination. Despite the fact that the majority of participants had healthcare providers who were conversant in Chinese, most reported no discussion of hepatitis B with their providers. There was a positive association between reported prior HBV screening and reports that the doctor had suggested being tested or vaccination. The study found that greater proactive participation by the health service model. A US study used a controlled trial design to assess the effect of an electronic health record prompt sent to primary care physicians 24 hours before a scheduled appointment with a patient with a Chinese surname. The prompt included CDC recommendations for HBV testing in at-risk Asian populations, information about HBV prevalence and laboratory tests for HBV screening and also a link to facilitate the ordering of tests. The study found that among patients in the intervention arm, 41% received an order for, and 34% completed, an HBV test, compared to 1.1% and 0% in the control (care as usual) arm (P<.001).

3.2.9 | One dedicated service for immunization of newborn babies to hepatitis B-infected mothers shows improvement in vaccination coverage in the UK

One intervention implemented in London, UK, provided a dedicated centralized immunization service aimed at increasing immunization coverage among babies born between 1992 and 1996 to hepatitis B-positive mothers (a small proportion of whom were identified as “Oriental”). The setting is an inner city area, with high proportion of immigrants from high prevalence countries and high mobility. In the UK, only targeted immunization of babies is available through primary care. The study found that greater proactivity on the part of the health service, to contact mothers whose babies remain unimmunized and to provide flexible opportunities for completion of hepatitis B immunization course, was effective at improving coverage in comparison with a similar neighbouring area.

3.2.10 | There is confounded evidence that education of healthcare practitioners is effective in increasing uptake of HBV screening, vaccination and treatment

Three survey papers examined practitioner knowledge. In one US study, most primary care physicians (83%) who knew that CHB was a serious condition were aware that the disease was prevalent in the Asian-American population. However, more than half (62%) were unfamiliar with the major treatment guidelines. Of two US studies, in an area with a high Chinese population density, one showed that as much as 30% of providers could not identify the correct test for HBV screening despite the fact that all of the respondents knew that Chinese immigrants had a higher prevalence of chronic HBV than non-Hispanic Whites or US-born Chinese people. The study also found that providers who spoke an Asian language and had greater knowledge of HBV were more likely to report that they would screen their patients for HBV. Another study that explored knowledge in hospital physicians by graded seniority, reported that only 24% could identify the appropriate serological tests, 41% could identify all the modes of transmission and 56% did not know they are mandated to report positive tests, correct responses were marginally higher in senior residents and physicians of Asian ethnicity (Chao et al 2015). Care may also be suboptimal for patients with the hepatitis B virus. A qualitative study found that little information about hepatitis B and its impact was given to participants at the point of diagnosis, and people with CHB had a poor understanding of their infection and had reservations regarding the capability of health professionals to respond effectively to their CHB queries.
| Authors | Location | Aim/focus | Research method | Setting | Participants |
|---------|----------|-----------|-----------------|---------|--------------|
| Cheung et al. (2005)\(^{54,60}\) | Vancouver, Canada | To determine level of concern, awareness and knowledge of HBV and associated factors | Cross-sectional survey | Community, via Asian commercial centres | Chinese and South-East Asians (993); born in China (310), Hong Kong (431), Taiwan (97), Vietnam (22), Other Asia (67), N America (57) |
| Hislop et al. (2007\(^{41}\), see Tu et al. 2009) | Vancouver, Canada | Exploration of factors associated with testing for HBV | Cross-sectional survey | Community, via telephone records | Chinese Canadians (504) |
| Li et al. (2012)\(^{46}\) | Toronto, Canada | Exploration of factors associated with testing for HBV; to determine whether stigma acts as a barrier | Cross-sectional survey | Community (ESL classes) and health clinic | Self-identified Chinese (343) |
| Thompson et al. (2003)\(^{38}\) | Vancouver, Canada | Exploration of factors associated with knowledge about HBV and with testing for HBV | Cross-sectional survey | Community, via Chinese surnames in telephone book in areas with high concentration of Chinese residents | Chinese-Canadian women (n: 147) |
| Tu et al. (2009;\(^{42}\) findings also published for USA and Canada separately: Coronado et al., 2007; Hislop et al., 2007) | Vancouver in Canada, Seattle in USA | Exploration of factors associated with testing for HBV; comparison between USA and Canada | Cross-sectional survey | Community, via telephone records | Chinese Americans (430) and Chinese Canadians (533) |
| Vu et al. (2012)\(^{47}\) | Brisbane, Australia | Exploration of factors associated with testing and vaccination for HBV | Cross-sectional survey | Community, via community organizations and events | Chinese (442) and Vietnamese (433) |
| Wu et al. (2009)\(^{51}\) | Toronto, Canada | Investigation of barriers to care for CHB | Cross-sectional survey | Health service, via primary care physician visits | Chinese Canadians with CHB (204) |

**Quantitative**

**Free at point of access**

| Authors | Location | Aim/focus | Research method | Setting | Participants |
|---------|----------|-----------|-----------------|---------|--------------|
| Chao et al. (2015)\(^{39}\) | California, USA | To investigate physicians' knowledge of chronic hepatitis B diagnosis, screening and management in various stages of their training. | Cross-sectional survey | Health service | Interns (63), 2nd year residents (60), chief residents (26), attending physicians (70) |
| Coronado et al. (2007) | Seattle, USA | Exploration of factors associated with testing for HBV | Cross-sectional survey | Community, via telephone records | Asian Americans (with Chinese surnames) men and women (442) |
| Cotler et al. (2012)\(^{48}\) | Chicago, USA | Assessment of stigma and validation of stigma measurement instrument | Cross-sectional survey | Community | Chinese immigrants (201) |
| Lai et al. (2007)\(^{48}\) | San Francisco, USA | Exploration of knowledge and practice among practitioners | Cross-sectional survey | Health service serving high number of Chinese patients | Providers: residents, fellows, nurses (91) |
| Ma et al. (2006)\(^{39}\) | New York City, USA | Exploration of factors associated with testing and vaccination for HBV | Cross-sectional survey | Community, via community organizations in disadvantaged area | Chinese Americans (429) |
| Ma et al. (2010)\(^{44}\) | Philadelphia, New Jersey, New York City, USA | Exploration of factors associated with testing for HBV | Cross-sectional survey | Community, via community organizations | Asian Americans (1,603); Chinese (718), Korean (289), Vietnamese (305) and Cambodians (291) |
| Ma et al. 2012\(^{45}\) (same study as Ma, 2010) | Philadelphia, New Jersey, New York City, USA | Exploration of factors associated with testing for HBV | Cross-sectional survey | Community, via community organizations | Asian Americans, adults (1,312); Chinese (718), Korean (289), Vietnamese (305) [Cambodians not included] |

(Continues)
| Authors | Location | Aim/focus | Research method | Setting | Participants |
|---------|----------|-----------|----------------|---------|--------------|
| Ma et al. 2015<sup>49</sup> (same study as Ma 2010, and Ma 2011) | Philadelphia, New Jersey, New York City, USA | Prediction of non-testing using sociocultural health behaviour model | Cross-sectional survey | Community | Chinese (718) |
| Nishimura et al. (2012)<sup>10</sup> | San Francisco, USA | Exploration of risk factors, knowledge and preventive behaviours | Cross-sectional survey | Persons reported by laboratories as HBV+ to health department | People with hepatitis B (829, Chinese 609) |
| Tanaka et al. 2013<sup>18</sup> (Baseline survey of trial participants reported in Hsu et al., 2007) | Washington DC, USA | Exploration of factors associated with testing for HBV and sources of knowledge | Cross-sectional survey | Community via various venues | Asian Americans (877); Chinese (303), Korean (294), Vietnamese (280) |
| Tokes et al. (2014)<sup>20</sup> | New York City, New Jersey, San Francisco, Los Angeles, USA | To explore perceptions and attitudes of CHB treatment among patients infected with HBV | Cross-sectional survey | Health service | Chinese (90), Korean (77), and Vietnamese (85) |
| Vijayan et al. (2015)<sup>19</sup> | USA | To assess the extent of screening family members of Asian patients with known HBV infection, and patient knowledge of disease | Cross-sectional survey | Health service | 58 Asian Americans including 32 Chinese |

**Qualitative**

Free at point of access

| Authors | Location | Aim/focus | Research method | Setting | Participants |
|---------|----------|-----------|----------------|---------|--------------|
| Chen et al. (2006)<sup>33</sup> | Vancouver in Canada, Seattle in USA | To learn about HB prevention, behaviour, knowledge, beliefs and perceptions of HBV screening and vaccination | Individual semi-structured interviews (40) and focus group discussions (8) | Community | North American Chinese, 18-64 y (total of 111 across interviews and groups) |
| Wallace et al. (2011)<sup>12</sup> | Victoria, New South Wales and South Australia | To record how people with CHB respond to their infection and inform better public health response to HBV in Australia | Semi-structured interviews with CHB patients (20) and focus group discussions with community and health workers (4) | Hospital | People with CHB (20) including 5 born in China and 6 born in Vietnam; and community health workers (40) |
| Sweeney et al. (2015)<sup>15</sup> | London, Bradford, UK | Exploration of knowledge, perceptions and folk models of hepatitis B and C among immigrant communities and lay and professional perspectives on a proposed model of targeted screening and treatment. | Semi-structured interviews and focus group discussions | Community and health service | Key informants (17, of whom 3 identified as Chinese); community members: Chinese (12), Pakistani (35), Roma (15), Somali (16), African (17); general practitioners (6) |

**Qualitative**

Fee for service health system

| Authors | Location | Aim/focus | Research method | Setting | Participants |
|---------|----------|-----------|----------------|---------|--------------|
| Chang et al. (2008)<sup>14</sup> | San Francisco Bay, USA | To identify motivation for and deterrents from taking preventive action against CHB and liver cancer, and spreading awareness of these diseases in the Chinese American community | Focus group discussions (6) | Community | Chinese Americans (47) |
| Hwang et al. (2010)<sup>13</sup> | Houston, USA | To explore the HBV beliefs, attitudes and practice patterns of medical providers serving Asian-American communities | Focus group discussions (3) | Health services | Medical providers serving Chinese, Korean and Vietnamese communities (23) |

(Continues)
| Authors                  | Location           | Aim/focus                                                                 | Research method                                                                 | Setting                                      | Participants                                      |
|-------------------------|--------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------------|--------------------------------------------------|
| Hwang et al. (2012)     | Houston, USA       | To explore attitudes about prevention, screening and treatment of HBV infection in American Chinese, Korean and Vietnamese communities | Focus group discussions (12)                                                    | Community                                    | Chinese, Korean and Vietnamese (113)             |
| Philbin et al. (2012)   | Maryland, USA      | To explore the knowledge, awareness and perceived barriers towards HBV screening and vaccinations | Focus group discussions (8)                                                    | Community                                    | Chinese, Korean and Vietnamese (58)              |
|                         |                    |                                                                           |                                                                                  |                                              |                                                  |
| Intervention            |                    |                                                                           |                                                                                  |                                              |                                                  |
| Free at point of access |                    |                                                                           |                                                                                  |                                              |                                                  |
| Larcher et al. (2001)   | London, UK         | Evaluation of intervention to increase HBV vaccination B of babies        | Retrospective case note review, comparison with data from similar neighbouring district | Hospital                                     | All babies born to mothers in the hospital (2% labelled as Oriental) |
|                         |                    |                                                                           |                                                                                  |                                              |                                                  |
| Taylor et al. (2008a)   | Vancouver, Canada  | Description of content of intervention to promote HBV knowledge and HBV testing | Qualitative, narrative description of intervention content                      | Community (ESL classes)                      | Chinese                                          |
|                         |                    |                                                                           |                                                                                  |                                              |                                                  |
| Taylor et al. (2009a)   | Vancouver, Canada  | Evaluation of intervention to promote HBV knowledge (via ESL classes)     | Randomized controlled trial (cluster)                                          | Community (ESL classes)                      | Chinese Canadians                                |
|                         |                    |                                                                           |                                                                                  |                                              |                                                  |
| Taylor et al. (2009b)   | Vancouver in Canada, Seattle in USA | Evaluation of intervention to promote HBV knowledge and HBV testing | Randomized controlled trial with process evaluation                             | Community (lay educators)                    | Chinese American and Chinese Canadians          |
|                         |                    |                                                                           |                                                                                  |                                              |                                                  |
| Taylor et al. (2011)    | British Columbia, Canada | Evaluation of intervention to promote HBV knowledge and HBV testing | Cluster randomized trial                                                         | Community (ESL classes)                      | Asian Canadian students (759) follow-up of untested (180) including Chinese (92) |
|                         |                    |                                                                           |                                                                                  |                                              |                                                  |
| Intervention            |                    |                                                                           |                                                                                  |                                              |                                                  |
| Fee for service health system |          |                                                                           |                                                                                  |                                              |                                                  |
| Bailey et al. (2011)    | San Francisco, USA | Evaluation of intervention to promote HBV knowledge, testing, vaccination and treatment | Descriptive process evaluation Before-and-after comparison of numbers of HBV tests | Community and health service; multi-component | Asian and Pacific Islanders including Chinese Americans; area-based intervention |
|                         |                    |                                                                           |                                                                                  |                                              |                                                  |
| Bastani et al. (2015)   | Los Angeles, USA   | Small group intervention to improve HBV testing                           | Cluster randomized trial                                                         | Community church-based                       | Koreans (1123)                                  |
|                         |                    |                                                                           |                                                                                  |                                              |                                                  |
| Burke et al. (2004)     | Seattle, USA       | Description of development of intervention to promote HBV knowledge and HBV testing | Qualitative, narrative description of process                                    | Community (lay educators)                    | Vietnamese Americans                             |
|                         |                    |                                                                           |                                                                                  |                                              |                                                  |
| Chang et al. (2009)     | San Francisco, USA | Evaluation of intervention to increase uptake of HBV testing and vaccination | Descriptive process evaluation with quantitative outcome measures               | Health service                               | Asian and Pacific Islanders including Chinese     |
|                         |                    |                                                                           |                                                                                  |                                              |                                                  |
| Chao et al. (2009)      | San Francisco Bay, USA | Evaluation of intervention to promote HBV knowledge, testing, vaccination and treatment | Descriptive observational study                                                   | Community, mass media and health service; multi-component | Asian Americans including Chinese Americans; area-based intervention |
|                         |                    |                                                                           |                                                                                  |                                              |                                                  |
| Chao & So (2011, same intervention as Chao et al. 2009) | San Francisco, USA | Description of development and design of intervention to promote HBV knowledge, testing, vaccination and treatment | Descriptive observational study                                                   | Community, mass media and health service; multi-component | Asian and Pacific Islanders including Chinese Americans; area-based intervention |
|                         |                    |                                                                           |                                                                                  |                                              |                                                  |

(Continues)
Multi-component initiatives also recognized the influential role of physicians and targeted them in an attempt to reduce missed opportunities within the healthcare system for testing and to support HBV service uptake. Bailey et al. (2011) introduced a range of measures aimed at practitioners’ role including educational events, a quick reference HBV diagnostic flowchart and practitioner pledge signing to confirm intended adherence to CDC recommendations.21 The Jade Ribbon Campaign in San Francisco included education for healthcare practitioners, including Chinese medicine providers.23,63 McPhee et al. (2003) report on another multi-component intervention that included engagement and registration of physicians as providers of low-cost hepatitis B services.25 The BeFreeNYC initiative in New York also included training for providers.26,27 However, it was not possible to ascertain the effect of these provider-focused interventions as they were part of complex multi-component interventions.

4 | DISCUSSION

The evidence base is currently skewed towards studies focused primarily on the knowledge and attitudes of Chinese immigrant groups including interventions to modify these, with less attention having been paid to practitioner attitudes and health system factors that could better support access to HBV screening, vaccination and care. However, findings from this review suggest that interventions focused on the target population alone are unlikely to be efficacious.
Indeed, there is evidence of the significant influential role of health providers.

Dixon-Woods\textsuperscript{11} describes access as a complex and interactive process whereby individuals within their social and economic context identify their own need for health care (termed “candidacy” in this model) and negotiate and navigate services that are more or less “permeable.” This review confirms that navigation and negotiation can be compromised by misunderstandings and poor knowledge of services and of the condition, but addressing these obstacles without addressing service accessibility does not effectively improve access. Health workers intervene in this negotiation by adjudicating candidacy and offering the right services, aligned with institutional, commissioning and policy guidance as well as skills and knowledge. Causations for reduced access to services are complex and multi-factorial, but understanding the interaction between individuals and services is essential to define and modify determinants of access.\textsuperscript{12} Contacts with primary healthcare providers present an important, but often unrealized, opportunity to promote HBV testing and follow-up. Individuals who are not registered with, or do not visit their physician, or who have not had positive interactions with their primary healthcare provider, are less likely to access HBV-related healthcare even if they themselves recognize a need for it.\textsuperscript{57,59} There may also be some reticence within migrant Chinese populations to access care or testing, due to various barriers such as stigma\textsuperscript{46,48} or poor understanding of the disease and its risks.\textsuperscript{38,40}

Primary care physicians are often the gatekeepers to HBV testing, vaccination and treatment and therefore hold an influential role in enabling access to services.\textsuperscript{11} Economic barriers may exist, the thought that treatments might be unaffordable was found to be an influential factor in practitioners’ decision to offer tests.\textsuperscript{55} but it is not clear whether this is a shared decision: a process whereby the patient and the physician are involved in a discussion of informed options, and reach and agreement in the decision-making process.\textsuperscript{66} If health workers make nonshared decisions that are in dissonance with the needs or choice of individuals, they may exert a disempowering effect in patients. A more comprehensive and holistic approach including health provider adaptations is required to improve the accessibility and acceptability of services. Enabling and empowering patients to successfully request tests and care for their individual needs also warrant attention.

A number of limitations of the reviewed evidence base, and our review methods, should be highlighted. Caution is warranted in extrapolating findings across often very divergent social and healthcare contexts. The majority of studies were published over the last 10 years and originate in USA, and there are very few studies from
other countries, particularly those where public health services are provided free. However, low uptake is reported in healthcare settings where the services should be free as well as those where they might be dependent on particular insurance status.

An important limitation is that most of the studies reviewed were not informed by any explicit theory, and those that referenced theoretical models did not explicate them clearly. Indeed, a lack of detailed theory-driven process evaluations meant that it is not possible to ascertain and validate the efficacy of the various interventions employed or their mechanisms of action. There was also a dearth of robust evaluations of interventions. Most of the interventional studies were of low or medium quality, and there was a reliance on self-reported measures of healthcare uptake. A lack of controlled designs further compromised the strength of conclusions that could be drawn from many of these studies. There was also very little information on the costs of these interventions, and there were no detailed assessments of the cost-effectiveness of the interventions studied. Consequently, the findings from the various studies have been mixed. Further studies using more robust methodology to elucidate the effectiveness of interventions to boost HBV testing and care are required. In addition, practical strategies to improve the accessibility of healthcare services deserve further exploration.

Another limitation of the existing evidence base is that the diversity within and between Chinese subgroups was not explored in much detail in most studies. While some gender, age, socioeconomic and migration status differences were examined, the results were inconsistent and it was not easy to identify the relevance to diverse settings, other than the general need to recognize diversity and to exercise caution in generalizations.

Finally, the review sought to examine papers in the English published literature only; therefore, potential useful findings in other languages were not studied. This study addressed only Chinese and related populations, but did not examine studies looking at other communities that may have information on common barriers in relation to chronic hepatitis B. This also applies to examination of studies addressing other conditions in Chinese populations that could have provided further understanding of barriers in this population.
5 | CONCLUSION

Migrant Chinese populations across the world are not a homogeneous group but extremely diverse in terms of their countries of origin, language and dialect groups, education levels, socioeconomic wealth and degree of acculturation, all of which are likely to have some bearing on their health seeking behaviours. Cognizance of this diversity is vital to ensure that interventions developed are tailored to the cultural and contextual specificities of each Chinese migrant community.

The current evidence base shows that low awareness, knowledge and access to testing and treatment for hepatitis B are a consistent pattern for migrant Chinese populations across diverse health service contexts. However, the evidence for interventions to address these healthcare gaps is patchy. Multi-pronged approaches to researching determinants of access, and to informing policy interventions, are necessary. It is likely that effective programmes to boost access to care and testing for hepatitis B will need to be carefully designed, multifaceted and target healthcare providers as well as the population groups, ensuring integration of programmes within the broader health systems.

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