

apjtm.org

Perspective

Asian Pacific Journal of Tropical Medicine

doi: 10.4103/apjtm.apjtm_225_26

From global targets to regional realities: Re-centering stigma as a structural bottleneck in the hepatitis B care cascade in Asia

Hung Van Nguyen, Trinh Thi Diem Le✉, Giao Huynh✉

Faculty of Public Health, University of Medicine and Pharmacy at Ho Chi Minh City, Ho Chi Minh City, Vietnam

The World Health Organization (WHO) 2030 targets, established in 2016, for hepatitis B virus (HBV) elimination, including a 90% reduction in incidence and a 65% reduction in mortality[1], are scientifically achievable through integrated strategies, including universal vaccination, antenatal screening, expanded diagnosis, linkage to care, and antiviral therapy. However, progress across Asia which bears the greatest burden of chronic HBV infection and HBV-related mortality remains uneven despite substantial advances in biomedical prevention and treatment[2]. In Asia, although universal childhood vaccination programmes have achieved high coverage in many settings, uptake of adult screening, linkage to care, antiviral treatment, and long-term follow-up remains suboptimal[3]. Across the region, many individuals with chronic HBV remain undiagnosed, untreated, or insufficiently engaged in care despite the availability of effective prevention and treatment tools. The persistent gaps in vaccination uptake, timely diagnosis, linkage to care, treatment initiation, and long-term retention suggest that biomedical scale-up alone is insufficient to achieve elimination goals[4].

HBV-related stigma is increasingly recognized as a major barrier to effective elimination efforts across Asia. Beyond its impact on individual experiences, stigma undermines multiple components of the HBV elimination continuum, including vaccination uptake, antenatal screening, diagnosis, linkage to care, antiviral treatment, and long-term retention in care. Fear of discrimination, anticipated social exclusion, and concerns regarding disclosure may discourage individuals from participating in screening programmes, seeking timely care, or maintaining long-term engagement with treatment services[5]. In some settings, stigma may also reduce community participation in public health campaigns and contribute to vaccine hesitancy, particularly when HBV infection is associated with social labeling or misconceptions regarding transmission.

HBV-related stigma should be reframed not merely as a social concern, but as a cross-cutting structural barrier that undermines multiple components of HBV elimination efforts. Stigma may reduce participation in vaccination and antenatal screening programmes, delay health-seeking behaviours, weaken linkage to care, compromise adherence to antiviral therapy, and limit sustained engagement in chronic disease management. These effects are further reinforced by persistent misconceptions regarding HBV transmission, including incorrect beliefs related to casual contact, shared meals, eating utensils, or hereditary transmission.

Persistent misunderstandings about HBV transmission remain an important driver of stigma in many Asian settings. Incorrect beliefs that HBV can be transmitted through casual contact, shared meals, eating utensils, or hereditary inheritance continue to reinforce fear-driven social distancing and discrimination toward affected individuals[6]. Evidence from Vietnam and other endemic countries suggests that inadequate public understanding of HBV may negatively influence vaccination attitudes, disclosure practices, and social interactions with people living with HBV[6]. These misconceptions may further discourage participation in antenatal screening and prevention programmes aimed at reducing mother-to-child transmission.

A socioecological perspective provides a useful framework for understanding how HBV-related stigma operates across interacting individual, interpersonal, community, institutional, and policy levels[7]. At the individual level, fear, shame, and internalized stigma may delay testing and reduce treatment uptake. At the interpersonal

✉To whom correspondence may be addressed. E-mail: trinhle309@ump.edu.vn; hgiaoytcc@ump.edu.vn

This is an open access article distributed under the terms of the Creative Commons Attribution-Non-Commercial-No Derivatives License 4.0 (CCBY-NC-ND), where it is permissible to download and share the work provided it is properly cited. The work cannot be changed in any way or used commercially without permission from the journal.

For reprints contact: reprints@medknow.com

©2026 *Asian Pacific Journal of Tropical Medicine* Produced by Wolters Kluwer-Medknow.

How to cite this article: Nguyen HV, Le TTD, Huynh G. From global targets to regional realities: Re-centering stigma as a structural bottleneck in the hepatitis B care cascade in Asia. Asian Pac J Trop Med 2026; 19(8): 333-334.

Article history: Received 30 April 2026 Revision 18 May 2026
Accepted 10 June 2026 Available online 12 June 2026

and community levels, misconceptions surrounding HBV transmission can foster concealment, social exclusion, and reduced engagement in prevention initiatives. At the institutional level, discriminatory practices—including employment-related screening and inadequate confidentiality protections—may discourage individuals from accessing healthcare services. At the policy level, insufficient legal safeguards against discrimination further reinforce structural vulnerability and limit equitable access to care.

Importantly, stigma does not operate independently of healthcare systems. Rather, it interacts with broader structural gaps, including fragmented integration between hepatitis services and primary care, insufficient public health communication, limited social protection mechanisms, and unequal access to affordable diagnostic testing and antiviral therapy in resource-constrained settings. These interacting barriers contribute to cumulative "points of disengagement" across the HBV care continuum, particularly during testing, linkage to care, treatment initiation, and long-term retention. As a result, expanded availability of diagnostic tools and antiviral therapy does not necessarily translate into effective utilization or sustained engagement in care.

To better align regional realities with global elimination goals, HBV strategies must move beyond biomedical scale-up alone and explicitly integrate stigma reduction into elimination planning. At the community level, targeted communication initiatives are needed to correct misconceptions regarding HBV transmission and normalize HBV as a manageable chronic condition. Within healthcare systems, strengthening provider capacity to deliver stigma-free, confidential, and patient-centred care remains essential, alongside integrating HBV services into primary care settings to reduce visibility-based discrimination and facilitate routine engagement. At the policy level, legal and regulatory protections against discrimination in employment and education should be strengthened, while non-evidence-based screening practices should be eliminated. Incorporating stigma-related indicators into national HBV monitoring frameworks may also support more comprehensive evaluation of barriers across the care continuum and inform data-driven interventions.

The WHO 2030 hepatitis B elimination targets remain achievable. However, progress in Asia will likely remain incomplete unless stigma is recognized as a central structural determinant of disengagement across the continuum of care. Re-centering stigma within HBV elimination strategies shifts the focus from awareness alone toward coordinated, multi-level interventions addressing the social and institutional conditions that shape access to testing, treatment, and long-term care. Ultimately, achieving HBV elimination will depend not only on expanding biomedical interventions, but also on transforming the environments in which individuals seek and sustain care.

Conflict of interest statement

The authors declare that there are no conflicts of interest.

Funding

The authors received no extramural funding for the study.

Authors' contributions

Hung Van Nguyen did the literature search and drafted the manuscript; Hung Van Nguyen, Giao Huynh, Trinh Thi Diem Le gave intellectual comments and reviewed the final version.

References

[1] World Health Organization. *Bringing hepatitis care closer to you. 2022*. [Online]. Available from: https://www.who.int/southeastasia/news/opinion-editorials/detail/bringing-hepatitis-care-closer-to-you. [Accessed on 13 April 2026].

[2] Al-Busafi SA, Alwassief A. Global perspectives on the hepatitis B vaccination: Challenges, achievements, and the road to elimination by 2030. *Vaccines* 2024; **12**(3): 288.

[3] Kim HN. Examining the hepatitis B care cascade through an equity lens. *JAMA Netw Open* 2023; **6**(4): e237000.

[4] Su S, Jia M, Song Q, Guo L, Peng N, Yu Y, et al. The hepatitis B care cascade among key populations towards global elimination: A systematic review and meta-analysis. *Lancet Reg Health West Pac* 2026; **67**: 101802.

[5] Freeland C, Qureshi A, Wallace J, Kabagambe K, Desalegn H, Munoz C, et al. Hepatitis B discrimination: Global responses requiring global data. *BMC Public Health* 2024; **24**(1): 1575.

[6] Huynh G, Pham LA, Tran TT, Cao NN, Nguyen TNH, Bui QV. How knowledge of hepatitis B disease and vaccine influences vaccination practices among parents in Ho Chi Minh City, Vietnam. *Asian Pac J Trop Med* 2021; **14**(3): 122.

[7] Earnshaw VA, Mousavi M, Qiu X, Fox AB. Mental illness and substance use disorder stigma: Mapping pathways between structures and individuals to accelerate research and intervention. *Annu Rev Clin Psychol* 2025; **21**(1): 85-111.

Publisher's note

The Publisher of the *Journal* remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

Edited by Zhang Q, Lei Y, Pan Y