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African Diaspora in Guangzhou, China: A Healthcare Needs Assessment

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Honours Bachelor of Science
University of Toronto
2007

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An abstract of
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Abstract

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By Lavinia Chi Shan Lin

Objectives: We qualitatively assessed healthcare access and perceived barriers to the use of health services among African migrants in Guangzhou, China.

Methods: A total of 25 semi-structured interviews and two focus groups with five members of each were conducted.

Results: Barriers to the utilization of health services identified by participants could be classified as predisposing factors (e.g., race, different health beliefs, and negative perceptions toward health personnel) and enabling factors (e.g., legal status, language barriers, providers' characteristics, costs, interpretation services and translated material, and hours). Participants were dissatisfied with the healthcare services and reported distrust of the medical system.

Conclusions: This is the first study to assess healthcare access and perceived barriers to health services among non-natives in China. This paper posits that there are many health challenges associated with international migrants as well as current gaps in China's healthcare system. As several middle-income nations continue to receive more foreigners, formal interpreter services and culturally appropriate services should be considered.

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Chapter I. Introduction

Since the "open door" policy in 1979, China has undergone tremendous economic reform, attracting large flows of migrants in search of business and employment opportunities and causing profound changes in Chinese society. According to the 2010 national census from China's National Bureau of Statistics, there are nearly 600,000 foreigners residing on the Chinese mainland.[1] The foreign population today is not limited to businessmen from developed countries as in two decades ago, but further expands to include businessmen and students from low-income countries, particularly African countries.[2]

The migration between China and Africa has evolved noticeably over the last 50 years. The relationship between China and Africa dates back to the late 1950s, when China signed the first official bilateral agreement with African countries.[3] Since then, China has supported African countries with economic, technical and military support in an attempt to counter the West and change the balance of power.[3] The first wave of African migrants to China was in 1960, when 118 African students arrived in China as part of a Chinese government program of fully-paid university education for the nationals of friendly countries.[4] Unfortunately, this time was marked by clashes between Chinese and African students over cultural differences and misunderstandings, which resulted in several riots and the subsequent departure of many of the African students.[4] The second wave of African migration to China occurred with the establishment of the Forum for China-Africa Cooperation (FOCAC) in 2000.[5] This created a platform to promote mutually beneficial sociopolitical, socioeconomic, and sociocultural relations between these two major parts of the world.[2] China is now the leading trade partner with Africa, with a total trade volume exceeding US$120 billion in 2010.[6] Today, the Chinese government still provides scholarships to African students, but another population of Africans in Chinese cities has

emerged. These are businessmen, merchants, and entrepreneurs, flocking to China for growing business opportunities.[2] Populations in China have become increasingly multi-ethnic as a result of the growth and deepening diplomatic ties with African countries.

Africans in Guangzhou

Guangzhou is the third most populated metropolitan region in China. The burgeoning economy of Guangzhou has attracted many young African students, businessmen and entrepreneurs to the city, leading some Chinese to dub some areas of the city as "African Town" or "Chocolate City."[7] Since 2003, the African population has been increasing at annual rates of 30 to 40%.[2] There are now an estimated 20,000 legal African residents in the city of Guangzhou, and an unknown number of illegal residents and short-term visitors could easily inflate the population figures to 100,000.[2] This includes African businessmen migrating to China for financial gains as small-time entrepreneurs, as well as African students pursuing education in China.[2]

Previous research has explored the cultural and economic roles of this newly emerging population;[7,8] however, to our knowledge, no studies have examined their health and social problems while in China. Thus, the main purpose of this study is to gather information on and gain insight into healthcare experiences among African migrants in Guangzhou, China. The study aims to: 1) assess this population's perception of its access to health services; and 2) explore their perceived barriers to the use of health services.

Theoretical Framework

The present study is based on an integrative framework informed by the Socio-Ecological Model[9] and Andersen's Behavioral Model of Health Services Utilization.[10,11]

Socio-Ecological Model

At the center of the model is the individual level. The characteristics of the individual level include knowledge, personal attitudes, and personality traits that influence behavior. This level is essentially influenced by many external forces that embody individual determinants. The second level of the model considers the first of these external forces, interpersonal processes. In this level, primary groups of social interaction, such as family, peers, and social networks provide social identity and role definition. The third level of the model is the organizational level, which refers to institutions that are organized and regulated by formal or informal means. These organizations intend to facilitate individual behavior through a common set of rules and policies. The community level refers to the interrelationships between local-area networks, neighborhoods, and organizations among individuals. At this level, many social norms and standards are generated. The outermost layer is the policy level, which includes the local, state and federal policies and laws that regulate healthy actions.[9] Although the socio-ecological model recognizes the various levels of influence, it does not necessarily specify interactions with healthcare systems. The Andersen's Behavioral Model of Health Services Utilization will contribute to a better understanding of health services use.

Behavioral Model of Health Services Utilization

The model conceives of health services access and use as a function of predisposing factors, enabling factors, and need factor. Predisposing factors refers to socio-cultural characteristics of individuals that exist prior to their illness, such as age, gender, education,

occupation, ethnicity, social support, acculturation, and health beliefs toward the healthcare system. Enabling factors refers to the logistical aspects of obtaining care, which are the personal, family, and community resources that facilitate or hinder an individual's ability to obtain healthcare. These include family income, health insurance, primary sources of care, waiting time, and availability of health personnel and facilities. Need factors refers to the perception of need for health services, whether individual, social, or clinical. Other factors, such as the external environment and healthcare system, will also determine and influence an individual's decisions about health service use. The healthcare system includes health resources, such as education of healthcare personnel and available equipment; and health policy, such as how an organization operates and manages its resources. In addition, the model indicates that health behaviors are the direct cause of health outcomes. Health behaviors include personal health practices and the use of health services, and health outcomes include perceived health status, evaluated health status, and consumer satisfaction.[10,11]

Integrating the two models into one conceptual framework provides a useful basis to assess healthcare access and perceived barriers to the use of health services among African migrants and offers a strong theoretical foundation for implications for culturally specific interventions at the individual, interpersonal, and organizational level. Figure 1 shows the modified integrative framework of the two models.

Chapter II. Literature Review

Migration can be defined as "a process of moving, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes."[12] At the international level, no universally accepted definition of migrant exists. The term migrants generally applies to persons and family members moving to another country or region to better their material or social conditions and improve the prospects for themselves or their family.[12] Migrants therefore encompass the overlapping categories of migrant workers and their families, long-term and short-term immigrants, internal migrants, international students, internally displaced people, asylum seekers, refugees, returnees, irregular migrants and victims of human trafficking.[12]

According to the International Organization for Migration (IOM), the number of international migrants increased from 76 million to 214 million between 1960 and 2010.[13,14] This figure represents approximately three percent of the world's population.[14] With increasing numbers of people on the move, international migration health issues have become a key global public health topic and have been raised to the highest levels of the public health agenda at national and local health levels.[14,15] However, knowledge about their health status is lacking. The lack of data is largely due to the absence of a universally accepted definition for migrants and the nature of this population. Thus, migrants are often excluded from health assessments.

Migration and Health

Studies have shown that migrants are a particularly vulnerable population in terms of health issues. They have a disproportionately higher risk of negative health outcomes compared to locals in the host country and their counterparts in their country of origin.[15,16]

Migrants are more prone to mental health problems, such as depression,[17,18] post-traumatic stress syndrome[19] and anxiety;[17] certain chronic diseases, such as cardiovascular[20] and diabetes[21]; and infectious diseases, such as tuberculosis,[16] hepatitis B[22] and hepatitis C.[22] Higher risks of negative health outcomes may be attributable to the multiple health risks that migrants face in the host country. The relationship between migration and health is a complex one, which is under the influences of genetic, behavioral, environmental and socioeconomic determinants of health.[15] Societal health threats include long-term impact of dietary changes on the incidence of certain diseases;[23] the importation of pharmaceutical products for self-medication;[24] but most importantly, the lack of resources to seek care early in the disease process.[15]

Migration and Access to Care

In the healthcare context, access to care may be defined as the timely use of appropriate health services to achieve the best possible health outcomes.[25] The importance of timeliness is underscored in this definition as a feature of good access to care. Unfortunately, access to care remains a fundamental problem for migrants. Slesinger and Cautley examined the self-perceived health status and the medical utilization patterns of the Hispanic workers who were selected from a 10% stratified random sample of 4,080 migrant agricultural workers surveyed in Wisconsin. They measured physician or clinic visits in the preceding year and ever having had a general physical examination, a dental visit, or a vision checkup. Survey results, based on unverified self-reported data, indicated that the use of health services by migrant workers, especially preventive care, was low compared with other populations. The survey also revealed that barriers to care were related to time, language, and costs.[26]

A descriptive study utilized data collected in a 1986 sample survey of 329 adult (18 to 50 years old) migrant farm workers in Colorado to determine their health needs, health services utilization, and overall access to care. The findings of this survey document revealed that a large majority of migrant farm workers perceived their health to be fair or poor, and one fourth of the population did not have a usual source of healthcare at their permanent residence. Researchers suggested replicating the survey in representative states to gather more information on the health status of the population in order to develop migrant health services.[27]

Perilla conducted a qualitative study in south Georgia among Latino migrant farm workers to assess their health and service needs. A total of 68 migrant farm workers participated in four focus groups. The inadequacy of services available to migrant farm workers was reported as the main concern. In addition, participants reported transportation problems, a limited range of services, and fear of immigration officers as serious obstacles in accessing health services. One interesting finding was all focus groups reported using herbs, massages, and consultation with community members for healing practices and home remedies. They did not consider them as a problem, rather as valid resources used by the migrant community in accordance with traditional practices and values. Based on this finding, the author suggested that health services must be designed and implemented within the cultural context of the people involved.[28]

In another qualitative study conducted among recent Latino immigrants in southeast Michigan, Harari et al. found that the principal barriers to care were lack of insurance, language barriers, and isolation in new communities. Approximately 48% (n=24) of respondents reported a feeling of isolation and lack of strong social or information

networks. Therefore, outreach efforts are needed to reach migrants and address their healthcare needs.[29]

Lack of access to care among migrants is also a critical public health problem in other Western countries. One study investigated standards of healthcare provision for asylum seekers in the 25 European Union (EU) countries using the method of email surveys. Asylum-seekers had restricted access to healthcare and were only entitled to emergency care in ten of these countries. The authors concluded that policies should be enacted to ensure access to healthcare for asylum seekers comparable with the medical rights of citizens.[30]

A recent qualitative study found that migrant patients in Australia face substantial barriers to viral hepatitis services, which may delay uptake of treatment in this population. These barriers include cultural differences, language difficulties, cultural beliefs, stigma and misinformation. The authors concluded that culturally and linguistically appropriate services should be an integral part of health delivery.[31]

Researchers have looked at the impact of linguistically appropriate services on healthcare experiences. Jacobs et al. utilized a randomized controlled study design to investigate how the provision of enhanced interpreter services impacts the costs of a hospital stay and patient satisfaction. An enhanced interpreter intervention was randomly assigned to one of the three hospitals. The authors found that the enhanced interpreter intervention did not significantly impact hospital costs, but significantly increased patient satisfaction with physician and overall hospital experience. This study underscored the importance of efforts to increase the ethnic and linguistic diversity of the medical profession.[32]

Researchers have also examined the impact of culturally appropriate services on healthcare experiences. Majumdar et al. conducted a randomized controlled trial to determine how healthcare providers with cultural sensitivity training impact the satisfaction

and health outcomes of patients from different minority groups. A total of 114 nurses and homecare providers from two homecare agencies and one hospital were randomly selected to receive cultural sensitivity training. Patients who received care from both experimental and control groups were asked to complete three questionnaires related to client satisfaction, client health outcomes, and physical and mental health assessment. Although there were no significant differences in client satisfaction scores between patients in the control and experimental groups, patients who received care from trained providers were more likely to utilize social resources and had an improvement in overall functional capacity without an increase in healthcare expenditures after 1.5 years. Results of the study supported the implementation of cultural sensitivity training programs among healthcare providers.[33]

In summary, the literature reviewed suggests that migrants and ethnic minorities, particularly those who are most disadvantaged, have reduced access to healthcare services. They encounter a number of barriers, which include language difficulties, cultural differences, economic barriers, and legal issues. Furthermore, social isolation from the community creates additional barriers to the utilization of healthcare services. It is imperative to implement professional interpreter services and cultural sensitive training programs for healthcare providers to better serve the migrant population in order to overcome these barriers.

International Migration in China

In an Asian setting, especially China, collaborative research is mainly focused on populations of internal migrants that are engaged in either rural-to-urban or urban-to-urban migration.[34,35] Currently, there are virtually no studies on international migrants and health services. The absence of similar studies conducted in Western countries may be due, in part, to the lack of reliable data linking health outcomes to migration status.[36] However, the trend

of globalization in Asia is now providing opportunities for such research, enhancing our understanding of the dynamics of international migration and its long-term health consequences in the region.

As different migrant populations have different vulnerability levels,[15] it is important to identify health threats and risks specific to the migrant population. For the purposes of this paper, we use the term migrants to refer only to individuals who cross the international border for the purpose of business opportunities, employment or temporary residence, including those with student or working visas. This is the first study to assess healthcare experiences among non-natives in China. This study utilized a qualitative approach to examine access to health services and perceived barriers to healthcare utilization among African migrants in Guangzhou.

Chapter III. Method

This study employed a qualitative research design to develop a holistic understanding of the healthcare access of the African community residing in Guangzhou. In-depth, semi-structured interviews and focus group discussions were used to investigate this topic. In-depth interviews were used to collect participants' narratives of healthcare experiences, while focus group discussions were used to seek a range of opinions on healthcare utlization.[37]

Sample

A total of 35 subjects participated in this study. Inclusion criteria included individuals who identified themselves as originating from an African country and who are at least 18 years of age. Each participant provided verbal consent, and was offered a free meal in exchange for their participation in this study. The study protocol was approved by the Institutional Review Board of the Guangdong Provincial Centre for STI and Skin Diseases Control and the University of Hong Kong (see Appendix I).

Data Collection

Data were collected over three consecutive weeks in July 2011. Three U.S. research assistants fluent in English and trained in qualitative methodologies conducted all interviews. The first phase was a formative stage focused on building rapport with the African community and identifying appropriate questions. The first phase was key informant interviews, which included three local African community leaders who helped revise the interview guide, contextualize the healthcare needs, and identify the most appropriate recruitment methods. Given that many Africans have marginal or uncertain legal status, working with community leaders to establish the trust and cooperation of local participants was an essential prerequisite.

The second phase was participant recruitment through community-based organizations. Two community leaders invited all members of the African migrants to a meeting at a local community center in a central location. At the meeting, researchers distributed recruitment flyers that included a description of the study and contact information for individuals to contact them directly. Subjects were also solicited face-to-face to generate a list of willing participants. A total of 38 participants attended the meeting, of whom four were scheduled for an in-depth one on one interview. The research team invited the remaining 34 participants, either directly by phone or email, to schedule interviews. Six individuals declined to participate, four individuals did not respond at the provided telephone number, four individuals were not in Guangzhou, and two individuals failed to attend their scheduled interview. In addition, three participants were recruited via referrals from other participants. This purposive sample of the African migrants included businessmen and students, men and women, those with legal and illegal status, and those who were single and married.

Twenty-five face-to-face, semi-structured interviews were conducted and two focus groups were organized. The in-depth, semi-structured interview, adapted from an interview guide developed by Harari et al.[29] and modified based on the feedback from key informants, consisted of open-ended questions focused on the following topics: healthcare experiences (medical and pharmacy) in Guangzhou, current barriers to accessing healthcare, and a comparison between local health services to those in their native country (see Appendix II). Semi-structured interviews occurred at locations preferred by the interviewees, such as restaurants or work offices. One interview was conducted by telephone at the request of the respondent. Interviews were conducted in English with a duration of 30 to 60 minutes. The focus groups lasted approximately 50 to 60 minutes. The focus group followed an interview

guide similar to the semi-structured interview (see Appendix III). All interviews and focus groups were audio-recorded and the information was transcribed into a word processing program.

Data Analysis

Data analysis was carried out in a team-based approach.[38] A team of five researchers was involved in the data analysis. During the first meeting, one member of the team assumed the role of the code keeper to create, update, and revise a codebook. The remaining team members, who were novel to the dataset, took the role of coders. A preliminary codebook was developed using the process of modified grounded theory, the stages of data analysis that occur in a circular process.[39] Grounded theory is a process for identifying, naming, categorizing and describing phenomena found in the text.[39] To refine the codebook and ensure consistency, all data were double coded by two team members coding independently. The results of their coding were then compared for consistency of code application and emergence of new topics. All team members, including the principle investigators, met biweekly to discuss coding discrepancies, review each code and definition in the codebook, and reach a consensus on new coding that needed to be identified (see Appendix IV). The team coded all transcripts using MAXQDA software.

Chapter IV. Results

Demographic characteristics of all participants (n=35) are summarized in Table 1. More than 70% (n=25) of the participants were male, and 64% (n=16) of them were married. The mean age of the participants was 33.7 years (standard deviation=3.1). The majority of the participants were businessmen (86.7%, n=26), and the mean length of stay in Guangzhou was 4.4 years (standard deviation=7.1). Approximately 86% (n=30) reported English as their first language, and 80% (n=28) of them could not speak Chinese. All participants were originated from an African country; most of them were from Nigeria (40.6%, n=13), followed by Uganda (15.6%, n=5), Sierra Leone (9.4%, n=3) and Ghana (9.4%, n=3).

Predisposing Factors

Predisposing factors are defined in Andersen's model as factors that exert their effects prior to a person's need and use of a particular health service. It includes social structure variables and health beliefs and attitudes towards health services.

Social Structure Variables

Race – Many participants (45.7%, n=16) reported experiencing forms of interpersonal discrimination in healthcare. Eight participants felt that Chinese doctors considered Chinese culture superior to African culture, that Chinese patients were given first priority and received preferential treatment: "There is one thing about Chinese and Blacks. The way they [the doctors] attend to Chinese is not gonna be the way they attend to Blacks because we are foreigners. Because they believe Chinese first and every other person follows" (Participant 5). Five participants reported that they had to pay more for the same treatment than native patients because of their racial background: "If a Chinese should pay 20, African is gonna pay like 35 or 40" (Participant 5). Three participants reported that Chinese doctors tended to

associate negative elements, such as drugs, illegal status and HIV, with African patients. They stated that Chinese doctors refused to touch them because they were afraid of being "infected with African diseases" (Focus Group 2.3) and African patients were "expected" (Focus Group 1.5) to have an HIV test even when they did not request a test. Racial discrimination establishes barriers to healthcare, limiting healthcare utilization by the African migrants.

Health Beliefs and Attitudes

Different health beliefs and practices – Fifteen (42.9%) participants expressed that the way Chinese providers practice conflict with their beliefs and traditional practices. Although participants considered that China has advanced medical technology and facilities, they questioned the skills of the Chinese providers. They stated that Chinese doctors put patients on intravenous drips regardless of any illness, leading to mistrust: "All the treatment that they give here is to put you on drips; everybody is almost the same way [drips] they treat them." (Participant 1) Participants also complained that the Chinese doctors were unfamiliar with common African diseases: "[Chinese doctors] are not aware of some ailments like malaria that are common in Nigeria." (Focus Group 2.1)

Perceptions toward health services – Approximately 46% (n=16) of the participants explained that the improprieties of Chinese providers caused them to have negative perceptions toward health services in China. Some participants (28.6%, n=10) felt that some Chinese hospitals and doctors were purely profit-motivated and had no intention to treat their illness. They stated that Chinese doctors would make up illnesses and push them to conduct unnecessary tests and treatments. For example, a Malian respondent was diagnosed with cancer by a Chinese doctor during her short stay in China and was asked to pay 11,000RMB (approximately US$1,700) to undergo an operation. She could not afford the operation and

returned to Africa, when she later found out she did not have cancer. Another respondent was told to pay 270RMB (approximately US$42) for his prescriptions, but later was asked to pay another 50 RMB (approximately US$8) without providing any explanation of the increase. In addition, two participants had experiences of being offered commission from their doctor if they would bring customers to the clinic. A few (five) of the participants were also dubious about the benefits of medicine prescribed by their doctor. They claimed that the medicine was ineffective and they did not see any improvement. One participant described the treatment in Guangzhou as "gamble" (Participant 10), because the doctor would try a new medicine every time to see which treatment would work on the patient. These negative experiences have distorted participants' trust toward health personnel in China, discouraging them from accessing health services.

Enabling Factors

Enabling factors are the conditions, such as availability and accessibility of resources, that facilitate or hinder the use of health services. More specific sub-themes emerged at the individual, interpersonal and organizational levels, and are discussed below. Figure 2 shows the modified integrative framework while examining the barriers to health services.

Individual Level

Legal status – Ten participants (28.6%) reported that not having a visa or residential permit can act as a barrier to access healthcare in China. Lack of legal status led to hesitation in seeking care due to fear of being arrested and facing subsequent deportation. Some participants (20.0%, n=7) reported that Chinese hospitals would not treat patients if they failed to show their passport or visa. One alarming trend was that participants were not sure whether the hospitals were associated with law enforcement agencies, such as the government or immigration: "The Chinese hospital always wants to see my passport before I

can see the doctor. But I never know if they want to look at the visa. Who does the nurse talk to? The police? The government? We never know these things (Focus Group 2.1)". Consequently, illegal patients are frightened to go to a hospital.

Interpersonal Level

Language barriers - All participants reported that the language barrier was the main obstacle to access healthcare services in Guangzhou. Participants stated that most of the doctors in Guangzhou did not speak English or French, which are the first languages of the participants in this sample. In addition, none of the local hospital had routine interpreter services. Thus, migrants had difficulty communicating with doctors and asking questions during their medical visits: "I don't understand what they [the doctors] were saying because everything was in Chinese" (Participant 8). Some participants were able to speak Chinese; however, their proficiency level was only sufficient for daily conversation and business communication, but not for a medical setting: "I can speak and understand Chinese (…) but something more difficult and more medical and scientific, I don't understand." (Participant 1) Limited second language proficiency leads to a communication breakdown and hinders both patients and doctors from obtaining, processing and understanding basic health information and services needed to make appropriate health decisions.

Chinese providers' characteristics – Twelve participants (34.3%) noted that Chinese providers were always "in haste" (Participant 25) and "rushed" (Participant 10) that they did not offer adequate information and time to patients. They also reported that the doctors did not listen to their problems and they would pretend they understood the patient by saying, "Okay, okay, just to get rid of them [patients]" (Participant 4). As a result, participants left appointments confused about the exact diagnosis or treatment instructions and side effects: "When the [test] result comes out, you don't understand what really happened to you. Only

the doctor knows. And when they give you drugs, you don't even know the side effects of the drugs you are taking" (Participant 4). Some participants (20%, n=7) felt rejected by the impersonal and dispassionate patient approach of the care providers. They reported that the doctors did not show any sympathy or provide any encouragement and support. Thus, participants felt that the Chinese doctors did not take them seriously and were discouraged from seeing a doctor.

Privacy - Some participants (11%, n=4) expressed their frustration that the Chinese doctors did not provide adequate privacy to the patient during their medical visit. They stated that the door was open during their physical examination and they were constantly interrupted by Chinese patients. A Ghanaian respondent elaborated on this:

Respondent: If I am there I must wait, but here many people coming coming and listening to your problem, it's not good.
Interviewer: There were a lot of people around you? Who were those people?
Respondent: Patients. If you are with the doctor, they [other patients] come [in]to the [clinic] room. They don't want to wait outside for you to finish.

One participant felt that care providers in China do not value confidentiality, which led him to believe that care providers might discuss his case openly and casually with others.

Organizational Level

Costs – Fifteen of the participants (42.3%) cited that the healthcare costs in Guangzhou was so high that they were forced to delay seeking healthcare or terminate certain therapies due to the expensive treatment. For example, a Ghanaian respondent reported that her husband had to stop his chemotherapy because they could not afford the treatment; each set of chemotherapy was 20,000RMB (approximately US$3,000). Another respondent stated that the cost of basic hospital services can be so high as "to put you out of business" (Participant 4). Nine participants reported that they needed to pay a deposit before getting seen by a doctor or receiving treatments. The amount of the deposit varied case-by-case, depending on

the different circumstances, ranging from 1,000RMB (approximately US$150) to 12,000RMB (approximately US$1,900).

Interpretation and Translation – Many participants (45.7%, n=16) complained that Chinese hospitals and clinics did not provide professional medical interpretation services or translated medical information, such as health reports, invoices, and medication labels. A few of the participants reported that some doctors would use phone or computer translation; however, sometimes the translation was not accurate, resulting in a wrong diagnosis: "Most of them [the doctors] believe in phone translation or computer translation. Sometimes the translation is not right. And what they give them there is what they're gonna write [on the medical report]." (Participant 5) When getting medicine prescribed by a doctor or from a pharmacy, participants claimed that "everything [medication label] was in Chinese writing" (Participant 8) and that they did not know what medicine they took, how many they should take or what the side effects were. Most hospitals do not have all signs in English: "Africans don't understand the [Chinese] language (…) you just go to the hospital and follow the cue. And that's it, wherever you end up that's where you end up. You don't know whether seeing a specialist here or etc." (Participant 18) The lack of interpretation services and appropriate translated information acts as a hindrance from accessing healthcare.

Hours of operations and waiting time – In China, most hospitals' operating hours are from 9AM to noon and from 2PM to 5PM; doctors will take a two-hour lunch break from noon to 2PM. One respondent said that during their break time doctors would not attend patients "even when you are dying." (Participant 8) Some participants (20%, n=7) complained that Chinese hospitals do not have an appointment booking system and most of them function as a walk-in clinic. They were frustrated that they were not able to schedule appointments with their preferred doctors and the waiting time was long. For example, a Sierra Leonean

respondent said that she waited for four hours to have an ultrasound. The limited opening hours, inconvenient appointment system, and prolonged waiting time are disadvantageous to the use of health services. Additional quotes can be found in Table 2.

Chapter V. Discussion

The purpose of this study was to assess healthcare access and perceived barriers to health services among African migrants in Guangzhou. A total of 35 participants were interviewed about their healthcare experiences in China informed by the Socio-Ecological Model and Andersen's Behavioral Model of Health Services Utilization. Our proposed model expands the existing Andersen model by integrating the different levels in the Socio-Ecological Model with enabling factors. Similar aspects of the integrated model have been utilized by other empirical studies.[40,41]

The analysis presented here suggests three emerging issues in need of future consideration. First, Chinese care providers' ethical systems and values are different from those in most Western countries. For example, beneficence and confidentially are strongly emphasized in the Western medical context, but not in a Chinese medical paradigm. Beneficence, which is the idea that a practitioner should act in the best interest of the patient, is not practiced by some Chinese care providers. The improprieties in the profession, such as overcharging patients, conducting unnecessary diagnosis and operations, and paying their patients to recruit other patients, have distorted physician-patient relationships. Additionally, privacy and confidentiality protections, which are considered as the gold standards for ethics in medical practices, are not commonly applied to conversations between Chinese physicians and their patients. These two important values are often neglected in Chinese medical settings. Rather, Chinese medical professionals have used efficiency and profits as a basis for healthcare delivery,[42] leading the African patients to distrust their care providers and to be discontent with the health services in China. Studies have found that trust plays an important role in various healthcare outcomes, including

adherence to treatment recommendations, more satisfaction with services received, and willingness to seek care.[43]

Second, China's medical services are oriented to native patients and are not accommodating of non-Chinese patients. African patients identified language barriers, cultural differences, and discrimination as three major barriers to healthcare. These findings are consistent with research on healthcare utilization among ethnic minorities in the United States, Europe, and Australia.[31,44,45] Specifically, these are similar to perceptions from Hispanic and other ethnic minorities in the United States.[46,47] Studies indicated that providing linguistically and culturally competent services has the potential to address these barriers and increase patient satisfaction with services.[48,49] Karliner et al. showed that the use of professional interpreters improved clinical care for patients with limited English proficiency.[50] Lee reported that limited English proficiency patients increased their number of health visits after the introduction of interpreter services.[51] A review by Anderson et al. assessed five culturally competent healthcare models; however, no empirical evidence is available to determine if these interventions can improve health outcomes, such as client satisfaction with care, improvement in health status, and use of health services.[52]

Third, there are many types of hospitals and clinics in China, such as public and private, and general and specialist. Patients can directly access specialists without contacting primary healthcare providers. Prices also vary among hospitals and clinics. It is unclear how the hospitals reinforce their regulations on standards of care and pricing by types of healthcare facilities.

Our study suggests that migrant patients in China have inequitable access to health services and are in urgent need of access to basic healthcare. In 2008, China's government announced a plan to reform the health system and provide universal healthcare for its 1.3

billion citizens.[53] However, this strategic plan failed to address the health disparities among migrants. Our study suggests that Chinese doctors require training and education in order to deliver culturally competent care. Traditional medical curricular in China have not focused on social medicine and the humanistic aspects of medicine, which are crucial for serving marginalized migrant groups.[42] In addition, Chinese hospitals must provide former interpreter services in order to effectively serve diverse communities who are not proficient in standard Mandarin Chinese.

Strengths and Limitations

This study reached thematic saturation in our 25 in-depth interviews and two focus groups. To our knowledge, this is the first study to assess healthcare access among African migrants in China. This is also the first description of foreigner perceptions of healthcare in China. The primary strength of this study is the use of social theoretical frameworks for examining healthcare utilization, and the use of a qualitative study design to generate themes and to gain insights into the healthcare experiences among African migrants.

Nevertheless, limitations of the study warrant note. First, this study has limited generalizability due to the use of convenience sampling methodology and the nature of a qualitative study design. The knowledge produced in this study may not be representative of other African migrants in the area or other African communities. Second, the self-selection of participants in the study may impose some inherent selection bias. It is possible that participants interviewed in the study may have had a particular interest in healthcare. Third, this study focused only on the barriers at the individual, interpersonal and organizational levels of the socio-ecological model. Further studies are needed to assess the community and policy level of China's healthcare system. Quantitative research on migrants' health behaviors and outcomes, such as personal health practices, perceived health status, and

evaluated health status, would also be useful to further explore health issues among migrants in China.

Conclusion

This is the first study to assess healthcare access and perceived barriers to health services among non-natives in China. Study findings made a significant contribution to the service provided for African migrants by a small clinic inside a health center in Guangzhou. This paper posits that there are many health challenges associated with international migrants and current gaps in China's healthcare system. As several middle-income nations continue to receive more foreigners, migration health needs will be best achieved by implementing formal interpreter services and culturally appropriate services delivering health services at the local level.

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Figure 1 – A modified integrative framework of the Socio-Ecological Model and Andersen's Behavioral Model of Health Services Utilization

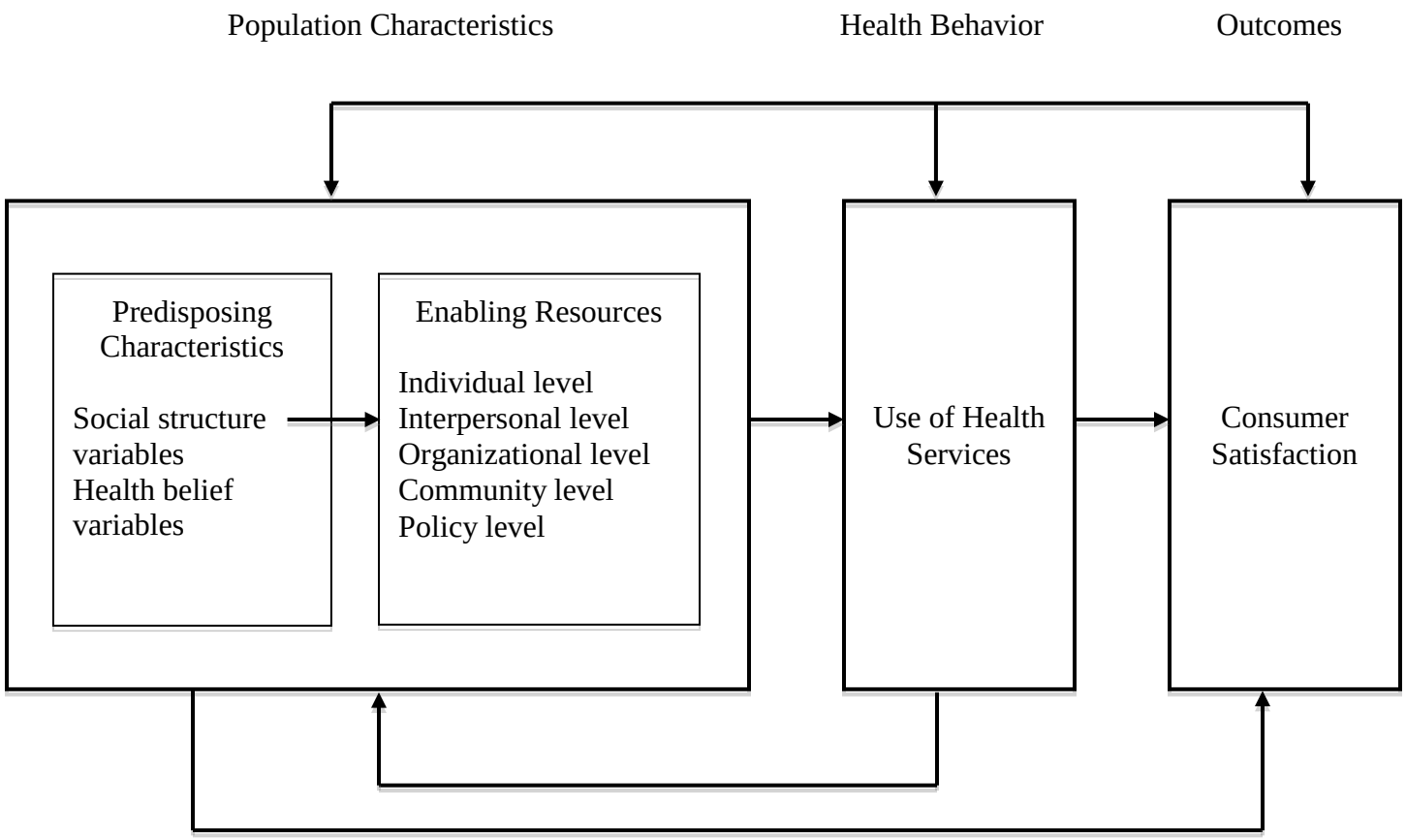

Figure 2 – A modified integrative framework of the Socio-Ecological Model and Andersen's Behavioral Model of Health Services Utilization while examining barriers to health services

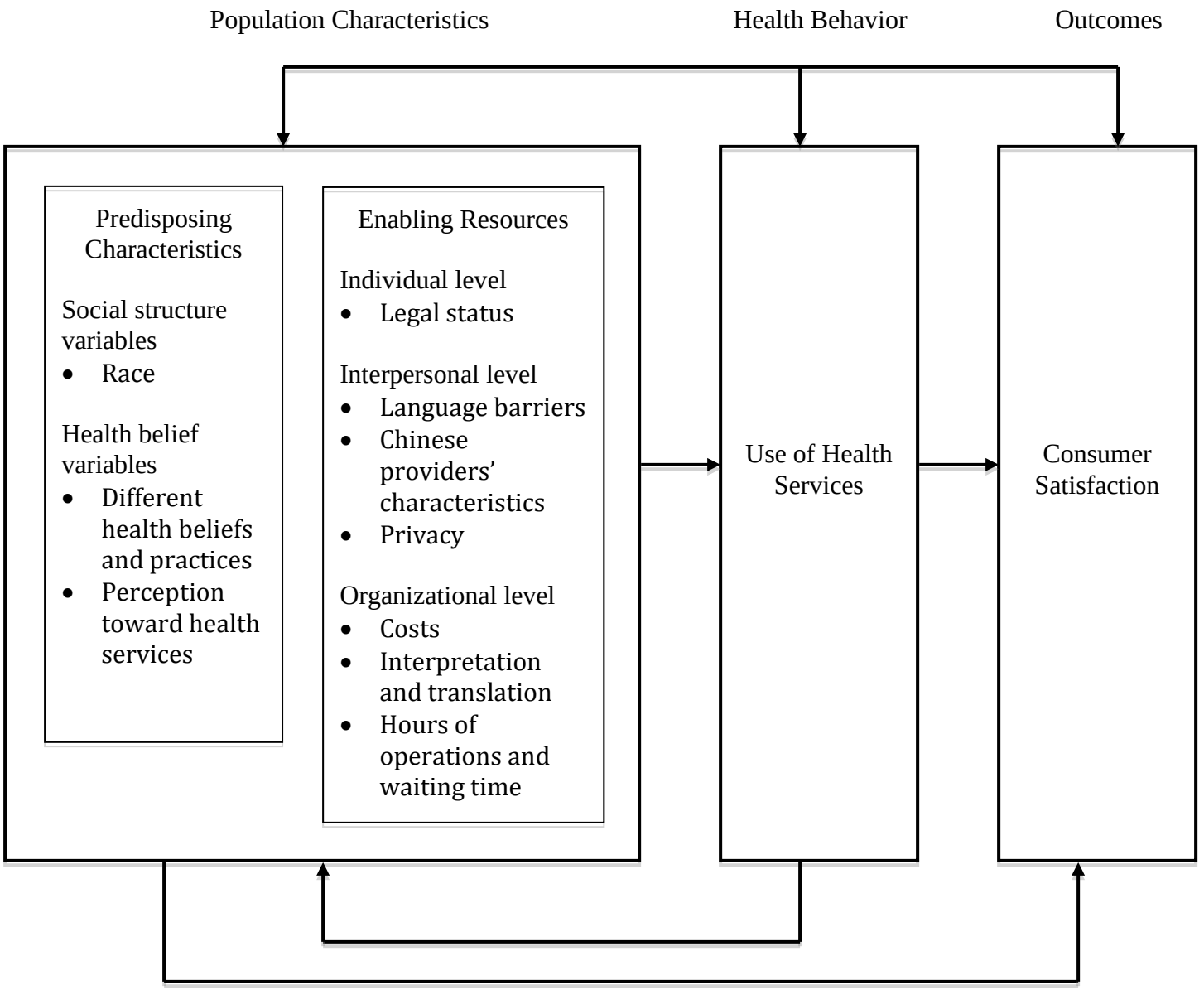

Table 1 – Demographic Characteristics of Participants (N=35)

Characteristics	N(%) or Mean (SD)
Gender	
Male	25 (71.4)
Female	10 (28.6)
Country of origin	
Nigeria	13 (40.6)
Uganda	5 (15.6)
Ghana	3 (9.4)
Sierra Leone	3 (9.4)
Togo	2 (6.3)
Congo	1 (3.1)
East Africa	1 (3.1)
Liberia	1 (3.1)
Mali	1 (3.1)
Gambia	1 (3.1)
Guinea	1 (3.1)
Marital status	
Single	9 (36.0)
Married	16 (64.0)
First language	
English	30 (85.7)
French	5 (14.3)
Unable to speak Chinese	28 (80.0)
Occupation	
Businessman	26 (86.7)
Student	2 (6.7)
Housewife	1 (3.3)
English Teacher	1 (3.3)
Age	33.7 (3.1)
Number of years in China	4.4 (7.1)
Note: N varies based on missing responses	

Table 2 – Selected Respondent Quotations that Illustrate Barriers to Healthcare

Barriers to Healthcare	Percent	Respondent Comments
Predisposing Factors		
Race	45.7%	"They give more room and open more heart to Chinese. That's for sure." (Participant 14) "[The cost was] Not just double, triple, because we are foreigners." (Participant 2)
Different health beliefs and practices	42.9%	"I'm not sure but I think the drugs that are given to the Chinese citizens [since] their immunity is different from foreigner, the percentage of aspirin of doses is below of what we are getting in [the] Western country. I find that normally in the Western country, they give you an injection but here they only give you drips." (Participant 4) "There are some types of sickness we [Africans] have that the Chinese don't have. We have malaria and typhoid, which the Chinese don't know anything about it. When we get a cold in China, the doctors don't know the right prescription to give. They don't know how to treat cold or pneumonia. One of our people died because of that." (Participant 11)
Perceptions toward health services	45.7%	"There are too many hospitals around. When somebody goes there they will say you have this and that thing, they call it some bad sickness. Many people when they are sick they will not even go there, they say, 'No, they will tell me something that will kill me.' So some people refuse to go to a hospital. That is the problem here. (Participants 9) "If he [the doctor] gives me medications, I expect to see some good results. But I keep coming and complaining for the same problem, he [the doctor] is like, 'No, just take it.' (Participant 18) "They make sure that you don't have [any more] money. They rip you off. When they say pay 20,000, you pay, when they say 10,000 you pay. Again, they ask you [to] pay 10,000, may be [before] it takes an hour to pay and today it takes 2 days to pay. They know that

		your money is drying out. Yeah, so they will tell you to go back to your home country because they know your money is actually finished." (Participant 14)
Enabling Factors		
Legal status	28.6%	"Sometimes China say no extension [for the visa], so for those who are not ready to travel or don't have money to travel, they will become an illegal resident. Most of them [illegal residents] are afraid of going to a hospital, because as far as China is concerned anywhere you go they can ask for [your] ID." (Participant 5) "Legal issue because a lot of stuff happening here are not under the radar of embassy (…) The embassy is located in Beijing. Foreigners without proper documents can go to a hospital in Beijing, because if the police show up I can call the embassy and they will follow. Here, by the time you call them [embassy] in Beijing, you are somewhere else." (Participant 18)
Language barriers	100%	"The doctor can only say 'how are you?' and [the conversation is] finished. He cannot hear other languages. Only 'how are you?' I tell my wife what I want him to do, and then they talk. They communicate in Chinese, which I don't hear even one word." (Participant 11) "When I went there [a hospital] because of the language barrier they saw my name because my name is XXXXX and they could not mention. I was sitting there, sitting there, sitting there and many people come and go. I spent about four hours there because it's difficult for them to mention my name." (Participant 7)
Chinese provider's characteristics	34.3%	"The doctor will never ask you, 'my friend, how are you feeling?" They will just rush and rush and ask you to go to this [other lab] and finish." (Participant 10) "They [the doctors] will tell you, 'Go home and die.' I don't understand why the doctors here would tell a patient that they are going to die. I don't understand what kind of medical ethics. I think even the person is dying, the doctor shouldn't say that. Why would they

		make him more depressed?" (Participant 14)
Costs	42.3%	"When you see a doctor in China the charges are 80% higher than what we are paying in Western countries. I have seen many cases when somebody breaks the bones of their leg. The first thing the doctor asked on that day was 35,000 RMB, which is equivalent to maybe US$4,500." (Participant 4) "The most important thing is the cost. A lot of foreigners here in Chin have problems with their finances." (Participant 10)
Interpretation and Translation	45.7%	"All I know it is a hospital. You cannot know whether it is a private or government hospital because they write in Chinese [character] you cannot understand." (Participant 23)
Hours of operations and waiting time	20.0%	"They [the doctors] will just say in the morning or in the afternoon, but during break time around noon, they will not attend to you even when you are dying, that's their custom." (Participant 8) "It's very difficult to find people [care providers] that speak English, because they [care providers] work by shift." (Participant 9)

Appendix I

广东省皮肤性病防治中心
网址：Http://www.gdvdc.com

Guangdong Provincial Skin Diseases and STI Control Center
Ethical Review Committee
No.10 Xian Lie Dong Heng Rd
Guangzhou 510500, China

Approval Notification of Ethical Committee

Project Title	A Health Needs Assessment of Africans in Guangdong Province					
Project source	Harvard and Guangdong Provincial Skin Diseases and STI Control Center			Duration of approval	Three years	
Project number	57832453			Approved informed consent number	13	
People in charge	Li-Gang Yang			Title	Researcher, Director	
Committee location	Guangzhou			Approval date	6/29/2011	
Members of Ethics Committee	Specialty	Approved	Disapproved	Approved after necessary revision	Terminate or pause an approved study	Signature
Bin Yang	STI/Derm	☐	☐	☐	☐	
You-Shou Gu	STI	☐	☐	☐	☐	
Yong-Feng Chen	Dermatology	☐	☐	☐	☐	
Shan Zhong	Medical education	☐	☐	☐	☐	
He-Ping Zheng	Basic science	☐	☐	☐	☐	
Ming Li	Leprosy	☐	☐	☐	☐	
Tie-Qiang Wu	Dermatology	☐	☐	☐	☐	

Li-Gang Yang	STI	☐	☐	☐	☐	
Hui-Zhong Li	Dermatology	☐	☐	☐	☐	
Zhi-Ping Li	Pharmacy	☐	☐	☐	☐	
Xue-Lian Mei	Law	☐	☐	☐	☐	
No. members presented: NA			No. members evaded: NA			No. members abstained: NA

Vote	Approved: 1	Disapproved: 0	Approved after revision: 0	Requested to resubmit after revision: 0

Comments:

The Committee Chairperson has reviewed the proposal and believes that the study, A Health Needs Assessment of Africans in Guangdong Province, is an international cooperation project. It focuses on understanding the health needs of Africans in Guangdong Province. This study is minimal risk and was evaluated on an expedited course for a three year period. All study subjects should be informed information including: objective of the research, risk-benefit from the research, confidential and based on voluntary according to the rules in the Declaration of Helsinki. The study can be conducted after obtaining the informed consent from the research subjects.

Bin Yang, MD, PhD
Chairperson, Guangdong Provincial Skin Diseases and STI Control Center

Appendix II

Health needs assessment of the African Community of Guangzhou
We want to learn about the basic healthcare needs and access to care of the African community of Guangzhou. This research will help to inform the implementation of a reduced fee clinic to serve the local African community.
Semi-structured interview guide:

1. Informed consent
2. Brief introduction of research and purpose
3. Interview topics

Basic Information

1. Where are you from? What language do you usually use in Guangzhou? Age range? How much formal education have you had
2. Tell me about your life in Guangzhou--how did you get here? What is your occupation? How long have you been living in Guangzhou? Who do you live with in Guangzhou? Is your family here as well? How many family members are here with you?

Going to the Hospital in Guangzhou

1. When you get sick do you usually go to a hospital, clinic, or pharmacy?
2. Have you ever gone to the hospital in Guangzhou? (follow-up- if you have not gone to the doctor, has there ever been a time you needed to go to the doctor?)
3. What was the name of the hospital or clinic you went to?
4. Who recommended the doctor to you or how did you find the doctor?
5. Did you go by yourself or did you go with someone?
6. Did you receive any testing (if so, did you know the tests that were going to be done before they were done? Did you have any choice to get the tests or not?)
7. Did you receive any treatment at the hospital/clinic? (follow-up – was any testing done before the treatment?)
8. Was the clinic difficult to get to?

Getting medicine in Guangzhou

1. Have you ever needed to take a medicine in Guangzhou?
2. Have you ever needed to see a pharmacist in Guangzhou?
3. How do you know when to go to a hospital versus just buying medicine yourself?

Quality of healthcare in Guangzhou

1. Were you satisfied with your visit to the doctor?
2. Did you feel better after you saw the doctor?
3. Would you go back to the same hospital? If yes, would you want to see that doctor or pharmacist again?
4. What were the experiences like? What did you like about it? Not like about it?
5. What was the cost of the clinic visit or medicine? Price range
6. What aspects of a visit with the doctor are most important to you?

Healthcare access in home country

1. How is accessing healthcare in Guangzhou different than it is in your home country? (Cost, length of wait time, communication)
2. How is getting medicine in Guangzhou different than getting medicine in your home country? (cost, communication)
3. Do you spend less money on healthcare in Guangzhou compared to home country?
4. How is healthcare treatment in Guangzhou different from treatment in your home country?
5. Do you trust doctors in Guangzhou as much as you trust doctors in your home country?
6. Is the medical technology better in your home country or in Guangzhou?
7. What have your experiences been like when seeking healthcare in your home country compared to Guangzhou?
8. How did the experience compare to seeing the doctor/pharmacist in your home country?

Barriers to healthcare in home country

1. What difficulties do you face when seeing a doctor in home country?
2. Is there anything that stops you from seeing the doctor when you need to when in your home country? If so, what?
3. What would make it easier for you to see a doctor in your home country?

Barriers to healthcare in Guangzhou

1. What would make it difficult for you to go to a hospital or pharmacy?
2. What would make it easier for you to go to a hospital or pharmacy?
3. What problems do you think you will face if you go to a Chinese hospital? (ie: communication, economic, stigma/discrimination, immigration status). If you have gone to a hospital in Guangzhou, what would make that experience easier for you?

Immigration and health

1. Do you feel comfortable going to a hospital if you don't have a visa or resident permit?
2. If you do have a visa, did your willingness to go to the doctor change after getting the visa?
3. Have you ever needed to get health testing in order to stay in China?

Going to an STD clinic

1. Do you get routine health checks at an STD clinic?
2. If you have a friend who has had an STD or a concern about an STD what would they do? (follow-up: Do they seek STD care in China or outside of China? If outside of china, where do they go?)

Ideal Clinic

1. What is important to you when looking for a clinic? (low cost, close by, quality of doctor, etc)
2. How important is it to see a foreign doctor or a foreign-trained medical doctor?
3. Would you see a Chinese doctor who can communicate in English fluently?
4. What language do you prefer when seeing a doctor? (Options: French, English, etc)

5. Would you feel more comfortable to go to a hospital/clinic if they do not ask for your passport or visa?

Child access to care

1. If you have children, what do you do when your children are sick?

Appendix III

Ugandan Meeting Agenda 1:

1. Introduction of ourselves and of the project
    a. Who we are
    b. What is this project
    c. Purpose of this meeting—we are trying to find out what issues people face when seeing the doctor in Guangzhou, China. All of the information that is gathered here today will be used in the development of a reduced fee general medicine clinic.
    d. The session is being recorded because we don't want to miss any of your comments. No one outside of this room will have access to these tapes and they will be destroyed after our report is written.
    e. Focus group ground rules:
        - In focus groups there are a lot of different opinions. There are no right or wrong answers – just your own opinions. That's OK. We just want to know what you think.
        - It's OK to react to each other's comments. Some of you may agree with each other and some of you may disagree.
        - Let's all try to respect each other's different cultural values, beliefs and opinions. Everyone is entitled to their own opinions so it is very important that everyone be heard.
        - Please try to talk one at a time so the group hears your opinions. We don't want to miss what you're saying. If people start side conversations with their neighbors we miss out on what's being shared.
        - All of your comments are confidential. What we say in this room stays in this room. Can everyone agree with that?
        - Your participation is voluntary. You can say "pass" on a question that is uncomfortable for you if you like.

2. Focus Group
    a. Introduction of everyone in the group
    b. Healthcare experience in China:
        - Have you ever gone to see the doctor in Guangzhou?
        - What problems do you face when going to see the doctor?
        - How do you know where to go?
        - Have you ever had to get medicine in China?
        - What is this experience like?
    c. Women's health:
        - What do you think are the most important health problems of women in general in community here in Guangzhou?
        - What are the barriers to getting female health services?
        - If a women's clinic could do only one thing to help women in the community, what would that be?
    d. Access to health in home country:

- How does going to the doctor here differ from going to the doctor in your home country?
- Do you trust the doctor in Guangzhou as much as you trust the doctor in your home country?

3. Q&A: We would like to hear your suggestions for us and field any questions you have about this clinic.

Appendix IV

Code	Definition
Race	Statements about inequity in care and unjust cost structure due to one's racial background.
Communication/Patient's level	Statements about **patient's** limited Chinese proficiency and health literacy to obtain, process, and understand basic health information and services needed to make appropriate health decisions.
Communication/Provider's level	Statements about **provider's** limited second language proficiency (English and/or French) can act as a barrier because of ineffective communications between patients and doctors.
Communication/System's level	Statements about the unavailability of trained medical interpretation services in hospitals in China.
Language services /availability	The availability of translated **written** materials such as brochures with health information, health reports, medicine label and prescriptions.
Language services /unavailability	The unavailability of translated **written** materials such as brochures with health information, health reports, medicine label and prescriptions.
Perceived distrust/Medicines	Patients are dubious about the benefits of medicines in China.
Perceived distrust/Health personnel	Patients do not trust their doctor or healthcare providers about their decisions of diagnosis and prescribed medications.
Physician interaction style/Physician-centered	Physician interacts in a paternalistic doctor-centered mode, and possesses authority and prestige while the patient is vulnerable and dependent.
Physician interaction style/Instrumental behavior	Physician communicates in a task-oriented behavior. This includes speech that provides information to the patient, discussing tests and procedures, and explaining reasons for treatment options.
Physician interaction style/Affective behavior	Physician's behavior and speech that are directed towards the patient as a case instead of as a person. This includes providing verbal encouragement and support, non-verbal communication such as touching the patient,

	and engaging in small talk.
Physician interaction style/Listening	Physician's inability to listen with sympathy and understanding to the patient's perception of the problem
Medical skills	Statements about **physician's** nonrecognition of medical needs of the patient and the lack of understandings of the African and Chinese body system.
Length of care	Statements about not taking adequate time with patients.
Privacy	Statements about providers do not provide adequate privacy to patients. (*The limitation of privacy is NOT due to the hospital room layout)
Profit-driven	Statements about doctors "loving" money too much. This code focuses on the provider's level.
Cultural imperialism	Statements about doctors see differences as a problem and identify Chinese culture is superior over African culture.
Legal status	Statements about not having the legal status or right documents can restrict them to access to healthcare services
China visa procedures	Statements about the regular procedures obtaining a visa
China visa procedures/screening test	Statements about patient's experience of visa medical test
Alternative visa procedures	Statements about how patient's obtained their visa via alternative methods but the legal procedure.
Acculturation	Statements about Africans adopt the beliefs and behaviors of Chinese, such as social interaction with ethnic Chinese and communication in Chinese.
Social support	Statements about family, friends, community members, and coworkers provide assistance and encouragement in difficult life situations. (*These individuals have no medical training.)
Traditional Chinese Medicine	Statements about **patient's** belief of TCM.
Knowledge about physiology and diseases	Statements about **patient's** belief of different body systems between Chinese and Africans.
Cost	Statements about high medical costs.
Service availability	Statements about **patient's** unawareness of service availability or lack of knowledge about the healthcare

	services (including STD treatment care)
Treatment procedures	Statements about standard treatment in China (eg. Drips).
Medical equipments	Statements about technology and facilities used in providing health services in China
Medical administration system/documents	Statements about intake procedures that patients need to show some kind of documentations in order to be seen by doctors. (This includes the patient's perception of the requirement of documents)
Medical administration system/deposits	Statements about intake procedures that patients need to pay deposits before receiving treatment. This fee structure applies to everyone.
Drug surveillance system	Statements about sales of counterfeit medications in pharmacies in China
Drugs availability	Statements about unavailability of certain drugs in China
Structural barriers/Hospital layout	Statements about poor designs of hospital layout.
Structural barriers/ hours	Statements about hospitals are only open during "regular" office hours, the inability to schedule appointments, and the long waiting time.
Structural barriers/Hospital names and signs	Statements about lack of appropriate translated signs in pharmacies and hospitals.
Depersonalization	Hospital room layout and curtains limit patient privacy; hospital or office room size does not accommodate having the patient's family attend the visit
Coping/Self-medications	Statements include patients seek treatment through over-the-counter medications or home remedies.
Coping/Importation of medications	Statements about use of medications that have been sent from family members or peers in home country or other country outside of China
Coping/Medical tourism-within mainland China	Statements about patients seek healthcare services within mainland China
Coping/Medical tourism-outside of mainland China	Statements about patients seek healthcare services outside of mainland China
Coping/Medical connections	Statements about the use of personal connections for

	medical consultations. Connections include family member physician, physicians based in home country, and physician who is part of the African diaspora in China.
Coping/Ad hoc interpreters	Statements about the use of family members, friends, colleagues, or any untrained individuals in medical interpretations
Suggestions/Better communication	Statements about having bilingual physicians and other medical staff in a hospital
Suggestions/Interpretation services	Statements about having professional medical interpretation services in a hospital
Suggestions/Knowledge of foreigner's culture	Suggestions on learning and familiarizing oneself with normative cultural values of the African or Western community (more support and empathy)
Suggestions/Health insurance	Suggestions on implementing health insurance system in a hospital
Suggestions/medical system	Suggestions on having a primary care provider and longer visiting time