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Ayoka Adams April 16, 2012

Deciphering the Impact of Culture and Society on the Health Care Seeking Behavior of Emory University Students

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Abstract

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Socio-cultural factors influence the health behaviors and outcomes of individuals. The university population represents a unique and diverse population whose needs must be understood and met by the institutions to which they belong. Understanding these needs, in relation to health behavior, is important in developing programs to cater to the population. Thus, the purpose of this thesis was to investigate the health care-seeking patterns of Emory University students and determine if there were any differences due to nationality, race/ethnicity or gender. The thesis also sought to investigate cultural and social factors that caused these differences. Online surveys were conducted on one hundred and two (102) Emory University Students, as well as, semi-structured interviews were conducted with twelve (12) of these survey respondents. These instruments were used to extract data about patterns of frequency and type of service utilization, barriers to health services access and factors affecting provider choice. The results showed that there were a few differences in the patterns of utilization between national groups, racial/ethnic groups and gender groups. However, it also showed that there were many similarities, especially as it related to barriers affecting health services utilization and determinants of provider choice.

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Chapter 1: Introduction and Background to Research

Introduction

Research Question

The purpose of this study was to investigate what effects, if any; cultural and social factors have on the health care- seeking behavior of Emory University students. Specifically, it looked at differences or similarities in health care utilization and ideas about health- based on factors, such as nationality, race/ethnicity and gender- among Emory University students. The specific research questions, which were investigated, were:

1. How often do students access health care services?
2. What kinds of services do students utilize?
3. Are there differences in utilization based on race/ ethnicity, nationality and gender?
4. If there are differences, why do these differences exist?

Key Terms

For a better understanding of the goals of this project, an explanation of certain key terms is necessary.

Health Care Seeking Behavior

The *Handbook of Immigrant Health* defines health care- seeking behavior as "the use of health care services, factors associated with utilization and the ways in which people interpret health-related symptoms, and take action to address these symptoms, including seeking help from a range of alternative sources to prevent, ameliorate, treat, or cope with the symptoms" (Ell and Castaneda 1998). In the context of this project, health care-seeking behavior refers to the

frequency of usage of health care services- that is any institute or practitioner who provides or claims to remedy some malady or illness- as well as the type of practitioners and services utilized by students in order to treat a perceived illness or health problem. The health care seeking behavior process can be broken up into a series of steps, which influence the final decision outcome. These steps can all be affected by various social and cultural factors and vary in experience and chronology from person to person. Several models for health seeking behavior have been proposed. However, one by Noel Chrisman will be used here. Chrisman proposes a five step model consisting of: symptom definition, illness related shifts in role behavior, lay consultation and referral, treatment actions, and adherence (Chrisman 1977).

Another theory that attempts to explain health care seeking behavior is the Health Belief Model (HBM). The Health Belief Model, developed by the US Public Health Services in the 1950s, as a result of non-compliance of patients and failure of many public health programs, is a psychological model used for explaining the health-related behavior of individuals (Strecher and Rosenstock 1997). The model states that people's health related behaviors and decisions to seek care are determined by the perceived susceptibility of themselves to an illness, the severity/ consequences of the illness, the benefits of the treatment and the barriers that would impede access to the treatment. The model acknowledges that many factors, such as the age, sex, ethnicity, personality, socioeconomics and knowledge of individuals, affect an individual's perception of disease severity and susceptibility (Strecher and Rosenstock 1997).

A review of several studies of the HBM by Janz and Becker found that perceived barriers and susceptibility (respectively) were the two most important determinants of health care-seeking behavior of individuals (Janz and Becker 1984). While barriers are mainly socioeconomic in nature, the perceived susceptibility of illness has much to do with understanding of disease,

which is based on cultural values and ideas. These cultural values and ideas differ from culture to culture.

Cultural Factors:

A single definition for the term ‘culture’ has been widely disputed within the anthropological community for some time. For the purpose of this project, Eric J. Bailey’s definition of culture as ‘a system of shared beliefs, values, customs, behaviors and artifacts that members of a society use in coping with one another and with their world, that is transmitted from generation to generation through learning’ (Bailey 1987) is appropriate. All persons have belief systems about health that they share with members of their community, and which are passed on from generation to generation.

Many studies have emphasized the idea that culture plays a significant role in the decisions people make about their health. African Americans are more likely to interpret racism in the health care system and less likely to donate organs and utilize other services as a result (Cort and Cort 2008; Roy, et al. 2004a). Hispanic immigrants in America have different health services utilization patterns because of their cultural beliefs about alternative care and forms of medicine (Rogers 2010). International students from China and India have different utilization patterns than American students (Rothstein and Rajapaksa 2003). In all of these examples, socioeconomics were controlled for and the results show that between different groups there are different culturally defined ideas of health that affect how individuals utilize health services. Rogers even says that, ‘Culture…gives meaning to health, health information, and perceptions about appropriate health-related behaviors”(Rogers 2010).

Social Factors:

Social factors refer to the social institutions and relationships, which affect the health care-seeking behavior of individuals. Looking at social factors- such as socioeconomic and institutional constraints and the social construction of gender identities- allows for a better understanding of all the factors that affect the health care-seeking behavior of individuals. Some even argue that these social factors are more important than cultural ones in recent times. In an article examining how socioeconomic status can be accounted for in cultural competency studies, Simon and Mosavel say that "the emphasis on diversity and difference has, unfortunately, also detracted from serious consideration of the things that cultures have in common and the possibility that socioeconomic differences are today far more important than cultural ones in determining healthcare outcomes." (Simon and Mosavel 2008). Garcia also mentions the importance of social factors as it relates to health by acknowledging that social class sometimes has more of an impact on health and health outcomes than ethnicity and culture (Garcia 2006).

The Anthropological Connection

An exploration of these types of factors takes what Ell and Castañeda refer to as an 'anthropological view', as well as, a 'sociological view' of health care-seeking behavior (Ell and Castaneda 1998). The anthropological view- a more holistic approach to looking at health care-seeking behavior- focuses on cultural influences and variations in health care-seeking behavior. The sociological view, however, focuses on the social-structural influences on individuals' health care-seeking behavior. The multimodal focus of this project is very much in line with the

modus operandi of medical anthropology. The Society for Medical Anthropology defines medical anthropology as:

> "…a subfield of anthropology that draws upon social, cultural, biological, and linguistic anthropology to better understand those factors which influence health and well being (broadly defined), the experience and the distribution of illness, the prevention and treatment of sickness, healing processes, the social relations of therapy management, and the cultural importance and utilization of pluralistic medical systems. The discipline of medical anthropology draws upon many different theoretical approaches…Medical anthropologists examine how the health of individuals, larger social formations, and the environment are affected by interrelationships between humans and other species; cultural norms and social institutions; micro and macro politics; and forces of globalization as each of these affects local worlds". (Anthropology 2009).

This research project is indeed a work of medical anthropology, if the above definition holds true. Specifically, it takes an ethnomedical and critical anthropological approach to studying health and disease (Brown, et al. 2009). It is ethnomedical because it looks at health differences between different cultural groups, and also critical anthropological because it recognizes that larger social forces are at play in individuals' decision-making. For further clarification, the project is based on two frameworks of medical anthropology, as defined in the book *Introducing Medical Anthropology*. It adheres to the Meaning-Centered framework (Singer and Baer 2007b) (similar to the ethnomedicine approach), in that it proposes that humans experience the world only through their cultural frameworks. That is, understanding of disease and subsequent behavior, is based on the understanding that disease is inherently cultural. There is meaning behind every behavior related to health. Secondly, the project also works within the framework of Critical Medical Anthropology, which asserts that any analysis of health and behavior must include an explanation of the structures of social structures, which influence individual and group decision-making (Singer and Baer 2007b). These two frameworks work

well together for the purpose of this thesis and allow for a broader lens through which to view health care-seeking behavior.

These two approaches are very good tools to examine a study population of this kind. The population being studied in this thesis is all Emory University Students. Emory University is a premier educational institution located in Atlanta, GA. It is consistently ranked in the top tiers of universities in the United States and attracts a wide range of students from all over the United States and the world (Research 2011). The University system is made up of nine schools- Emory College of Arts and Sciences, Oxford College, Nell Hodgson Woodruff School of Nursing, Goizueta Business School, James T. Laney School of Graduate Studies, School of Law, School of Medicine, Rollins School of Public Health and the Candler School of Theology (Research 2011). The university provides an excellent opportunity to study these cultural and social factors, because the environment acts as a control of sorts. It can be assumed that because the University provides Student Health Services for students right on campus and requires all students to have health insurance, this removes some of the barriers associated with access to healthcare.

Background

This study is an important one to undertake, not only because it contributes to the body of research on health care-seeking behavior, but also because the demographics of the United States population and higher education student body have been changing rapidly and there seems to be no indication of it slowing down. Therefore, an understanding of how culture and society affect health behavior is going to be even more important in daily life, as the homogeneity of the U.S. population is reduced.

U.S. Migration and Changing Demographics

Globalization has meant that travel to and from different parts of the world has become commonplace. The United States population represents this trend very well. Immigration in the United States can be classified into three eras: The Classic Era, The Long Hiatus and The New Regime (Massey 1995). The last period is of most interest here. This period, which continues until today to some degree, refers to the increase in migration into the United States again from 1970 onwards. The national origin of migrants in this period was mainly non-European, as compared to earlier migration period.

Migration has led to an ever-changing landscape of the demographic make-up of the United States population. Statistics report that by the year 2042 the United States will become a 'majority-minority' nation; that is, 'minority' population- most notably Hispanics- will outnumber the 'majority' non-Hispanic whites (Mather, et al. 2011). Data from the 2010 Census showed that ninety-two percent (92%) of the population growth between 2000 and 2010 was due to increases in minority populations alone (Mather, et al. 2011). This is in large part due to the

increase in migration from Mexico and Latin America and the high fertility rates among these immigrant groups and dropping fertility rates among black and white Americans (Mather, et al. 2011). Although the rate of immigration has slowed in the recent recession, immigrants are still drawn to the United States in high numbers, due to a strong economy here, a demand for both low and high skilled workers and various push factors in their home countries (Mather, et al. 2011). Hispanic and Latino migrants come for low skilled jobs, while Asian immigrants- who are also a significant immigrant population (two thirds of Asian Americans are believed to be foreign born) - tend to come for education and to work in the science and technology industry (Mather, et al. 2011). Additionally, both of these groups consist of people from many different cultures, of different national origin and who speak different languages. Thus, the true contribution to diversity of these immigrant groups is beyond simply adding numbers.

Migration, Diversity and Higher Education

To narrow this perspective down to one more closely related to this project- similar immigration trends are present in higher education in the United States. Migration trends in higher education mimic those found in the wider American population, to some degree. While the demographic makeup of persons who come to the United States to study differs from the general United States immigrant population, there is still an ever-increasing number of international students coming to study in the United States, just as there are immigrants coming for reasons outside of education. Generally, these students come to the United States in order to enhance their career opportunities in the future and because of the reputation of American institutions throughout the world (Obst, et al.). International students are important to the United

States education system and economy. They contribute billions of dollars to the economy and aid in the internationalization of classrooms and increase in diversity, as well as teach and carry out research in the science and technology fields (Obst, et al.).

Since data started being collected in 1948, there has been an increase in the number of international students enrolled in American institutions of higher education every year except for four (1971, 2003, 2004 and 2005) (Education 2011b). As of the academic year 2010/11 there were about twenty and a half million (20,550,000) international students studying in the United States (Education 2011b). A little over seven hundred thousand (723,277) of those enrolled in that year alone (Education 2011b). International students accounted for three and a half percent (3.5%) of the entire population of students in tertiary education (Education 2011b). For the academic years 2009/10 and 2010/11, the top five countries of origin of international students were China, India, South Korea, Canada and Taiwan (Education 2011d). However, students came from a total of two hundred and twenty one (221) countries, from every region of the world (Education 2011c).

Notably, although the majority of these students are found in large Doctoral/Research Universities, international students are found at all levels of tertiary institutions- from these large institutions to smaller two year ones (Education 2011a). Many institutions recognize the importance of international students and their contribution to diversity on campus, and have made efforts to improve recruitment and ensure that adequate advising and resources are available for these students once they get to the United States.

The demographics of higher education student populations have not only become more diverse due to increases in international student enrollments, but also due to higher numbers of American minorities and females entering institutions of higher education. The profile of the

American student has changed from that of the rich white male to a more diverse one. Between 2000 and 2008 the percentage of males and the percentage of students who identified as white enrolled in institutes of higher education dropped, while rates for all other racial/ ethnic groups and females consistently rose (Aud, et al. 2010). This is true for both graduate and undergraduate institutions. In 2008, the undergraduate student population was about sixty-four percent (63.9%) white, and almost sixty percent (56.9%) female, and the graduate student population was just above sixty-three percent (63.3%) white, and fifty-nine percent (59%) female (Aud, et al. 2010). These statistics show a definite improvement over those for 2000, which showed that the undergraduate population was just over eighty-two percent (82.2%) White and forty-eight percent (48%) female, and the graduate student population was just above eighty five percent (85.3%) white and almost forty-three percent (42.7%) female (Aud, et al. 2010).

Emory's Diversity

Emory University is no exception to the increase in diversity of student bodies across the United States. Firstly, international students and scholars make up a significant portion of Emory's student body. In the year 2010/11, one hundred and seven (107) countries were represented within the student body of Emory University- that is F-1 and J-1 students alone (Services 2011), with India, China and Korea accounting for the majority of international students at every level at Emory (Services 2011). In total, there were one thousand, eight hundred and forty-two (1,842) persons from foreign countries studying at Emory University in 2010/11 (Research 2011). This represented a little more than thirteen percent (13.3%) of all Emory University students for that year (Research 2011). Emory has recognized the importance

of this group of students and has made a great effort to recruit more international students and develop programs to make studying in the United States easier. According to Scott Allen, the Senior Associate Dean of Admissions in The Office of Undergraduate Admissions, the University has made it their goal to ensure that between ten (10%) to twelve percent (12%) of the entering undergraduate class each year is from outside of the United States and have increased their recruiting efforts overseas to do so (Allen 2012).

Emory, as an institution, has a commitment to diversity, represented, not only in its large international student population, but also in its relatively large minority population. In the year 2010/11 Emory's minority student population made up a little more than thirty-one percent (31.4%) of the entire student body (Research 2011). This is an improvement over the just under twenty-five percent (24.6%) minority population that the University reported in 2000 (Diversity, et al. 2008). Emory actively recruits minority students and this effort is seen in the demographic make-up of its student body. The largest minority groups represented at Emory are Asian (16.8%), Black/African American (10.0%) and Hispanic (4.4%) (Research 2011). In fact, students who identified themselves as White accounted for less than half of the University's student population, at only forty-six percent (46.0%) (Research 2011). The University has many programs in place- such as International Student and Scholar Services (ISSS), the Office of Multicultural programs and Services (OMPS) and the Office of Community and Diversity- to support its diverse student body.

Rationale

As was explained in the preceding section, Emory University is a diverse institute of higher learning made up of students from all over the world and the United States. The student body is constantly changing and represents growing trends in the United States as a whole. Along with the changing demographics of the student body, the policies of the university must also change to accommodate it. The University continues to be committed to understanding and providing for the needs of its community and there is no indication that it is falling short of its goals. However, as patterns of enrollment change, the University needs to keep abreast of these changes, in order to cater to their students. Thus, research of the kind provided in this thesis will provide important data that the University can use in its commitment to meeting the needs of its diverse student population. Health is one such need area to which attention should be paid- an understanding of culture is essential to providing health services that serve the needs of this diverse population. This idea brings to light the concept of cultural competency, which has played a large role in recent medical education and practice.

Cultural Competency in Healthcare

Anthropologist Benjamin Paul says that, “The success or failure of a health program is largely governed by the way in which it fits the modes of thought and action of the recipient population” (Paul 1963). And furthermore, “Health care service utilization is directly related to…the population targeted for service” (Russell and Jewell 1992). That is, the cultural beliefs of the target population play a large role in determining the degree to which they utilize healthcare services. This idea is the basis for cultural competency training in healthcare. An official definition, given by Brown et. al. describes it as “the training of health care providers in basic

knowledge about cultural differences among patients and skills in cross-cultural communication" (Brown, et al. 2009). Paul describes the problem cultural competency attempts to fix as 'The Cultural Gap' (Paul 1963). He asserts that health professionals view the world through their own culturally tinted glasses, which are often incompatible with the patients they serve (Paul 1963). Thus, in order for the gap to be closed health professionals need to understand the cultural beliefs of the people they serve. That is, they need to understand the patients' explanatory models of their illness- the beliefs they have about their illness causation (Brown, et al. 2009).

For the purpose of this study, the definition of 'cultural competency' should be expanded to include training about those socially constructed ideas, beliefs or decisions about health, which can often be in conflict with the health care provider. Such things include socially constructed ideas about gender identity, social tensions- such as discrimination and inequality- and other socioeconomic factors that influence the beliefs and decisions people have about health. Based on this, this project is important because it could aid in developing cultural competency programs specific to the population at Emory University. At the very least, it would provide insight into challenges that Student Health Services may face, and should address, when dealing with the diverse population of this school.

Chapter 2: Literature Review

Literature Review

Health and accessing healthcare is a complex issue which is influenced by several different factors (Basu 1990; Cort and Cort 2008; Eisler and Hersen 2000; Flores, et al. 1999; Manzoor, et al. 2009; Rogers 2010; Rothstein and Rajapaksa 2003; Roy, et al. 2004b; Russell and Jewell 1992; Stern 1986). These factors range from biological and environmental causes to socioeconomics and access to resources to cultural beliefs and ideologies. Understanding the ways students think about and internalize health issues and how this affects their behavior regarding accessing healthcare, is essential to providing programs that work for them.

It was already discussed briefly in the *Introduction* the effect that cultural beliefs and ideas have on health- ideas about health are based on cultural understandings of illness and disease causation and the ways in which they can be helped. In the third chapter of the book *Introducing Medical Anthropology*, Singer and Baer attempt to explain that there are differences in how different illness and diseases are experienced and understood cross-culturally (Singer and Baer 2007a). They examine different theories, conceptualizations and narratives of illness and disease in different cultures. It is therefore appropriate to say that "cultural or regional identity has an important bearing on the knowledge, attitudes and practices relevant to the use of health care facilities" (Basu 1990). Basu came to this conclusion after investigating differences between two groups of women from different cultural groups in India and the way in which they utilized health services. Nancy Waxler examined how the experience of leprosy differed from region to region based on differences in the understanding and construction of the disease (Waxler 2009). These are just a few of such studies. Many other researchers have published similar findings that show differences in utilization patterns between different cultural groups, often separated by

race/ethnicity or national origin. It has been shown that African Americans have unique culturally mediated health care utilization patterns different from the dominant norms (Bailey 1987; Bailey 2000; Bailey and ebrary Inc. 2002; Eisler and Hersen 2000; Lillie-Blanton, et al. 2000; Roy, et al. 2004a; Russell and Jewell 1992), and that immigrant populations often show different, also culturally mediated, patterns of health care utilization as well as ideas about health from the populations native to their country of immigration (Carrasco-Garrido, et al. 2007; Ell and Castaneda 1998; Leclere, et al. 1994; Ma 1999; Rogers 2010; Rothstein and Rajapaksa 2003).

A review of the literature concerning the influence of culture and society on health care-seeking behavior, and ideologies about health, shows that research on this topic is extensive and diverse. Here, an attempt will be made to consolidate some common trends, which occurred in the review, specifically from those studies in the fields of Public Health, Nursing, Medical Anthropology and Medical Sociology. The research in these fields provided the most data about the connection between health behaviors and cultural and social influential factors.

Non-Cultural Factors which Influence Healthcare Seeking Behavior

Before the cultural influences on an individual's healthcare seeking behavior can be discussed, an examination of the role other factors play in determining the healthcare seeking behavior of people must be carried out. Culture is but one factor, which influences healthcare seeking behavior. However, by focusing on culture alone we run the risk of confusing culture for 'structural violence' as anthropologist Paul Farmer has often argued in his discussions on the health of the poor (Farmer 1990). Farmer argues that in the quest to simplify a problem or place

the blame on the victim, social factors that constrain the behavior of people in relation to their health, - that is structural violence- are often ignored and simply placed into the category of 'culture'. He has shown by examining cases of noncompliance with tuberculosis treatment in Haiti and Peru, that by ignoring the impact of structural violence and other social factors, the true issues underlying an individual's healthcare seeking behavior cannot be determined (Farmer 1990).

Social constraints, such as a lack of insurance, inability to access resources, racism and poverty, are determinants of health and healthcare seeking behavior.(Adamson, et al. 2003; Dunlop, et al. 2000; Eisler and Hersen 2000; Janz and Becker 1984; Rogers 2010; Roy, et al. 2004b; Russell and Jewell 1992; Strecher and Rosenstock 1997). Even in the United States, millions of people do not have access to basic medical care because of their lack of insurance coverage (Cohen, et al. 2009). This could be due to location issues, lack of transportation, lack of money to afford services and other factors. Farmer would collectively refer to these things as structural violence (Farmer 1990) because they are factors beyond the control of the individual which impact their health outcomes. Farmer defines structural violence as the large-scale social forces that affect the health behaviors and outcomes of individuals (Farmer 1996; Farmer, et al. 2006).

One of the social factors that affect healthcare seeking behavior of individuals is socioeconomic constraints. There is an abundance of research on the topic. Socioeconomics affect healthcare seeking behavior of different groups of people in several different ways. For example, access to and the quality of healthcare received- for African Americans, the inability to pay, lack of transport and child care, lack of understanding of treatment plans, inability to

incorporate health plans into the daily living patterns (Russell and Jewell 1992)- are all factors which act as barriers to utilization of healthcare services and which affect healthcare seeking behavior.

Healthcare Seeking Behavior among University Students

As a population, university students have unique influences on their healthcare seeking behavior. Although generally healthy, they are more likely to engage in risky behaviors- such as alcohol consumption, tobacco smoking, recreational drug use and risky sexual behaviors- as well as, are particularly susceptible to stress and injury due to their changing social status (Werch, et al. 2007). Studies have shown that there are gender differences between male and female university students in both their risk taking behaviors, as well as desire to seek help. Males tend to engage in more risk taking behaviors, while having less help seeking behaviors (Davies, et al. 2000; Stock, et al. 2001). This is one constant between the University population and the general population- gender differences in health services utilization. Alternatively, University Students, by virtue of their age group are included among the age group category that has lowest rates of health services utilization in the general public (Statistics 2011). Data from the National Health Survey showed that 18 to 24 year olds were the most likely to report that they had had no visits to doctor's offices, emergency departments and home health visits within the past twelve months than any other group (Statistics 2011). They also had the second lowest percentage of respondents saying they have visited ten (10) times or more throughout the past 12 months (Statistics 2011). Considering that this is the age group most associated with university students,

it points to the idea that students may be less likely than the general public to utilize health care services.

Some research has also shown that the health concerns of university students differ from the general public in their content. University students are more likely to be concerned about sexual health, drugs and alcohol behavior, stress effects, body image and HIV/AIDS (Davies, et al. 2000; Ford 1994; Vaez and Laflamme 2003). Based on this, it is safe to assume that these would be the types of services university students would utilize. Additionally, University students are influenced in their decisions about health by parents and family (Birch, et al. 1997) and, for a large portion, the internet (Escoffery, et al. 2005). Even considering this, the amount of information specifically available on the health care seeking behavior of university students is limited. Research has focused on health behaviors- specifically risky ones- among students and interventions for these risky behaviors.

Race/Ethnicity

There are differences in healthcare seeking behavior of people of different races and ethnicities within the United States (Bailey 1987; Bailey 2000; Bailey and ebrary Inc. 2002; Basu 1990; Blackhall, et al. 1995; Cort and Cort 2008; Eisler and Hersen 2000; Flores, et al. 1999; Lindley, et al. 2009; Rogers 2010; Roy, et al. 2004b; Russell and Jewell 1992; Statistics 2011; Stern 1986; Strecher and Rosenstock 1997). Several of these differences are often due to differences in socioeconomics. Minorities, for the most part, are less likely than the general population to access healthcare services, more likely to use the Emergency Room as a source of primary healthcare, are often less educated about health and more likely to have adverse health

outcomes (Eisler and Hersen 2000; Flores, et al. 1999; Rogers 2010; Russell and Jewell 1992). They are also more likely to mix biomedical practices with other types of traditional or folk practices (Flores, et al. 1999; Rogers 2010; Stern 1986) - that is cultural practices that are different to the dominant norm and which are usually carried out by a non-medical practitioner. The literature examined for this study showed similar trends in healthcare seeking patterns and the factors which influences these patterns for a few minority groups- including African Americans, Hispanics and Native Americans. Most of the literature focused on African Americans and Hispanics. It should be noted, however, that the patterns discussed below should not be considered universal, as within each group there will be those who adhere to and deviate from the norms and patterns. These accounts simply show patterns that have been found within these particular minority groups.

African Americans

The literature on healthcare seeking behavior, and how race influences it, is heavily weighted towards research on African Americans. Overwhelmingly, it was found that African Americans were less likely than their white counterparts to access primary healthcare services, practice preventive medical practices, more likely to seek informal sources of support or instruction on healthcare or self-care, felt that religion and spirituality played a role in health and illness and were more distrusting of the medical staff and services. African Americans are also more likely to self-treat, as well as, use folk or traditional beliefs (Eisler and Hersen 2000; Flores, et al. 1999; Rogers 2010; Russell and Jewell 1992; Stern 1986). The underlying cultural beliefs associated with this type of behavior are a holistic view of health and an intrinsic mind-body connection as

well as the belief that health was a gift or blessing from God (Russell and Jewell 1992). Russell and Jewel even say that:

> "Rather than dichotomize health into physiological and psychological components as defined within the traditional science oriented framework of health, African Americans characterize health as a continuum evolving around mind, body and spirit."(Russell and Jewell 1992)

One theme which kept occurring in the literature on the healthcare seeking behavior of African Americans was that for many there was a distrust of medical practitioners and the medical system as a whole (Cort and Cort 2008; Roy, et al. 2004b; Russell and Jewell 1992; Strecher and Rosenstock 1997). This distrust was due to fear of racism or discrimination owing to their race. These fears are based in the history of medical abuses-which have occurred in the African American community in the past. Incidents like the Tuskegee Experiments, where African American males were infected with and left to suffer from Syphilis, remain present in the consciousness of many African Americans and result in a reluctance to participate in the dominant medical system. This can be seen as one of those barriers to accessing healthcare discussed in the Health Belief Model (Strecher and Rosenstock 1997). Additionally, African Americans rely a lot more heavily on informal social support networks and religion for their health and wellbeing. Thus, they more readily consult friends and families about medical problems, or turn to someone within these social systems, in order to seek treatment (Eisler and Hersen 2000; Flores, et al. 1999; Rogers 2010; Russell and Jewell 1992; Stern 1986) .

Hispanics

Hispanics hold a unique place in this study, as they can be classed as both immigrants and a racial/ethnic minority of United States citizens. Hispanics have been in America for a much shorter period than most other minorities and thus many of the cultural factors that influence their healthcare seeking behavior have much overlap with those of immigrant populations. The literature on the topic, for the most part, did not distinguish between the two groups- immigrant Hispanics and American Hispanics. As with African Americans, they reported lowered use of healthcare services, more reliance on social support systems and a distrust or unease in visiting biomedical practitioners (Flores, et al. 1999; Rogers 2010). They also had their own set of folk or traditional beliefs to which they adhered.

Overall, cultural beliefs, associated with race and ethnicity, do play a role in determining the healthcare seeking behavior of populations. These cultural beliefs are often in opposition to, or at the very least, dissimilar to the dominant (white) Western biomedical beliefs about health and wellness. This generally results in lower rates of use of these dominant health services and wariness about using them. Non-minority individuals, as would be expected, generally hold beliefs similar to those of the dominant "White" culture and thus find it easier to adhere to 'proper' healthcare seeking behavior (Penn, et al. 1995).

It can be assumed that similar differences would exist for other minority groups due to their common socioeconomic status and similar feelings of disconnect with the dominant culture.

Nationality

In order to look at nationality in this study, the literature about immigrant populations was examined. Although international students are not considered immigrants, as they are here on non-immigrant Visas, they share many characteristics with them. Both groups of people are caught between two worlds. They are working within the framework of both their own beliefs specific to their home nation and those they encounter when they come to the United States. As was discussed before, although ethnic and racial minorities in the United States do have cultural differences, which cause differences in their healthcare seeking behavior, many of these differences are actually due to socioeconomic factors (Adamson, et al. 2003; Bailey 1987; Dunlop, et al. 2000; Garcia 2006; Geertsen, et al. 1975). Oftentimes these same socioeconomic concerns do not pertain to International because they are often of middle to high socioeconomic status- owing to the fact that only these individuals are able to pay the fees required to attend university in the United States (Waters 2006).

Overwhelmingly, the main factor that was discussed when looking at healthcare seeking behavior among immigrant populations was that of the employment of pluralism of care. (Flores, et al. 1999; Ma 1999; Rogers 2010; Rothstein and Rajapaksa 2003). That is, the mixing of traditional medical practices with the dominant biomedical ones. Instead of forsaking one for the other, many immigrants develop a belief system that allows them to use both systems of medicine alongside one another. They have normalized this pluralism of care by assigning each type of medical care to particular types of diseases or severity of the disease. The severity of a disease determines which medical system will be used (Ma 1999; Rogers 2010). There is a general belief that western dominant biomedicine is harmful and thus should be used only for

serious illnesses or when rapid relief is needed. One study by Ma, showed that among Chinese immigrants in Houston and Los Angeles there was high utilization of home treatment and home remedies- especially for less severe maladies-, medium rates of utilization of integrated Western and traditional services and low rates of exclusive use of either medicine system (Ma 1999). Another study by Rothstein, identified similar trends among Indian and Chinese born students in an American university (Rothstein and Rajapaksa 2003).

Among immigrants, as there is among ethnic and racial minorities, there exists the perception that dominant practitioners do not or would not be able to relate properly to them or that they would receive discrimination to some degree (Ma 1999; Rogers 2010). This acts as a barrier to some to accessing healthcare. Additionally, there was a general lack of familiarity with Western procedures that also discouraged many immigrants from utilizing these services as often as the average (Ma 1999; Rogers 2010; Rothstein and Rajapaksa 2003). People tend to use things, which are familiar to them. Additionally, language and cultural differences also act as a barrier (Ma 1999; Rogers 2010; Rothstein and Rajapaksa 2003).

Another factor that greatly affects the healthcare seeking behavior of immigrants is their beliefs about the causes of health. These are often considered more holistic than the dominant biomedical belief system. Many immigrants hold a concept of holistic health and that care should only be sought when things became serious (Ma 1999; Rogers 2010; Rothstein and Rajapaksa 2003). Although not many consider themselves very healthy, they saw no need to seek treatment for minor ailments (Ma 1999; Rogers 2010; Rothstein and Rajapaksa 2003). In the cases where things were not deemed severe enough for formal medical attention self-treatment or informal treatment within the social network was carried out.

A Note on Acculturation

Acculturation refers to the degree to which minority or immigrant populations have accepted and internalized dominant beliefs and ideologies within themselves. Gordon-Larsen et. al defines it as “the acquisition of dominant cultural norms by a non-dominant group” (Gordon-Larsen, et al. 2003). U.S.-born immigrants and immigrants who have been in the United States for a long time tend to adopt norms similar to those of the dominant American culture (Arcia, et al. 2001). Acculturation has been shown to cause differences- both positive and negative- in health and health behaviors (Abraido-Lanza, et al. 2006). One study by Gordon-Larson et. al found an increase in obesity related behaviors, as well as English proficiency, in U.S.- born Hispanic immigrants, compared to foreign born Hispanic immigrants (Gordon-Larsen, et al. 2003). The literature on acculturation and its effects on health behaviors of immigrant populations is still growing. Currently, much of the research focuses on Hispanic and Latino immigrant populations. The little that is known, however, shows that there should be differences in the health care-seeking behavior of forgiven-born students and first generation American students.

Gender

Gender, or rather the social construction of gender, plays an important role in the healthcare seeking behavior of individuals. This is especially true of men. Firstly, it must be acknowledged that because of women’s reproductive life and childbirth, overall, women do utilize health services more often than men do (Bertakis, et al. 2000; Cleary, et al. 1982). This, however, is because of a biological difference and not a socio-cultural one. The ways in which men and women are socialized and the respective gender roles they adhere to impact the way that

they view health and the behaviors associated with healthcare seeking (Cleary, et al. 1982; Courtenay 2000; Galdas, et al. 2005; Macintyre, et al. 1996; Noone and Stephens 2008). One study by Davies et al found that college men were more likely than women to engage in unhealthy behaviors, but less likely to seek care, even when they were knowledgeable about how to seek care. They proposed that the gender socialization of young men was a primary barrier to health care seeking for college men (Davies, et al. 2000).

The main point which can be drawn from the literature is that men are far less likely than women to access healthcare services, in order to maintain their masculinity (Annandale and Hunt 1990; Bertakis, et al. 2000; Courtenay 2000; Davies, et al. 2000; Galdas, et al. 2005; Noone and Stephens 2008; Sabo and Gordon 1995). Use of healthcare services- that symbolizes illness- is seen as for the weak and essentially feminine in nature (Courtenay 2000). Men are reluctant to seek healthcare services in order not to appear weak or effeminate. This trend is seen throughout all races, ethnicities, nationalities and socioeconomic groups and points to an almost universal socialization of men. There is also the common belief that women tend to seek care for trivial illnesses, while men tend to take the opposite approach and are told to bear the discomfort until it is severe enough to need medical attention.(Galdas, et al. 2005).

The literature has shown that there are differences in healthcare seeking behavior- due to social, economic, political and cultural factors- among different groups of people. That is, that African Americans and other minorities tend to be more wary of racism and utilize health services less and self-care at home more, immigrants are more likely to utilize a plurality of care and that men are less likely to access health services to preserve ideas of masculinity. The review has also identified some possible factors, which may act as barriers to accessing healthcare

services. These include socioeconomic disadvantages, such as lack of financial resources and health insurance, as well as structural constraints, such as distance and location of service. What the review has not shown however, is how this translates to university campuses. This gap will be attempted to be addressed with this thesis. Based on the information collected in this literature review, a hypothesis can be stated. The hypothesis is that there will be differences in the health care seeking behavior of Emory University students based on race/ethnicity, gender, nationality and socioeconomics, and that these differences will be seen in the frequency and type of utilization of health care services by students.

Chapter 3: Methodology

Methodology

Project Goals

The goals of this research project were to:

- Identify similarities and differences in health care seeking behavior trends among Emory University students based on race/ethnicity, national origin and gender.
- Identify cultural and social reasons for these similarities and differences.

Preliminary Research and IRB Approval

This project was submitted for Emory Institutional Review Board (IRB) approval in the Fall of 2011. Approval for the project was granted on February 2, 2012. Prior to submission, research was done on the study population and background information garnered about the research topic. This information was used to develop the research questions stated in the *Introduction* of this project, as well as to develop an outline for the plan of the project. A review of the literature was also carried out during this period.

Questionnaire and Interview Script Development

Once research questions had been determined and a study population identified, the research tools were developed. It was determined that a fifteen (15) minute online questionnaire and semi-structured interview lasting no more than half an hour would be the methods of data

collection used for this project. This would allow for the collection of both quantitative and qualitative data and provide breadth, as well as depth to the results.

In order to develop questions for the survey and interview, information from the review of the literature was used. Particular themes and ideas about health were identified and questions related to those themes were developed. Similar surveys in other projects were also used as guides for the design of the survey. Once a preliminary survey instrument had been developed, it was further refined and questions added to it, by having informal interviews with six (6) members of the study population. The information that arose in these interviews was used to add more questions to the survey and interview script. A twenty- four (24) question survey resulted, asking questions about respondent demographics, as well as, about degree of use of health services and ideas about health. There were both closed ended, as well as two (2) open ended questions on the survey.

Once a final questionnaire had been developed in Microsoft Word, the survey was then created online, using the Google Docs program and emailed to five members of the study population in order to determine the length of time needed to complete it. These trial runs showed that the survey could be completed within ten (10) to fifteen (15) minutes. This was in line with the information detailed in the Protocol for IRB approval, and thus the questionnaire was ready to be sent out to the study sample.

A semi-structured interview, with selected students who had completed the questionnaire, was also developed. Interview questions were not as detailed as survey questions, however, the interview was designed as a way to gain deeper insight into respondents' beliefs about health, rather than their utilization behaviors. The Interview script was developed along similar lines as

the survey. Questions were based on prior research, as well as based on the pattern of questions in the survey.

Study Population and Recruitment

The study population for this project was all enrolled Emory University Students. This included students from all of Emory's nine schools on the Atlanta campus, as well as students who were studying abroad but who were still enrolled in the University, both full time and part time students and students from all degree levels. This represents a population of approximately fourteen thousand (13,893) students (Research 2011).

Participants were recruited for the survey portion of this study through email. Approximately six hundred (600) emails were sent directly to students' email addresses. Email addresses were selected from student groups of which the author was a member and from the Directory on Emory's FirstClass system LearnLink. In addition to these personal emails, announcements were made in two anthropology classes of approximately three hundred and seventy (370) students in total, additional professors were contacted about forwarding the email to their students, student group leaders were contacted about sharing the link with their members, and the International Students and Scholars Services (ISSS) office sent out a recruitment email to the International Student mailing list. It was emphasized- especially when using professors for recruitment- that participation was voluntary and would have no impact on students' academic standing in the University. Students were sent personal reminder emails and student group leaders were also sent a reminder email one week after initial contact.

Participants for the semi-structured interviews were recruited by giving survey participants the option of being contacted for a follow up interview, by including an email address at the end of the survey. The list of email addresses collected from the surveys was then compared to the demographics of respondents. Participants for interviews were then contacted by email based on their demographic data- that is race/ethnicity, gender and nationality. Where possible, two (2) members from each demographic group were selected to see if they would be willing to participate in an interview. Those selected were also sent a reminder email one week after initial contact.

Sample Size

The original predicted target sample size for this project was one hundred and fifty (150) survey respondents and thirty (30) semi-structured interviews. These sample size predictions represented about one percent (1%) of the total Emory student population and was considered large enough to gain statistically significant results. It was also targeted that the sample be split evenly between international and American students. It was understood that these projections were estimates and would be subject to change based on time and recruitment constraints.

Sampling could best be described as a mixture of Simple Random Sampling and Stratified Sampling, since although particular groups were targeted to send emails to- International students and students with particular ethnic surnames- people within these groups were randomly selected along with those outside of these groups. Based on the data collected, the actual sample size was one hundred and two (102) survey respondents and twelve (12)

interview respondents. Since it is very difficult to track exactly how many individuals received the link to the survey, it is difficult to assess exact response rates.

Data Collection

Data was collected during the period of February 23, 2012 to March 25, 2012. Online surveys were collected continuously during this period. Access to the online survey was halted on March 25, 2012. Semi-structured interviews took place during the period March 8, 2012 to March 28, 2012. Interviews were conducted at various places on the Emory University campus, depending on the participant's preference. Every effort was made to ensure that locations were private and free from distraction and noise. Interviews lasted between fifteen (15) and twenty (20) minutes each.

Surveys collected mainly quantitative data, while the semi-structured interview provided qualitative, ethnographic data, to complement that collected from the surveys. An additional interview was also carried out with Dr. Michael Huey, the Director of Student Health Services on March 30, 2012, in order to gain more contextual data.

Data Analysis

Data was analyzed using both quantitative and qualitative methods. Data from online surveys were downloaded into Microsoft Excel files for analysis, and then further analyzed using SAS JMP9. Semi-structured interviews were partially transcribed for further analysis.

Survey data was examined to identify patterns based on demographic profiles. For quantitative data, descriptive statistics were used for analysis. Where necessary, Chi Square calculations were carried out to determine if differences observed between groups were significant. For qualitative survey data, common key words were identified among respondents' answers, in order to draw conclusions about patterns.

Semi-structured interviews were listened to and partially transcribed when relevant data was identified and compared to the data collected in the surveys.

Chapter 4: Results

Results

Respondent Profile

For the purposes of this project, respondents were sorted into three categories based on their national origin.

- International Students: these respondents identified as being F-1 VISA students or as having grown up outside of the United States. There were twenty-eight (28) such respondents. This represents almost twenty-eight percent (27.5%) of total respondents (Table 1).
- First Generation American Students: these respondents identified as being American citizens or growing up in the United States, but having one or more parents who were born or who grew up outside of the United States. There were thirty-six (36) such respondents. This represented just under thirty-six percent (35.3%) of total respondents (Table 1).
- American Students: these respondents identified as being American citizens or growing up in the United States and as having parents who were also American citizens or grew up in the United States. There were thirty-eight (38) such respondents. This represented just over thirty-seven percent (37.3%) of total respondents (Table 1).

One hundred and two (102) persons responded to the online survey. The typical respondent was a Christian heterosexual female, Emory College student, under the age of 25 who identified as being of the Upper Middle class, was a United States citizen and considered herself to be in good health (Table 1).

Table 1: Respondent profile

Nationality Group	**N, number of respondents**	**Percentage of respondents**
International Students	28	27.5
First Generation American Students	36	35.3
American Students	38	37.3
Gender	**N, number of respondents**	**Percentage of respondents**
Male	21	20.6
Female	80	78.4
Transgender	1	1.0
Race/ Ethnicity	**N, number of respondents**	**Percentage of respondents**
Black/African American	33	32.4
Caucasian/ White	28	27.5
Asian	26	25.5
Other	15	14.7
Socioeconomic Status	**N, number of respondents**	**Percentage of respondents**
Upper	14	13.7
Upper Middle	45	44.1
Lower Middle	30	29.4
Lower	13	12.7

The male and female composition was similar across the differing nationality groups, with significantly more women than men in each group. This was especially true of First Generation American Students. There was one transgendered respondent in the International

Student group. American Students tended to be White/Caucasians (23%), which differed from International Students who were primarily Asian (15%). There was a relatively even distribution of Blacks/African Americans among International Students and First Generation American Students (Figure 1).

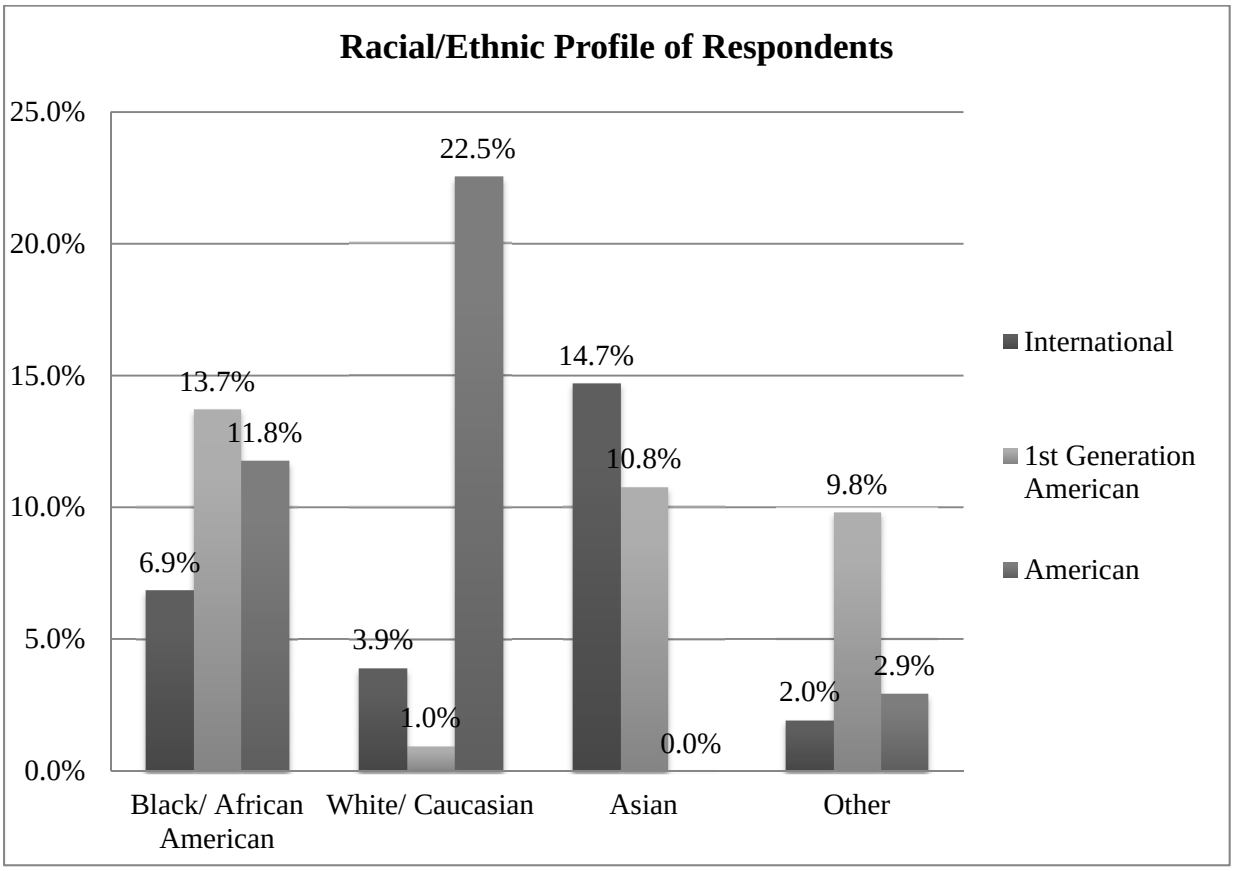

Figure 1: Racial/ethnic profile of respondents, separated by nationality group.

Participants also differed by their socioeconomic class, which also varied by immigration. The majority of individuals were of the middle class socioeconomic groups (29% Lower Middle class and 45% Upper Middle class). There were many more International Students

and American Students in the Upper classes (23% International and 20% American) and more First Generation American Students in the Lower classes (20%) (Figure 2).

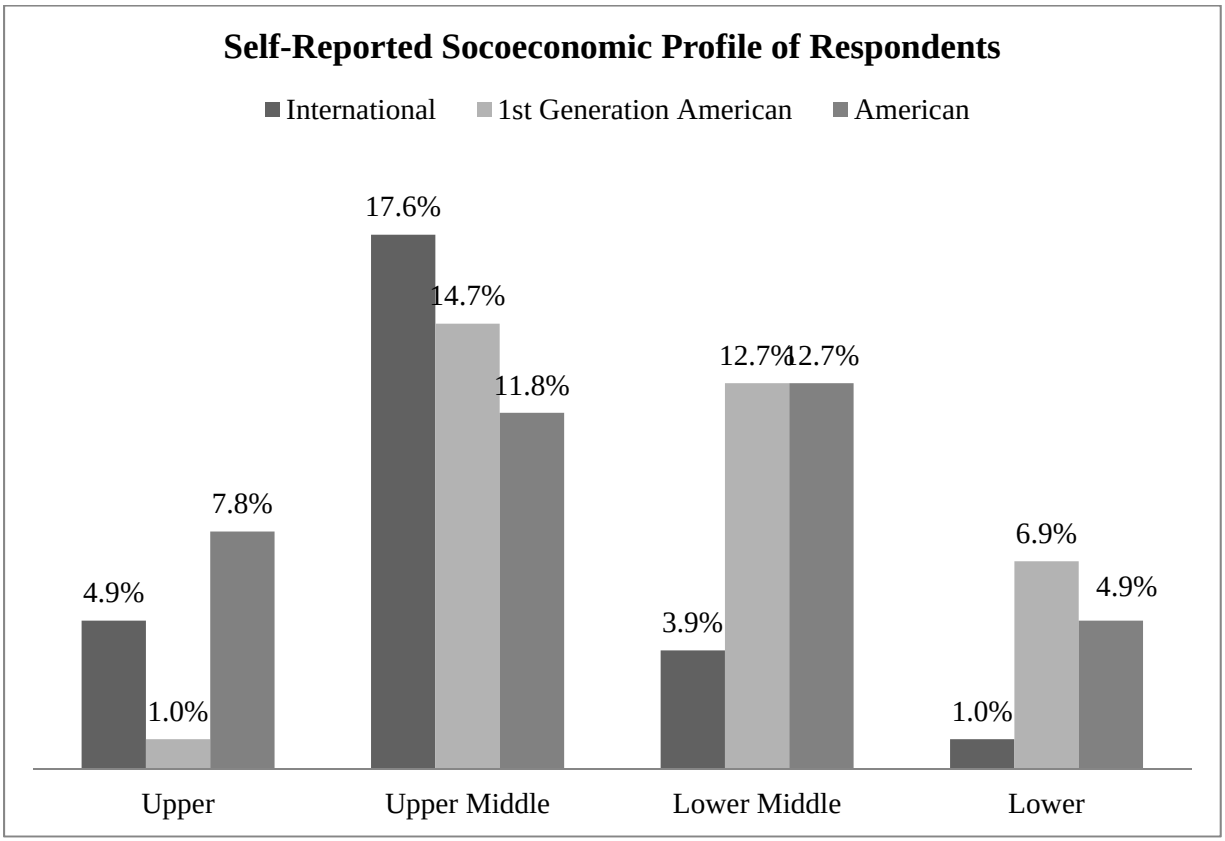

Figure 2: Self-Reported socioeconomic profile of respondents, separated by nationality group.

The sample of International Students and First Generation American Students represents a great variety of backgrounds and nationalities. These two groups of students represented thirty-two (32) countries (Table 2) within ten (10) regions (Table 2) of the world. The majority of countries represented were from Asia- including South Asia, Southeast Asia and East Asia- with twenty-six (26) respondents (Table 2). The Caribbean region was the second most represented region with fourteen (14) respondents, then Africa with eight (8) respondents (Table 2). Of the

countries represented, China (8 respondents), India (7 respondents) and Jamaica (7 respondents) were the most frequently represented (Table 2).

Table 2: Countries represented within International Students and First Generation American Students groups.

World Region	International Students' Countries of Origin (# respondents)	First Generation American Students' Parents' Countries of Origin (# respondents)
Latin America	El Salvador (1)	Cuba (1), Mexico (2), Panama (1), Cuba/Mexico (1)
Caribbean	Bahamas (1), Jamaica (1), Trinidad and Tobago (1)	Jamaica/Barbados (1), Haiti (3), Jamaica (4), Antigua (1), Haiti/Jamaica (1), Trinidad and Tobago (1)
South America	Brazil (1)	-
North America	Canada (2)	-
Europe	Turkey (1), U.K. (1, Germany (1), Belgium (1)	Germany (1), Italy (1)
Africa	Kenya (1), Nigeria (1)	Nigeria (4), Tanzania (1), Kenya (1)
South Asia	India (3)	India (4), Myanmar and Pakistan (1)
Southeast Asia	Singapore (2), Thailand (1), Malaysia (1)	Cambodia (1), Thailand (1), Philippines (1), Vietnam (1)
East Asia	China (6), Korea (1)	China (1), Korea (1), China/Taiwan (1)
Middle East	Syria (1)	-

Health Care Services Utilization

The research questions of this thesis were to determine how often students accessed health care services, which kinds of services they utilized and whether or not there were any differences based on race/ethnicity, nationality or gender. I address these questions in this section by analyzing the frequency with which, and which types of healthcare services were utilized by Emory University students within the past five years. It is based on the information obtained from the survey question, which asked, *'Over the last five years have you used any of the following health services?',* as well as data obtained from semi-structured interviews. Patterns were observed in relation to the nationalities, gender and race/ethnicity of respondents. The main differences in health care services utilization were due to nationality and race/ethnicity. Significant differences based on gender, although described in detail in the semi-structured interview data, were not found in survey results. Additional data regarding reasons why the particular trends in utilization were seen is also presented in this section.

Nationality

American Students accessed healthcare services at a greater rate than both International Students and First Generation American Students. American Students were least likely to report never having accessed a particular health service in all but three categories- Other Clinic, Chiropractor and Alternative Medicine (Table 3). For these categories, First Generation American Students were least likely to have never accessed Other Clinic and Chiropractor, while International Students were least likely to have never accessed Alternative Medicine services (Table 3). There were significant differences (as indicated by a p-value of less than 0.05 in the Chi-squared test)

in four (4) of the seventeen (17) categories given- Other Private Doctor, Traditional Healers, Mental Health Services and Online Services (Table 3). In all four of these categories, American Students reported higher levels of service utilization (Table 3). Overall, International Students had the lowest rate of health care services utilization and American Students had the highest with First Generation American Students having intermediate levels of utilization between International Students and American Students.

In addition to these results, data provided by Dr. Michael Huey, the Director of Student Health Services, showed that International Students utilize their student health insurance benefits at a far lesser rate than First Generation American Students and American Students combined (data was not provided for these two groups separately). For the academic year 2010/2011 International Students had a Loss Ratio (dollars spent by insurance company paying for claims divided by the total premium dollars collected) of fifty-eight percent (58%) (Huey 2012). Although this number has risen in the last couple of years, it is still little more than half of the ratio for First Generation American Students and American Students (Loss Ratio 98.2%) (Huey 2012).

Table 3: Respondents who have n*ever* accessed health services in the last five years, separated by nationality group.

	International Students (n=28)	**First Generation American Students (n=36)**	**American Students (n=38)**	**p-value**
Emory Private Doctor	81.5%	77.8%	55.3%	0.1647
Emory Hospital	81.5%	63.9%	60.5%	0.1992
Emory Clinic	51.9%	61.1%	44.7%	0.8458

	International Students (n=28)	First Generation American Students (n=36)	American Students (n=38)	p-value
Emory Student Health	29.6%	11.1%	7.9%	0.1094
Other Private Doctor	**44.4%**	**16.7%**	**2.6%**	**0.0049**
Other Hospital	55.6%	58.3%	55.3%	0.6978
Other Clinic	59.3%	52.8%	55.3%	0.2542
Traditional Healer	**96.3%**	**94.4%**	**81.6%**	**0.0473**
Religious Person	96.3%	91.7%	81.6%	0.1126
Medical Specialist	55.6%	72.2%	47.4%	0.2264
Chiropractor	88.9%	83.3%	89.5%	0.8395
Alternative Medicine	85.2%	91.7%	86.8%	0.3952
Pharmacist	55.6%	41.7%	26.3%	0.0759
Physical Therapist	81.5%	83.3%	76.3%	0.8679
Mental Health Services	**70.4%**	**83.3%**	**47.4%**	**0.0311**
Nutritionist	81.5%	88.9%	71.1%	0.2830
Online Services	**63.0%**	**36.1%**	**13.2%**	**0.0007**

Data from the semi-structured interviews explain, somewhat, the findings in this section. There was general agreement among International Students that a biomedical practitioner, of any kind, should only be sought after some sort of self-care was done at home or if the problem was severe and could not be solved on its own. When asked about when someone should use biomedical medicine a female International Student said, “when something they try at home does

not work". Most International Students thought that alternative medicine should be the primary source of treatment for mild illnesses. When asked the question about when they thought someone should seek care from an alternative medical practitioner the response was often along the lines of, "If either it's something that's not really too bad or if it's mild symptoms…" (Male International Student or "When an ailment isn't super threatening or severe." (Male First Generation American Student). Two responses that sum up many of the views expressed by International Students, and some First Generation American Students, are:

> "I think we should not take it [biomedical drugs] too much. For some not serious disease- like a cold or fever-, I would rather recover by ourselves. Unless I have a serious problem, I won't use it [biomedicine]. It can save people's lives but if your disease is okay, your human body will have natural reactions so you don't need to take it. I noticed about most Americans that they like to take pain killer pills. I think it is a really bad thing because with Chinese students we never take it unless you're doing a serious surgery. Once you take it, you need to take it more next time because your body gets used to it. I would more prefer traditional Chinese medicine because it is healthier. We use herbal. It has less side effects." (Female International Student)

> " I think that it's [alternative medical treatments] helpful to some extent especially when you're dealing with things that aren't super serious as far as needing biomedicine….I think that they can be highly effective…but not always as effective as biomedicine." (Male First Generation American Student)

Additionally, International Students and First Generation American Students expressed a greater tolerance for and use of alternative medical practices than American Students. International Students were most tolerant. Their semi-structured interview responses indicated that they were more open to alternative forms of medicine and, in the case of most International Students, and some First Generation American Students, used them regularly. Even when an individual did not use alternative medical practices, they were not as harsh in their judgment

about it. For example, a First Generation American Student with Nigerian parents said that although he did not personally use alternative medicine, “I don’t have a negative view against them at all. I think that they are legitimate, that they probably do work for people who use them.” Conversely, American Students tended to see alternative medical practices as a last resort and as ineffective. For example, one female American Student said, ‘I consider these pseudo-science because they have no real firm data that they work, compared to what I would use and going to a doctor and medication”. Another female American Student who said that she thinks her use of alternative therapies is very much against the norm of most Americans beliefs, made the comment several times that there is the view that “biomedicine is the best thing ever” and that Americans generally are not open to alternative forms of medication and treatment.

In addition to these underlying cultural beliefs, another factor that was brought up in semi-structured interviews with both students and Dr. Michael Huey was that there was a difficulty navigating the American health care system for international students. For many, especially those from Asia, it was a very different system from the systems with which they were familiar. This could possibly be another reason for lower levels of utilization among International Students. Two interview respondents recounted their parents experience as immigrants and utilizing the American healthcare system. One African American First Generation American female explained “…so Americans know how to handle the healthcare system, whereas for immigrants…you don’t really know what is going on…” Another Asian First Generation American respondent said that “Especially for immigrants… [they] have a very difficult time navigating between these two very different spheres of medicine [biomedical and alternative/traditional]…”

Additionally, data from the survey question that asked respondents the degree to which they agreed with or did not agree with particular statements about health, adds more support for the survey results suggesting cultural differences might drive differences in health care services utilization. Two statements in particular provide information about possible reasons for differences in health care services utilization between national groups. Although overall, all respondents regardless of nationality group, agreed with the statement that *'Depression is a legitimate medical concern',* American Students were significantly more likely (p-value less than 0.05) than International Students and First Generation American Students to agree with this statement. Eight-nine percent (89%) of American Students agreed with the statement, while fifty percent (50%) of First Generation American Students and sixty-seven percent (67%) of International Students agreed with the statement. This provides support for the higher levels of utilization of Mental Health services by American Students than First Generation American Students and International Students. In addition, there were notable differences in the degree of agreement with the statement that. *'One should always try to 'tough it out' before seeking medical care'*. More American Students disagreed with the statement than agreed with it (45% disagreed, 32% agreed), while First Generation American Students agreed with the statement, rather than disagreed with it (39% agreed, 28% disagreed). International Students agreed and disagreed with the statement to the same degree (26% agreed as well as disagreed). These variations provide support for the idea that International Students and First Generation American Students are probably more likely to delay seeking care, at least from a biomedical doctor, than American Students.

These results show that there are small differences in utilization patterns based on nationality. International Students utilize biomedical services, as well as mental health services

less than American Students and are more open to the use of alternative medical treatments. First Generation American Students have intermediate levels of utilization.

Gender

The distinction between frequency of utilization of health services between men and women was not as distinct as it was between national groups, which is also contrary to broader patterns seen in the literature on health seeking. There were no statistically significant differences in health care utilization by gender in the survey. This was possibly due to the relatively small number of male respondents compared to female respondents in the sample. However, women were slightly more likely than men to access health services regularly (at least once per year). Women reported higher levels of regular attendance in ten (10) out of the seventeen (17) types of health services given as options. They were more likely to regularly utilize Emory Private Doctors, Emory Hospitals, Emory Clinics, Emory Student Health, Other Private Doctors, Religious Persons, Chiropractors, Alternative Medicine Specialists, Pharmacists and Mental Health Services. Men were more likely to regularly utilize Other Hospitals, Other Clinics, Traditional Healers, Medical Specialists, Physical Therapists, Nutritionists and Online Services. Overall, men were less likely than women to have ever accessed health services. Men reported higher percentages of respondents having never accessed health services in all but four of the categories- Other Hospital, Other Clinics, Medical Specialists and Physical Therapists.

Although there was a lack of statistical significance in survey results, data from the semi-structured interviews indicated that gender differences between the health care services utilization patterns of men and women likely exist. Most notable, there was a perception by all

interview participants, regardless of national origin or race/ethnicity, that men were less likely than women to access medical services and that this was tied into ideas of masculinity and femininity. Many indicated that men tended to avoid care or waited longer to seek care to not seem weak or less masculine. They played into the idea of the 'tough guy' mentality.

> "I know the men in my family are really stubborn about going to the doctor. My dad will be bleeding from the top of his head and instead of going to the ER, he will put a cloth on it. He doesn't want to, especially in front of my brother, he doesn't want to look less of a man," (African American, American Student female)
>
> "The sort of masculine thing is not to seek health care for things that you don't consider serious". (Caucasian International Student male)
>
> "I think men would see going to the doctor as weak…there is this machismo where going to the doctor is like why are you obsessing over your health, whereas in terms of femininity, it is seen as a necessity…not something to make fun of." (African American, First Generation American Student male)
>
> "As a male a lot of times you just want to have this kind of toughness about you where you might be more reluctant to seek healthcare for something that you consider a small injury." (Mixed First Generation American Student male)

There was also the impression given that women would be more conscious and comfortable about their health and seeking care for smaller, less serious things and did it much more regularly. One First Generation American, African American male said, "Women are very cautious. They want to make sure that everything is okay." Men tended to feel that health care was only needed when things became more serious, otherwise they were making it into too much of a big deal. On why he did not like to go and see a doctor before he had a serious injury, an International, Caucasian male said, "I felt like I was wasting people's time, etc."

There is also the impression among many individuals that there are differences in utilization simply because women, due to their biology, need to see about their health more often than men do. One First Generation American, African American female said that, “I think women need to go to the doctor more than men because…certain stuff affects women worse- like stress- so I feel like women need to visit the doctor more regularly”. There is an emphasis on the idea of women’s health, whereas men’s health is not seen as a concern- “We talk about women’s health but no one really talks about men’s health” (American, Caucasian female).

The following statement embodies many of the ideas raised about differences between the health seeking behavior of men and women: “I think a man’s idea of when he would be sick enough to seek healthcare would be different from a woman’s. They would go to the absolute point of breaking before they seek health care because they feel like they could wait it out or stick it out because that is the nature of the man” (International, African American female)

Further support to the idea that men are less likely to seek care comes from the survey results asking respondents to agree or disagree with certain statements about health. Although both men and women overall disagreed with the statement that ‘*real men do not get sick’*, men were significantly less likely than women to disagree (p-value less than 0.05) with this statement. Seventy-six percent (76%) of men disagreed with the statement, while ninety-one percent (91%) of women disagreed with the statement.

Another statement, which showed statistically significant differences (p-value less than 0.05) between men and women was that ‘*traditional medical practices do not work’*. Men were more likely than women to agree with the statement. Twenty-four percent (24%) of men agreed

with the statement, while three (3%) of women did. These results suggest a lack of openness to use of alternative and traditional therapies by men.

These results show that there is a perception among Emory University students, which was not represented statistically in the data, that men were less likely than women to access health care services due to ideas of masculinity.

Race/Ethnicity

To allow for better comparison, the respondents from three racial groups- Black/African Americans, Caucasians/Whites and Asians- were used for comparison. These three groups represented the largest racial/ethnic groups and allowed for the best comparisons. Differences in patterns of utilization between races/ethnicities were less clear than those between nationalities. Overall, Asians were more likely than both Blacks/African Americans and Caucasians/Whites to have never accessed health services except for one (1) category- Alternative Medicine (Table 4). A clear distinction between usage patterns of Blacks/African Americans and Caucasians/Whites was not easily identified. Blacks/ African Americans had greatest utilization of six (6) categories- Emory Private Doctor, Emory Hospital, Emory Clinic, Emory Student Health, Other Clinic and Nutritionist (Table 4). The other ten (10) categories were most utilized by Caucasians/Whites (Table 4).

Of the fourteen (14) categories identified in the survey, seven (7) showed statistically significant differences between levels of utilization among racial/ ethnic groups (as defined by a p-value less than 0.05). These were:- Emory Private Doctor, Emory Student Health, Other

Hospital, Other Clinic, Traditional Healer, Mental health Services and Online Services (Table 4). Asians had the lowest levels of utilization of all these categories except for Traditional Healer, in which Blacks/ African Americans accounted for the lowest level of utilization (Table 4).

Table 4: Respondents who have *never* accessed health services in the last five years, separated by race/ethnicity.

	Black/ African American (n=33)	**White/ Caucasian (n=28)**	**Asian (n=26)**	**p-value**
Emory Private Doctor	**54.5%**	**60.7%**	**88.5%**	**0.0017**
Emory Hospital	51.5%	64.3%	88.5%	0.0941
Emory Clinic	45.5%	50.0%	61.5%	0.6143
Emory Student Health	**3.0%**	**7.1%**	**34.6%**	**0.0163**
Other Private Doctor	21.2%	7.1%	34.6%	0.0881
Other Hospital	**51.5%**	**50.0%**	**57.7%**	**0.0366**
Other Clinic	**51.5%**	**53.6%**	**53.8%**	**0.0032**
Traditional Healer	**100.0%**	**71.4%**	**92.3%**	**0.0370**
Religious Person	93.9%	71.4%	100.0%	0.0606
Medical Specialist	57.6%	39.3%	65.4%	0.2599
Chiropractor	90.9%	85.7%	88.5%	0.4224
Alternative Medicine	97.0%	82.1%	80.8%	0.3392
Pharmacist	33.3%	28.6%	65.4%	0.2201
Physical Therapist	81.8%	71.4%	84.6%	0.4614

	Black/ African American (n=33)	White/ Caucasian (n=28)	Asian (n=26)	p-value
Mental Health Services	**54.5%**	**50.0%**	**88.5%**	**0.0077**
Nutritionist	72.7%	78.6%	84.6%	0.4214
Online Services	18.2%	14.3%	69.2%	0.0006

Asians in the survey sample were more open to and utilized more alternative forms of medicine, and used biomedical services less often than Whites/ Caucasians and Blacks/ African Americans. Blacks/ African Americans have utilization rates in the middle of these two groups for most categories, although these rates tended to be closer to those of Whites/Caucasians. For example, about sixty-nine percent (69.2%) of Asians had never utilized Online Services, while about eighteen percent (18.2%) of Blacks/African Americans had not and about fourteen percent (14%) of Whites/ Caucasians had not. Additionally, fifty percent (50%) of Whites/ Caucasians had never accessed Mental health Services, while about fifty-four percent of Black/ African Americans and about eighty-nine percent (89%) of Asians had not.

Very little notable data relevant to what might account for these racial/ethnic differences was uncovered in the semi-structured interviews. However, two ideas that came out from both semi-structured interview data and survey data- about the degree to which individuals agree or disagree with particular statements about health- are that:

- Blacks/ African Americans and Whites/ Caucasians were more open to the use of religious means to treat disease. Survey data shows that while one hundred percent (100%) of Asian respondents indicated that they had never used religious services,

ninety-four percent (94%) of Blacks/ African Americans and about seventy-one percent (71.4%) of Whites/ Caucasians had reported never using these services. Overall, this type of utilization was very low- eight-eight percent (88%) of all respondents reported never using these services-, however. While additional data from semi-structured interviews did not reveal a reason for utilization levels among Whites/ Caucasians, two African American females gave anecdotes within their semi-structured interviews about their grandmothers using religious means to attempt to heal themselves. One female's view on it was as follows, "I'm not against it but I get scared when people choose not to go to a doctor because they just want to pray on it". The other individual felt that while her grandmother believed that God healed her, she was more of the mind that "God provided a way for her to be healed". Blacks/ African Americans were also most likely to agree with the statement that *'prayer can heal'*. Eighty-eight percent (88%) of Blacks/ African Americans agreed with the statement, while twenty-nine percent (29%) of Whites/ Caucasians and forty-two percent (42%) of Asians did. Blacks/ African Americans were more likely to utilize and were more open to this as a form of medical treatment.

- Blacks/ African Americans and Asians do not utilize mental health services as frequently as Whites/ Caucasians. Both racial groups were also less likely to agree with the statement that *'depression is a legitimate medical concern'*. Eighty-nine percent (89%) of Whites/ Caucasians agreed with the statement, while seventy percent (70%) of Blacks/ African Americans and seventy-three percent (73%) of Asians agreed with it.

These results show that, generally, there are very few differences in utilization patterns between races. However, minorities, specifically Asians, have slightly lower utilization frequencies than Blacks/ African Americans and Whites/ Caucasians.

Cultural Consensus Model

While some differences were noted between the different groups of respondents, in terms of their frequency and type of health services utilization, these differences were not as extensive as expected, based on a review of the literature. A cultural consensus analysis of survey data shows this. A cultural consensus analysis seeks to identify if there is a single shared way of answering a shared set of questions by different groups. Different groups may or may not have different ways of answering particular questions, based on their cultural beliefs. The analysis was carried out on a survey question that asked individuals the degree to which they agreed or disagreed with particular statements about health (they selected from Strongly Disagree, Disagree, Neutral, Agree or Strongly Agree). The analysis tested to see if there was a shared model of cultural beliefs between students, based on relatedness of answers of this survey question.

The analysis relied on a statistical method known as Quadratic Assignment Procedure (QAP) matrix regression. It asked whether the responses of students were more similar to one another than they were different. Evidence of single shared cultural model- that is responses more similar than different to one another- is typically exhibited by a large ratio of the first to second eigenvalues. If there is a single shared model then the cultural consensus analysis can also be used to produce the "culturally correct" answer key (Table 5). This answer key shows what the "culturally correct" response is for each statement about health. That is, the degree to which the entire sample population agrees with or disagrees with each statement.

Results of the analysis support a single shared model. The ratio of eigenvalues was large at 6.6, which indicates a good fit of the model and is consistent with a single cultural model. This

shows that there are more cultural similarities between groups of students than differences, in terms of their responses to ideas about health.

Table 5: Culturally correct answers for the questions on health and health seeking. Values are between 1 and 5 with 5 being Strongly disagree and 1 being strongly agree.

Thinking about the views of your community, how much do you think they agree with the following statements about health?

Statement	Culturally Correct Answers
Real men do not get sick	4.67
Men who seek medical care are often just weak	4.64
Hospitals are places where people go to die	4.55
People do not need to access medical care unless it is life-threatening	4.26
Health problems are a result of God or other supernatural forces	4.09
Doctors, hospitals and other biomedical institutions should be a last resort	3.93
If someone gets ill is beyond their control	3.86
Traditional medical practices do not work	3.85
When someone has a cold they should seek medical care immediately	3.81
Biomedical/ Pharmaceutical drugs do more harm than good	3.76
Pain and tiredness are normal effects of aging and one should not seek medical care for them	3.67
Traditional medical practices are better than biomedical ones	3.51
Medical problems are an individual's private business and should not be shared with anyone else, even family and friends	3.5

Thinking about the views of your community, how much do you think they agree with the following statements about health?

Statement	Culturally Correct Answers
Medication should not be taken unless the problem is very severe	3.5
People only seek medical care when encouraged to do so by someone else	3.42
The quality of care someone receives is determined by their race/ ethnicity	3.37
Women need more medical care than men	3.24
People feel as if they will experience stigma/ discrimination from healthcare professionals	3.19
People feel embarrassed when seeking medical care	3.12
People do not feel comfortable discussing their medical problems with healthcare practitioners	3.1
One should always try to 'tough it out' before seeking medical care	3.07
It is more comfortable for someone to see a healthcare practitioner of their same race/ethnicity	2.95
It is more comfortable for someone to see a healthcare practitioner of their same nationality	2.95
Alternative medical practices, such as acupuncture, are effective	2.75
Home remedies should be used to self-treat when ill	2.73
Family and friends should know about an individual's medical problems and help make decisions about them	2.7
Prayer can heal	2.59

Thinking about the views of your community, how much do you think they agree with the following statements about health?

Statement	Culturally Correct Answers
It is more comfortable for someone to see a healthcare practitioner of their same gender	2.22
When someone has a cold they should seek medical care only if it becomes very serious and prolonged	1.95
Depression is a legitimate medical condition	1.72
It is more comfortable for someone to see a healthcare practitioner who speaks the same language as them	1.7
It is ok to seek counseling for depression	1.48

Barriers to Health Services Utilization

The previous sections documented subtle differences by race/ethnicity and nationality in health care utilization. In this section, the extent to which barriers to utilization exist and differ across gender, nationality and race/ethnicity is explored. The data in this section is based on the survey question, which asked respondents to identify reasons why they have not accessed a particular health service in the past, if they needed to. This information aims to identify barriers to accessing healthcare for individuals. Again, the data is observed based on nationality, gender, and race/ethnicity. The data showed that barriers to access to health services were mainly due to socioeconomic or structural reasons.

Nationality, Gender and Race/ Ethnicity

For all respondents, across all three nationality groups, two genders and three major racial/ethnic groups (Figure 3) the primary reasons for not seeking care were:- lack of time (37% of all respondents), expense (33% of all respondents) and the impression that accessing services would not help their problem (28% of all respondents). The two other main reasons given for non-access were a lack of trust in the service provider (17% of all respondents) and previous bad experiences (16% of all respondents). These main reasons remained constant across racial/ethnic, national and gender groups (Figure 3).

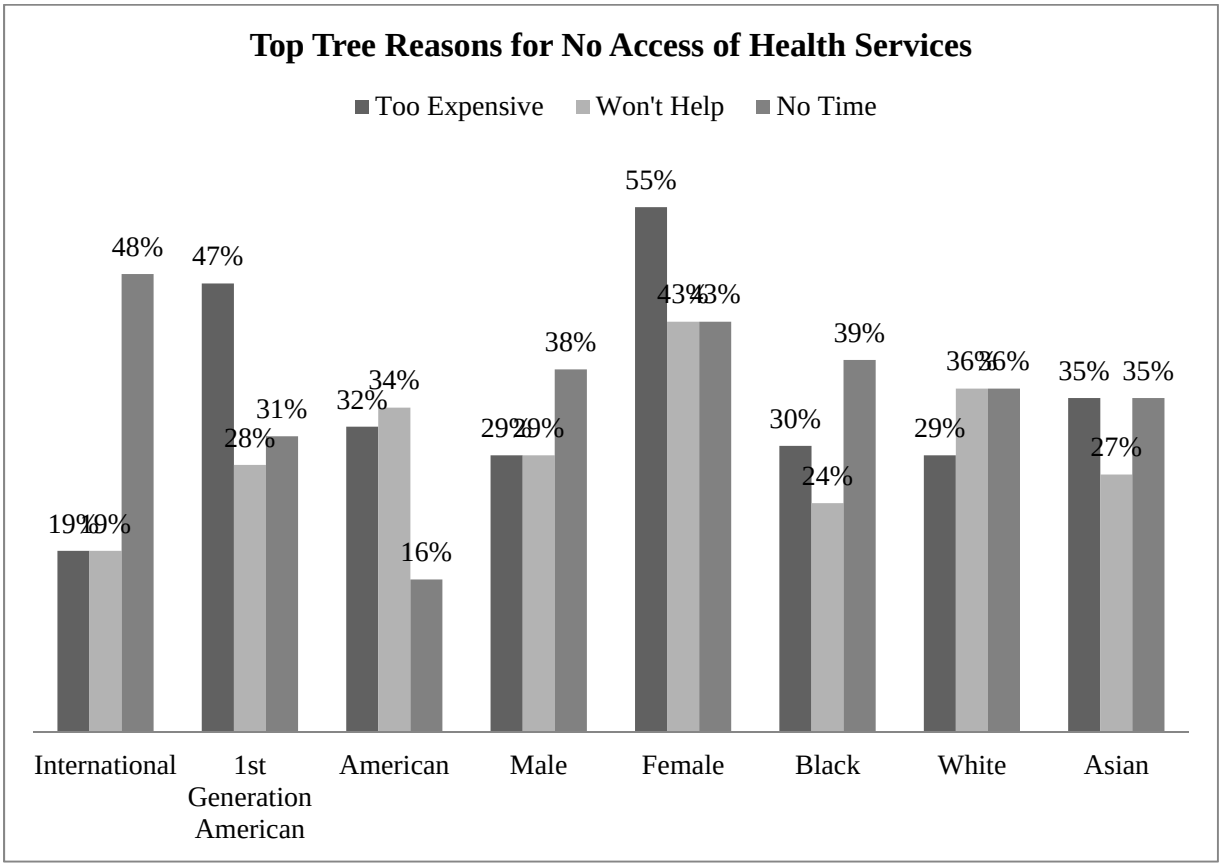

Figure 3: Reasons for non-access of health services across national, gender and ethnic groups.

These results repeat themselves somewhat in an alternative question, which examined open-ended answers about the factors that influence decisions about health. Of the statements provided by respondents, cost or economics were mentioned the most (38%) as factors which influence health care seeking behavior. Again, there were no statistically significant differences based on race/ethnicity, nationality and gender. Some statements that embody this are:

> "Costs and convenience seem to be the main reasons that affect whether or not people in the surrounding community take action about their health."
>
> "Financial factors largely drive decisions on health."
>
> "I think how much of medical costs are covered by insurance, how much excess funds they have to protect their health and treat their illnesses…all affect decisions about their health."
>
> "Expenses. For me, It sucks that my parents don't have insurance…My parents haven't been to the doctor in forever…"
>
> "I believe that economic status is the major factor. Not only do people choose not to seek medical attention due to the costs, but it also affects their choice to exercise…and especially their food choices…"

Socioeconomic Status

While the reasons for not accessing health services were not significantly different along lines of nationality, gender and race/ethnicity, a few important differences are seen along lines of socioeconomic status. The belief that the service would not help the problem and a lack of time remained two of the primary reasons for not accessing health care services among all socioeconomic statuses. However, among Upper Class respondents, expense was no longer a major factor in the decision not to seek care (Table 6), although it was for those who identified as Upper Middle Class, Lower Middle Class and Lower Class individuals (Table 6). Additionally,

Lower Middle and Lower Class individuals identified a lack of insurance as one of the main reasons for lack of access, while Upper and Upper Middle Class individuals did not (Table 6).

Table 4: Reasons for lack of access of health services among socioeconomic groups.

	Upper (n=14)	Upper Middle (n=45)	Lower Middle (n=30)	Lower (n=13)
Too Expensive	14%	20%	50%	62%
No Insurance	7%	4%	20%	23%
Won't Help	29%	27%	27%	38%
No Trust	29%	18%	7%	23%
Afraid of Outcome	7%	2%	0%	23%
Provider Discrimination	7%	4%	3%	15%
Societal Discrimination	7%	2%	0%	15%
Too Far	29%	7%	3%	15%
Language Barrier	0%	0%	0%	0%
Lack of Privacy	0%	2%	3%	15%
No Resources	7%	7%	7%	15%
Going Alone	0%	2%	3%	8%
No Time	36%	40%	33%	38%
Bad Experience	21%	11%	17%	23%
Family/Friend Bad Experience	0%	0%	0%	23%

Persons Who Influence Health Services Utilization

The data in this section comes from questions that asked individuals who or what influences them in their health care decisions. Data is both quantitative and qualitative and seeks

to identify the main factors, which influence the health care behavior of individuals and the ideas they have about health. A key result to emerge from the data is that family and upbringing are the main determinants of individuals' health care seeking behavior.

Family was, overwhelmingly nominated as the primary influence on the health care seeking behavior of individuals, and his was true regardless of race/ethnicity, gender and nationality. Sixty-four percent (64%) of all respondents identified "family" as influencing their health care decisions "A Lot". Coming in second was the influence of Doctors/ Other Biomedical Practitioners. Forty-six percent (46%) of respondents identified Doctors/ Other Biomedical Practitioners as influencing their health care decisions 'A Lot". Interestingly, American Students were significantly more likely than International Students or First Generation American Students to indicate that they were influenced by traditional healers (6% to 0%). Otherwise, there were no significant differences on influence based on race/ethnicity, gender or nationality.

These results were also seen in interview data. Most of the respondents reported that their parents or families had a significant influence on the decisions they made about their health. Many also noted their upbringing as having a significant impact on their health decisions and behavior. Parents or families were often cited as the ones who helped develop certain patterns or health care behavior in children. One respondent said that "There are some things in my family that they don't consider is a real problem so certain things I don't go seek help for because to them 'oh you can get over it, this isn't an issue'". Family members also encouraged individuals to seek care. For example, another respondent said, "my parents try and get me to go to physicals every year." Even though some respondents identified a greater deal of independence in their

health decision making in college-, for example “Now that I’m actually here in college I think that it’s more of my decision versus my parents’ decisions”-, many respondents still turned to parents for help with their medical decisions in college.

Factors that Influence Provider Choice

This section examines the factors that determine the choice of provider for individuals. Again, data is examined along lines of race/ethnicity, nationality, gender and socioeconomic status.

The top five factors that determine provider choice among participants- regardless of race/ethnicity, gender, nationality and socioeconomic status- were Location/Distance of the Provider (65% of all respondents), Level of Qualifications of the provider (60% of all respondents), Insurance Coverage (59% of all respondents), Bedside Manner/Attitude (52% of all respondents) and the Number of Years of Experience of the Provider (51% of all respondents) (Figure 4). Another factor, Reviews/References from others, was cited among the top five determinants of provider choice among International Students, Males, Blacks/African Americans, Asians and Lower Middle Class individuals. Reviews/ References from others accounted for thirty-seven percent (37%) of all respondents (Figure 4).

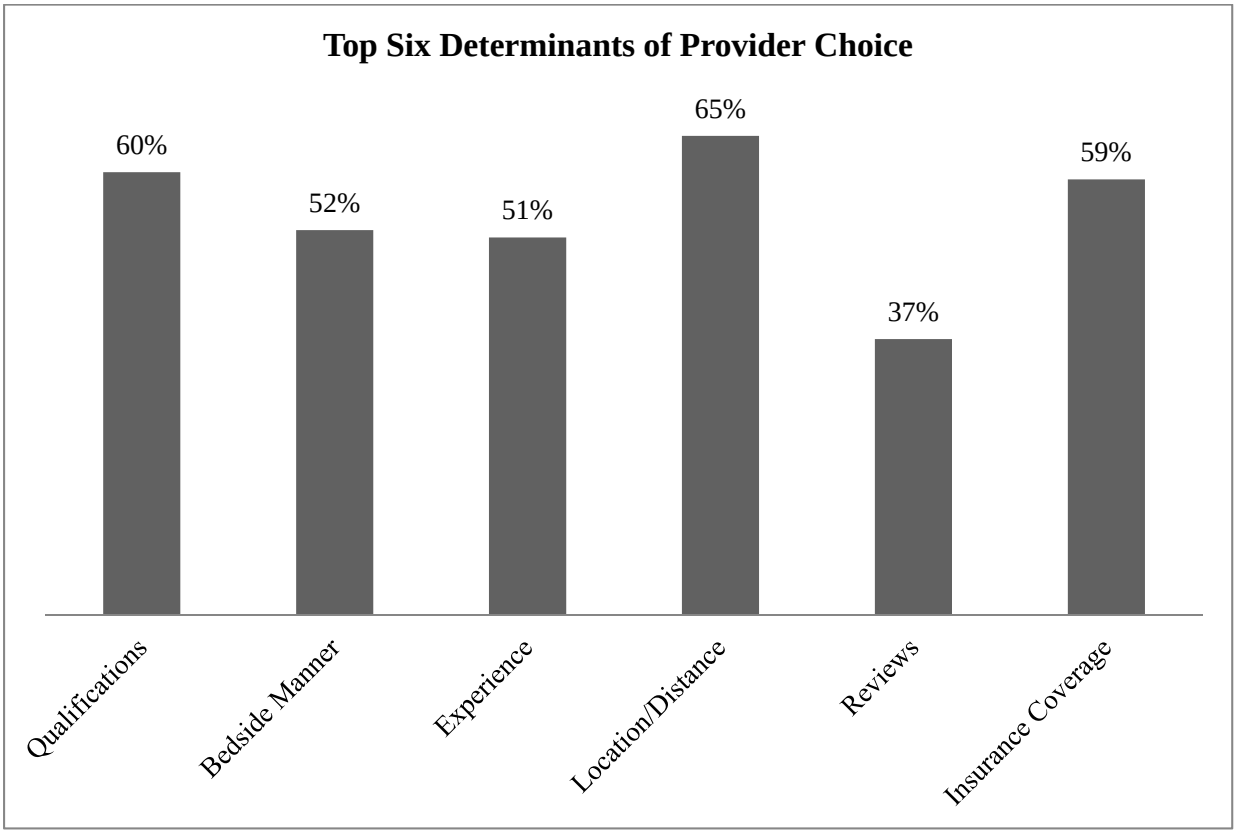

Figure 4: Top determinants of provider choice among respondents.

A few important distinctions between groups were also noted.

- Asian and Black/African American respondents were more likely than Whites/Caucasians- 15% (Blacks/ African Americans and Asians) compared to 0% (Whites/ Caucasians) - to indicate the race/ethnicity of the provider as being a determinant to provider choice. This difference was not statistically significant (p-value = 0.0580). This information was supported by the fact that Blacks/ African Americans and Asians disagreed less with the statement that *'It is more comfortable for someone to see a healthcare practitioner of their same race/ ethnicity'*, than Whites/ Caucasians. Eighteen percent (18%) of Blacks/ African Americans disagreed with the statement, thirty-five

percent (35%) of Asians disagreed with it and forty-six percent (46%) of Whites/ Caucasians disagreed with it.

- Females were statistically significantly more likely (p-value = 0.0310) than males to indicate gender (36% females compared to 5% males) as a determinant to provider choice. Additionally, all female respondents in the interview data said that gender was one of the factors they considered when choosing a health care provider and that they would all prefer female practitioners, especially for women's health services.

Interview data concurred with the data presented above. Most interviewees indicated factors such as qualifications, bedside manner, insurance coverage and level of experience as the factors that influenced selection of a health care provider.

Chapter 5: Discussion and Limitations

Discussion

In this thesis I sought to explore patterns of health care behavior among students of different races/ethnicities, nationalities and genders at Emory University and looked to see how cultural and social factors might impact the health care seeking behavior of these groups of students. I found two primary results. Firstly, there are different patterns of utilization- although not as distinctly different as expected based on the review of the literature- between national groups, as well as gender and race/ethnic groups. These differences are: 1) International Students employ a plurality of care- utilizing both biomedicine and alternative medical practices-, while American students tend to employ mainly biomedical treatments, 2) there is an idea of masculinity associated with delayed or infrequent health care seeking, and men tend to play into these notions and not seek or delay seeking care and 3) ethnic minorities are slightly less likely to utilize health services than non-minorities. The second result is that health care seeking behavior of Emory University students tends to be mediated by similar social and structural factors, such as the availability of socioeconomic resources and the convenience of access to services.

What Are The Differences?

International Students Have a Plurality of Care

As was expected from the review of the literature on the topic, international students tended to utilize both biomedicine and alternative medical procedures common to their culture. They also used western health services to a lesser degree than American students did and used alternative

medicine more than American students did. For the most part, American students tended to utilize more biomedical services and at a greater rate than international students. This difference between national groups points to the importance of both types of medicine in maintaining health to this demographic group. International students placed value on both types of medicine, but realized that there was a time and a place for each. Thus, it can be inferred, that for these individuals, their cultural understanding of how disease should be treated played a role in the types of health care services they accessed.

One difference, however, between International students and the literature review data reported on immigrants is that there does not seem to be as great a conflict with navigating between the two types of medicine. This could possibly be because they grew up in a world where the two medical systems were used side by side. Based on interview discussions, the international students that come to Emory University are primarily from large urban centers in their home countries. These cities tend to be very cosmopolitan and westernized, thus students should be somewhat familiar with western biomedicine and more comfortable accessing it. The cultural consensus model, which shows greater relatedness than un-relatedness between groups of students, provides further support for the idea that the international students who come to Emory have grown up in cultural environments which is very similar, in terms of health beliefs, to American ones. Additionally, a large portion of this survey sample was from Europe and the Americas. This could have skewed data since these regions tend to employ very western medical systems and many are English-speaking countries.

Another possible explanation for less variation than was expected could be that international students tend to assimilate to their new environment once they get to Emory. One

First Generation American Student female recounts why she thinks her views are more similar to dominant American ones “When we got to America my mom really tried to live the American lifestyle…” A male International Student also noted that there were differences in how he accessed healthcare at home and here at Emory, including difference in frequency: he was a lot more likely to access services here at Emory than at home. In this sense, being a member of a new society and having to reconcile their beliefs from home and the ones in the society in which they live has resulted, for some, in assimilation into western culture. This assimilation would also account for the intermediary levels of access seen in First Generation American Students. They grew up navigating the two worlds and assimilated to some degree into the western world in which they grew up. The survey data supports this intermediate level of care utilization, because for eight (8) of the seventeen categories of health services students were asked to report frequency of utilization for, First Generation American Students reported frequencies of utilization levels between those of American Students and International Students.

In essence, although International Students did show a plurality of care utilization, their beliefs about health seem to be more similar to, than different from those of American Students.

Race Plays a Role…Somewhat

Utilization patterns between races were difficult to observe. Even Dr. Michael Huey, noted that, in his opinion, there were not that many differences between the health care seeking behavior of Emory students based on race/ethnicity. This finding, especially as it relates to African American students, was unexpected. As was noted in the *Literature Review*, in the past, culture has definitely been one of the contributing factors in the health behavior of African Americans (Ford

1994; Lillie-Blanton, et al. 2000; Russell and Jewell 1992). As a group, they have been shown to have lower levels of utilization, beliefs about discrimination and belief in religious and traditional methods to treat illness (Bailey and ebrary Inc. 2002; Ford 1994). However, minorities at Emory University seemed more comfortable with accessing biomedical health services, than those in wider society. One possible reason for this is a generational shift, where the younger generation has assimilated to the more dominant (white) belief systems. Another possible reason for this difference could be that many of the African Americans identified in the survey were of non- American backgrounds- they were either international students or students of immigrant parents. This could have skewed the data somewhat as these groups of individuals would not have the same cultural understandings and fears of accessing health care as American students.

Alternatively, the low level of utilization among the Asian demographic group is tied, most likely, to the fact that all of the respondents who identified themselves as Asian also identified themselves as being International Students or First Generation American Students. In the same way, the high levels of utilization in the White/ Caucasian demographic is probably tied to the fact that there are very few International Students and First Generation American Students who identify with this racial/ ethnic group. Therefore, the reasoning for the differences in utilization among national groups would also apply to differences in racial and ethnic groups.

Overall, it can be said that racial differences in utilization of care, like differences in nationality, are less than in the general public. The Emory minority ethnic/ racial groups feel more comfortable than their non-Emory counterparts in accessing health services.

The Idea of the 'Macho' Man and Changing Gender Ideologies

Although it was not prominent in the survey results, the semi-structured interview data suggests that the same gender ideologies that cause low levels of health care service utilization in men in the wider public, cause similar differences in the males on Emory University's campus. Male students tend to access medical services less and possibly, at a later stage than female Emory University students do. This is tied into ideas of masculinity and being 'tough'. However, these differences are at a lower level in Emory University students than would have been expected based on previous research. One possible reason for this is that ideas of masculinity have been changing over time (Anderson 2009). Male students grew up in a generation much more open to fluidity in sexuality and gender roles and one possible manifestation of this could be greater concern for health and less of a need to 'tough it out'. One male indicated that 'We're not in the sixties anymore. Things are changing. It's more acceptable to do things that would be considered feminine."

About half of the males interviewed attributed these 'macho' behaviors to other males, and said that they tended not to play into these traditional gender roles. This could be because of society's changing gender roles and their position as college-educated students. However, these same males made comments that contradicted this to some degree. One male indicated that he goes to physical checkups mainly because his parents made him, if left up to his own devices, he probably would not think to go. Similarly, another male indicated that he does not go for regular checkups and said that he tries to wait sometime before he does go to see a doctor. These discrepancies between what people actually do and what people say they do, a common theory in

Anthropology, could account somewhat for the lack of statistically significant differences seen in the survey data, but high significance seen in semi-structured interview data.

On the other hand, females are far more open to talking about and accessing health care than males. It is almost seen as something innate or expected, rather than socially constructed. The focus on women's health in medicine and public health has also probably played a large role in the level of comfort women feel with visiting health care providers. Gender also plays a role in the type of provider individuals choose. Although women are more comfortable with seeing medical practitioners than men are, they have much greater preference for someone of the same gender. This, however, does not seem to act as a barrier or reason for no access or delayed care seeking among women.

In the case of gender, the societal expectations placed on men negatively affect the ways in which they access and think about health care. While, for women it programs them to be more comfortable with accessing and talking about healthcare.

What Are The Similarities?

While there were some differences in the degree to which, and which types of services students accessed, the similarities observed mainly dealt with barriers to health care seeking, as well as influences in the selection of health care services and providers. It was found that there were more similarities than differences across groups in these two areas. The data shown in this area supports the point that Paul Farmer makes often, that sometimes we are too quick to blame

culture for health disparities, non-compliance and lack of service utilization, while often socioeconomics and social institutions and structures are to blame (Farmer 1990).

Barriers to Accessing Healthcare are Mainly Socioeconomic and Structural

Overwhelmingly, respondents identified socioeconomic and structural concerns as a main factor in the degree to which they access health services. The cost of a service and the degree to which it was covered by insurance were two of the main reasons that came up repeatedly in both the survey and semi-structured interview data. This may account for the lower numbers of Black/ African American students who access health care services compared to White/Caucasian Americans, although their cultural beliefs, as indicated by survey and interview data, seem to be closely aligned with them. Black/ African American students, tended to be from lower socioeconomic groups than their White / Caucasian counterparts were.

Additionally, the high number of respondents who indicated a lack of time as a barrier to accessing healthcare, as well as other factors- such as convenience, location and distance-, points to the idea that individuals simply do not want to be inconvenienced in order to seek health care. It is not necessarily a high priority in the lives of many busy college students. They have classes, jobs, group meetings, projects to work on, among other things that take precedence. One respondent said explicitly about why she avoided seeking care, “It is time consuming and I prefer to not have to make the time to make the appointment to go and see a doctor.”

Another interesting point which came out in semi-structured interview data was that many respondents, both International and American, and of all races/ethnicities and both genders

felt to some degree that the American medical system was too profit driven and did not necessarily operate in the best interest of the patient. They cited over prescription of medications, sensationalist media campaigns and a market driven system as negatives. It is possible that this, along with other ideas of discrimination and lack of faith in the outcome of the procedure, would account for the high percentage of respondents who cited a lack of trust as a barrier to seeking health care and a belief that treatment will not help the problem. Since these beliefs seemed to be universal across respondents, it can be inferred that they are not cultural in nature, but rather a result of social consciousness or education about the health care system.

One point that was brought up in discussion with Dr. Huey, but which was not shown in the survey or semi-structured interview data, was that, for some international students, language would be a barrier to accessing healthcare, especially spoken language. He cited the implementation of a completely online portal for students to interact with Student Health Services, as one of the ways in which more international students have been encouraged to access health services at Emory in recent years. One reason for this discrepancy between Dr. Huey's comments and the survey and semi-structured interview results is that international students who probably were not as comfortable with their English language skills may not have even taken the survey. It is definitely an important point, which should be considered. Even though many students may feel comfortable accessing health care and it is culturally appropriate for them to do so, fear of an inability to communicate could prevent them from doing so. Again, it could be said that this is more a social/ structural barrier than a cultural one.

Overall, social and structural factors were the primary barriers to accessing health services across all racial/ethnic, national and gender groups.

Family and Upbringing Shape the Ideas Students Have about Health…But Society Plays a Role Also

Family is the primary influencer in the lives of many university students concerning their health behavior. This would be the way in which they develop their cultural understanding of health, ideas about when someone should seek care and how to determine which services they should use. However, for university students, away from home, society and school also play a role in influencing their health behavior. After Family, Doctors and Other Health Care Practitioners were cited as the main influencers of health behavior. Additionally, many students mentioned during the semi-structured interviews that going out and finding information for themselves about health was one way in which they got information to inform their decisions. This is one reason for the high level of use of online services as a form of treatment or way to educate themselves about medical concerns. These points suggest a greater degree of independence in the decision making as well as self-education and awareness about their health and health decisions. Additionally, many students, especially those interested in careers in health care, report taking classes and exploring new options available on campus as influences that have changed their views on health since coming to Emory University.

Comparison to Expected Results

Overall, the results obtained here were slightly different from those that would have been expected, looking at patterns in the wider population. Overall, it could be said that national, racial/ethnic and gender groups hold views and behaviors towards health that are more similar to,

than different from one another. There are many reasons that could be given for these findings. One of which, is that this sample could have been self-selecting- individuals who were more concerned about health and interested in it may have been more likely to participate in the study. Additionally, this sample represents a unique subset of individuals. Although diverse on paper, they possess many characteristics that would cause similarities in their behaviors. These similarities include exposure to western medical care and ideas about health, age and education levels.

Globalization and the Dominant West

Western medicine has pervaded many parts of the world. Globalization has meant that much of the same information and services available to individuals in America are also available to those in other parts of the world (Finkler 2004). Many Emory international students grew up in societies where these ideas of medical care were just as prominent, if not more so, than more traditional and alternative medicine. Thus, their cultural ideas about health and appropriate behaviors would be more similar to western ones than one would expect.

Globalization has also worked the other way. The explosion of complementary and alternative treatments available in the United States in recent years has changed the landscape in terms of health treatments available (Aud, et al. 2010; Neldner 2000). Although still very much opposed by many allopathic physicians, many are beginning to incorporate it into their practices in some way. Some medical schools have even begun teaching complementary and alternative medicine (CAM) sequences. This generation of Americans has grown up in a more diverse health environment, where yoga is seen as just as important to a healthy lifestyle as going to see

your doctor regularly. So, it is possible, that just as international students grew up more culturally comfortable with western medicine, they also have less of a problem utilizing an American medical system because the Western medicine ideologies are more in line with theirs than they would have been many years ago.

Age Group

One factor that cannot be ignored is that University students, by the very nature of their age, tend to be healthier than the general public. Ninety-one percent (91%) of respondents reported that they considered themselves to be in Good or Excellent Health. When they did consider themselves unhealthy, the reasons they gave generally had to do with unhealthy eating habits, body weight and risky behavior. These are not conditions that would prompt regular health service visits. People of this age group typically have fewer health problems and access health services less. This is true of the overall American population (Statistics 2011). Thus, this would account for the fact that the majority of respondents in the survey have relatively low levels of utilization of services overall and fewer differences in accessing health care were seen, simply because students did not access services enough to see substantial differences.

Level of Education

According to the Health Belief Model and other studies, education of both an individual and their parents affects their health and healthcare seeking behavior (Eisler and Hersen 2000; Flores, et al. 1999; Strecher and Rosenstock 1997). Education refers to, not only the level of formal

education received, which often translates to socioeconomic status, but the level of knowledge about illness, treatment and medical services. Studies have shown that individuals who have a better understanding of illness, treatment and procedures are often more willing to access them and have better outcomes (Eisler and Hersen 2000; Flores, et al. 1999; Strecher and Rosenstock 1997). Emory University students definitely fit into a privileged group of individuals, in terms of their level of education. All have, at least, graduated high school and are attaining tertiary level degrees. They would also tend to be more informed of the information out there as well as open to accessing this information. Thus, education levels the cultural and social playing field somewhat, accounting for the lower levels of variation among groups of students.

Cultural and social factors both affect the health care seeking behavior of Emory University students. They account for differences in health care seeking behavior as well as similarities seen between different cultural and social groups. It is difficult to say that one has a greater impact than the other. The research shows that, although from many different parts of the world and the United States, and brought up in very different environments, Emory University students exhibit more similarities than differences in health care seeking behavior. Even so, the differences that were seen are important and should not be ignored.

Limitations

With any research project, there are limitations and difficulties associated with carrying out research. This project was no exception. Several limitations caused problems with research design, data collection, data analysis and recruitment. Although all attempts were made to ensure that the project was as valid and accurate as possible, there were certain things, which could not be avoided. The following description of limitations and difficulties associated with this project will assist in putting the overall research into better context.

Author Contextualization

In any type of research, it is important for the research and the researcher to be placed in context. The author's identity as a female international student at Emory University has effects on the research. Firstly, the author's identity means that she comes to the project with her own set of preconceived notions about health and what she believes the research will show. Acknowledging this and understanding it would help reduce bias.

Additionally, the author's position as a student at Emory would cause some bias in sample recruitment and participant response. Persons familiar with the author would be more likely to respond to the survey. This was definitely shown in the high number of students of Caribbean heritage in the sample population, as compared to the Emory student population. It also meant that students from Emory College were disproportionately represented. Attempts were made to avoid this by sending out emails to as wide a range of students as possible and avoiding coercion of individuals with whom the author was familiar.

Lastly, the author's inexperience as a researcher is definitely a limitation in this project, which should be noted. As an undergraduate researcher carrying out a project of this magnitude for the first time, difficulties experienced would not be the same as those experienced with a more experienced researcher- such as interview efficacy at data collection.

Sample Demographics

Firstly, response rates were one limitation, which occurred in this project. The desired sample size was not reached because of a lack of responses to email notifications. A possible solution to low response rates could be an alternative method of recruitment- such as in person recruitment. The impersonal nature of an online survey, although it allowed for greater anonymity and dispersal to a wider audience, could have been one reason for low response rates. Additionally, earlier and longer periods of recruitment at different times of the semester could have resulted in higher response rates.

The demographics of the actual research sample also were a limitation. The demographic makeup of the study sample does not correctly represent that of the population. This was seen most notably in the national origin of the international student respondents. Although South Korea is the country that sends the third largest number of students to Emory, only two respondents represented this demographic. Contacting and getting the opportunity to communicate with this group of students was an extremely difficult process. The author's position as an outsider in this group as well as possible language restrictions with completing the survey, were probably reasons for low survey response in these groups.

Generalizations

One limitation about the categorization of various groups within this project should be noted. The fact that International Students, First Generation American Students and American Students were examined as single groups, does not account for the wide range of diversity within these three national groups. Each of these groups consists of many subsets of racial, ethnic and cultural groups which may not all hold the same beliefs or show the same patterns of utilization as those seen in the group as a whole. The same limitation applies for the racial and ethnic grouping of individuals.

Time and Resource Constraints

Time and resources- such as labor and money- were limited. This led to limitations on the amount of recruitment that could be done, number of interviews, which could be done, and the overall scale of the project.

Chapter 6: Conclusion and Recommendations

Conclusion and Recommendations

There were more similarities than differences than expected in the health care-seeking behavior patterns of Emory University students. Both cultural and social factors helped shape these health behavior patterns. Cultural ideas about health services and treatment accounted for the differences in utilization patterns seen between national groups and race/ethnic groups. The social construction of gender accounted for a perceived difference, by respondents, of differences in utilization patterns between males and females- although these patterns were not supported by statistically significant data. Additionally, similar social and structural factors- such as economic constraints and convenience- acted as barriers to health services utilization and selection of a health care provider across all cultural and social groups examined. These results showed that cultural and social factors work together to determine the health care-seeking behavior of Emory University students.

This study has provided some insight into the health behavior patterns of Emory University students, but should not be taken as comprehensive by any means. It does provide, however, a launching point for further research into this area. A wider range of students can be investigated; students of other schools can be included in the sample population and comparisons done on the two; differences between Graduate and Undergraduate students can be researched, among other things. University students are a unique population with their own needs and behaviors different from the wider society, and this thesis helped bring light to this.

At Emory, where Student Health Services and the University, as a whole, have been actively recruiting and attempting to cater to the needs of its diverse students, studies of this kind

could help with the development of programs that better fit the needs of their ever-evolving student body. Based on the results of this research, a few recommendations can be made. If possible, Student Health should look into opportunities for including complementary and alternative treatment options or referrals for students in their range of services. At the very least, opening up a dialogue on campus about these methods may be a way to reach students who feel that they cannot access health services because of a difference in beliefs about biomedicine. Additionally, dialogue with and education of groups identified as lower users of health services, should be continued. Steps that Student Health Services have already taken- such as the online appointment system, presentations at different student group events and the creation of brochures in different languages- are steps in the right direction, but other options should also be looked into- such as presentations at International Student Orientation and seminars on Health Insurance. Other than these two recommendations, ongoing efforts to make health care more accessible- through hours that are more convenient- and more affordable to students should be continued.

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Appendix

Appendix 1: Survey Questionnaire

Title: Culture, Nationality and Gender: Effects on Healthcare Seeking Behavior of Emory University Students

Principal Investigator: Dr. Craig Hadley

Co-Investigator: Ayoka Adams

Introduction

You are being asked to be in a research study. This form is designed to tell you everything you need to think about before you decide to consent (agree) to be in the study or not to be in the study. **It is entirely your choice. If you decide to take part, you can change your mind later on and withdraw from the research study. You can skip any questions that you do not wish to answer.**

- Before making your decision:
- Please carefully read this form or have it read to you
- Please ask questions about anything that is not clear
- You can take a copy of this consent form, to keep. Feel free to take your time thinking about whether you would like to participate. By signing this form, you will not give up any legal rights.

Study Overview

The purpose of this study is to investigate how the cultural beliefs and ideas about medicine and health, nationality and gender of Emory University students affect their utilization of health services.

Procedures

For this study, you will be asked to complete an online survey. The survey will last approximately 15 minutes and will ask questions about your racial and ethnic background, religious beliefs, country of origin, gender and views on medicine and health. At the end of the survey, you will have the option of being contacted for a follow-up interview lasting approximately 1 hour.

Risks and Discomforts

The risks associated with this study are minimal. Sitting for the duration of the survey may cause boredom or mild physical discomfort. To minimize this, you will not be given a time limit to complete the survey and thus are free to move about as desired. As a student, you should know that participation in this study in no way affects your relationship or standing with the University.

Benefits

This study is not designed to benefit you directly. This study is designed to learn more about healthcare service seeking behaviors of Emory University students. The study results may be used to help others in the future by catering health services better to the needs of students.

Compensation

You will not be compensated for being in this study.

Confidentiality

Certain offices and people other than the researchers may look at study records. Government agencies and Emory employees overseeing proper study conduct may look at your study records. These offices include the Emory Institutional Review Board, the Emory Office of Research Compliance and the Emory Department of Anthropology. Emory will keep any research records we create private to the extent we are required to do so by law. A study number rather than your name will be used on study records wherever possible. Your name and other facts that might point to you will not appear when we present this study or publish its results.

Study records can be opened by court order. They may also be produced in response to a subpoena or a request for production of documents.

Voluntary Participation and Withdrawal from the Study

You have the right to leave a study at any time without penalty. You may refuse to answer any questions that you do not wish to answer. However, any information given can be used by the researcher in the study.

Contact Information

Contact Ayoka Adams at 678-431-8264 or amadam2@emory.edu:

- if you have any questions about this study or your part in it,
  Or
- if you have questions, concerns or complaints about the research

Contact the Emory Institutional Review Board at 404-712-0720 or 877-503-9797 or irb@emory.edu:

- If you have questions about your rights as a research participant.
- If you have questions, concerns or complaints about the research.
- You may also let the IRB know about your experience as a research participant through our Research Participant Survey at http://www.surveymonkey.com/s/6ZDMW75.

1. By checking the box below you are acknowledging that you have read the information above and are giving your consent to participate in this study.

   ☐ I agree to be part of this study

Personal Information

2. Emory School:

   Oxford College

   Emory College

   Emory School of Law

   Emory Medical School

   Rollins School of Public Health

   Laney Graduate School

   Goizueta Business School

   Nell Hodgeson Woodruff School of Nursing

   Candler School of Theology

3. What is the highest level of education achieved by your parents/ guardians?
   a. Parent/Guardian 1

   Some High School

   High School Diploma/GED

Some College Masters Degree

Associates Degree Doctorate

Bachelors Degree

b. Parent/Guardian 2

Some High School Bachelors Degree

High School Diploma/GED Masters Degree

Some College Doctorate

Associates Degree

4. What is the highest level of education you have achieved?

Some High School Bachelors Degree

High School Diploma/GED Masters Degree

Some College Doctorate

Associates Degree

5. Age:

6. Gender:

Male Female Transgender

Other:_____

7. Sexual Orientation:

Heterosexual Homosexual Bisexual

Other:_____
__

8. What is your religion

Christian Muslim

Hindu Sikh

Buddhist Jain

Jewish Tao

No Religion Other:_____

Baha'i ___

9. Are you an International Student (F-1,J-1 VISA)?
   Yes No
   c. If yes, which country?_____

10. Did you grow up outside of the United States?
    Yes No
    d. If yes, which country?_____

11. Were either of your parents born outside the United States?
    Yes No
    e. If yes, which country?_____

12. Did either of your parents grow up outside of the United States?
    Yes No
    f. If yes, which country?_____

13. How far from Emory do your parents live?

< 5 miles

5 – 10 miles

10 – 15 miles

Outside of the United States

15 – 20 miles

20 – 25 miles

>25 miles

14. What is your Race/ Ethnicity?

Black/African American

Caucasian/ White

Hispanic/ Latino

American Indian

Native Hawaiian/ Other Pacific Islander

Asian

Mixed Race

Other:

15. Which socioeconomic group do you fall into?

Upper Class

Upper Middle Class

Lower Middle Class

Lower Class

Access of Health Services:

16. Over the last five years have you used any of the following health services?

Type of Service	More Than Once a Year	Once a Year	Less than Once a Year	Never
Emory Private Doctor				
Emory Hospital				
Emory Clinic				
Emory Student Health				
Other Private Doctor				
Other Hospital				
Other Clinic				
Traditional Healer				
Religious Person/ Method				
Medical Specialist				

(e.g. cardiologist)				
Chiropractor				
Alternative Medicine (e.g. Acupuncture, massage)				
Pharmacist				
Physical Therapist				
Psychologist/ Therapist/ Counselor				
Nutritionist				
Online Services (e.g. WedMD)				

17. Within the past five years, which types of services have you seen a practitioner for?

Service	More Than Once a Year	Once a Year	Less than Once a Year	Never
Women's Health				
Physical Checkup				
Emergency Services				
Mental Health Services/ Counseling				
Sexual Health Services (e.g. STD testing, contraceptives)				
Substance Abuse Services				
Vaccinations				
Injuries				
Chronic/ Ongoing Illness (e.g. diabetes, hypertension)				
Acute/ One-time Illness (e.g. infection)				
Dental Services				
Eye care services				

18. If in the past you have needed to use a particular health service but chose NOT to, which of the following were reasons why? (Check all that apply)

Too expensive	Language Barrier
No insurance	Fear of lack of privacy
Won't help the problem	Did not provide the resources/services I wanted
Did not trust health services/practitioner	Fear of going alone
Afraid of outcome	Did not have the time to
Fear of discrimination/ stigma by provider	Previous bad experience
Fear of discrimination/stigma by others in society	Family/friend's previous bad experience
Too far/ No way to get there	Other:_____

19. When choosing a healthcare practitioner what things do you consider? (check all that apply)

Race/ Ethnicity	Location/ Distance
Gender	Language spoken
Level of qualifications	Reviews/ references from others
Religious beliefs	Age
Bedside manner/attitude	Nationality
Malpractice history	Insurance coverage
Amount of experience	Other:_____

Perceptions about health:

20. What does it mean to you to be healthy?

_____

_____

_____

21. How would you rate your current state of health?

Excellent	Fair
Good	Poor

22. From your point of view, what are the main factors that influence the decisions people in your community make about their health?

_____
_____
_____
_____

23. How much do the following influence the decisions you make about your health?

	A lot	Somewhat	Not at All
Family			
Religious Leader			
Friends			
Doctors/ Other Biomedical practitioner			
Traditional Healer			
Media/ Television shows			
Significant other/ partner			
Internet			
Professors/ mentors			
Insurance provider			

24. Thinking about the views of your community, how much do you think they agree with the following statements about health?

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
When someone has a cold they should seek medical care immediately					
When someone has a cold they should seek medical care only if it becomes very serious and					

prolonged					
Home remedies should be used to self-treat when ill					
Depression is a legitimate medical condition					
It is ok to seek counseling for depression					
Women need more medical care than men					
People do not need to access medical care unless it is life-threatening					
Traditional medical practices do not work					
Health problems are a result of God or other supernatural forces					
Real men do not get sick					
Biomedical/ Pharmaceutical drugs do more harm than good					
Doctors, hospitals and other biomedical institutions should be a last resort					
Hospitals are places where people go to die					
Prayer can heal					
Traditional medical					

practices are better than biomedical ones					
If someone gets ill is beyond their control					
Men who seek medical care often are just weak					
The quality of care someone receive is determined by their race/ethnicity					
Pain and tiredness are just normal effects of old age and one should not seek medical care for them					
Alternative medical practices, such as acupuncture, are effective					
One should always try to ‘tough it out’ before seeking medical care					
It is more comfortable for someone to see a healthcare practitioner of their same gender					
It is more comfortable for someone to see a healthcare practitioner of their same race/ ethnicity					
It is more					

comfortable for someone to see a healthcare practitioner of their same nationality					
It is more comfortable for someone to see a healthcare practitioner who speaks the same language as them					
People feel embarrassed when seeking medical care					
My medical problems are an individual's private business and should not be shared with anyone else, even family and friends					
Family and friends should know about an individual's medical problems and help make decisions about them					
People only seek medical care when encouraged to do so by someone else					
Medication should not be taken unless the problem is very severe					
People do not feel comfortable					

discussing their medical problems with their practitioner					
People feel as if they will experience stigma/ discrimination from healthcare professionals					

25. End of Study. Thank you for participating in this survey!
    If you would be willing to be contacted for a follow up interview, lasting no more than an hour, please include your email address in the box below.
    _____
    _____

Appendix 2: Interview Script

Personal/ Demographic Data

1. Which school at Emory do you attend?
2. How old are you?
3. What is you gender?
4. What is your religion?
5. Are you an international student or grew up outside of the United States?
    a. If yes, where?
6. Are either of your parents immigrants or grew up outside of the United States?
    a. If yes, where?
7. What is your race/ ethnicity?
8. Of the things stated above, which do you think most determine your ideas about health?

Views on Health and Accessing Healthcare

9. Do you consider yourself a healthy person?
    a. Why/ why not?
10. What do you think causes diseases/illness?
    a. Why?
11. What are your views on biomedicine?
12. What are your views on alternative medical practices?
13. What are your views of the use of religious or spiritual cures/treatment?
14. Do you use any type of healthcare service?
    a. Why/Why not?
    b. Which kinds?
15. When do you think someone should go see a biomedical practitioner about their health?
16. When do you think someone should go see an alternative practitioner about their health?
17. When do you think someone should go see a religious person about their health?
18. When do you think someone should go to a hospital?
19. How do you feel about having to visit a healthcare service?
20. What factors influence you in your selection of a healthcare provider (why do you choose the type of practitioner/service you do)?
21. Do your friends influence the decisions you make about health?
    a. How?
22. Do your parents/family influence the decisions you make about health?
    a. How?

23. Does the media influence the decisions you make about health?
    a. How?
24. Do you think that your gender plays a role in which services you access, how often you access and the way in which you access different health services?
25. What differences do you think there are between men and women in their healthcare seeking behaviors?
26. Is health seeking behavior tied into ideas of masculinity and femininity?
27. Do you think that the decisions you make about accessing healthcare are similar or different to:
    a. People of your race/ethnicity?
    b. People of your religion?
    c. People of your gender?
    d. People of your country?

Concluding Remarks

28. Is there anything else you would like to share pertaining to the influence of culture, nationality and gender on your healthcare seeking behavior?