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## Overcoming Barriers to Health Care Access: A Qualitative Study among African Migrants in Guangzhou, China

Lavinia Lin<sup>a,\*</sup>, Katherine B. Brown<sup>b</sup>, Brian J. Hall<sup>c</sup>, Fan Yu<sup>a</sup>, Jingqi Yang<sup>a</sup>, Jason Wang<sup>a</sup>, Joshua M. Schrock<sup>a</sup>, Adams B. Bodo<sup>d</sup>, Ligang Yang<sup>e</sup>, Bin Yang<sup>e</sup>, Eric J. Nehl<sup>a</sup>, Joseph D. Tucker<sup>f</sup>, and Frank Y. Wong<sup>a</sup>

<sup>a</sup> Department of Behavioral Sciences and Health Education, Rollins School of Public Health, Emory University, Atlanta, Georgia, USA

<sup>b</sup> College of Physicians and Surgeons, Columbia University, New York, New York, USA

<sup>c</sup> Department of Psychology, Faculty of Social Sciences, University of Macau, Taipa, Macau (SAR), People's Republic of China

<sup>d</sup> African Studies Department, Global African Diaspora Studies (GADS) Research Platform, University of Vienna, Vienna, Austria

<sup>e</sup> Guangdong Provincial Center for Skin Diseases and STD Control, Guangzhou, Guangdong Province, China

<sup>f</sup> UNC Project-China, Guangzhou, Guangdong Province, China

### Abstract

Guangzhou is China's third most populous city, and the region's burgeoning manufacturing economy has attracted many young African businessmen and entrepreneurs to the city. The aims of this study were to examine strategies that African migrants in Guangzhou have adopted in response to health care barriers, and explore their perceptions of how to address their needs. Twenty-five semi-structured interviews and two focus groups were conducted among African migrants residing in Guangzhou, China. Facing multiple barriers to care, African migrants have adopted a number of suboptimal and unsustainable approaches to access health care. These included: using their Chinese friends or partners as interpreters, self-medicating, using personal connections to medical doctors, and traveling to home countries or countries that offer English-speaking doctors for health care. Health care providers and health organizations in Guangzhou have not yet acquired sufficient cultural competence to address the needs of African migrants residing in the city. Introducing linguistically and culturally competent health care services in communities concentrated with African migrants may better serve the population. With the growing international migration to China, it is essential to develop sustainable approaches to improving health care access for international migrants, particularly those who are marginalized.

\*Corresponding Author. lavinia.lin@gmail.com.

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## Keywords

Africa; migrants; health care barriers; access to care; China

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## Introduction

International migration is a global phenomenon and migrant health has become an important public health matter (Zimmerman, Kiss, & Hossain, 2011). In the last decade, the total number of international migrants has increased from an estimated 150 million to 214 million people (International Organization for Migration, 2010). Generally, migrants move from low- to middle- and high-income countries in search of employment and business opportunities. However, migrants often face numerous challenges throughout the migration process that may impact their health (M. Carballo, Cody, & O'Reilly, 2011; M. Carballo & Siem, 2006; Gushulak, Weekers, & Macpherson, 2009). For example, migrants report limited access to health care and experience significant delays in engagement in health and social services (Harari, Davis, & Heisler, 2008; Wolff et al., 2008). Among the reasons for this lack of access to care are a combination of linguistic and cultural barriers, legal status, lack of awareness or knowledge of health care services, discrimination, poverty, and social isolation (Harari et al., 2008; Magalhaes, Carrasco, & Gastaldo, 2010; Morales, Lara, Kington, Valdez, & Escarce, 2002; Nygren-Krug & World Health Organization., 2003).

A number of exemplary policies have been developed in several Western countries to bridge the gap between health services and migrant communities. For example, the Office of Minority Health in the United States established “Culturally and Linguistically Appropriate Standards” in 2000 to provide a framework for all health care organizations to best serve the nation's increasingly diverse communities (The Office of Minority Health, 2013), while the European commission launched the “European Migrant Friendly Hospital Initiative” in 2002 to strengthen the role of hospitals in promoting culturally competent health care (Ludwig Boltzmann Institute for the Sociology of Health and Medicine, 2005). The concept of cultural competence has become ubiquitous in health care and is now an important component of curriculums in medical education programs. Cultural competence refers to an ability of a medical provider to possess the cultural awareness, knowledge, and skills to interact effectively with patients of different cultures and socio-economic backgrounds. Developing cultural competence enables the provider to accurately diagnose medical problems and collaborate with their patients efficiently, improving access to high-quality health care.

China has made tremendous economic transformations, leading to globalization and an influx of foreign visitors and labor migrants. According to the Ministry of Public Security, about 2.85 million foreigners entered China in 2007 for employment (Xinhua News Agency, 2010). Historically, migrants in China mainly consisted of individuals travelling from neighboring Asian countries and high-income nations (National Bureau of Statistics of the People's Republic of China, 2011), but the establishment of the Forum on China-Africa Cooperation in 2000 have promoted immigration from African countries (Brown & Chun, 2009). The deepening diplomatic relations between African countries and China have

advanced economic and trade cooperation, and China is now Africa's largest trade partner. In 2012, the total volume of China-Africa trade was nearly \$200 billion US dollars (Sun & Rettig, 2014), and the total trade volume between South China and African nations reached \$7.5 billion US dollars (Yaolan, 2013).

Guangzhou, capital of Guangdong province, has long been identified as one of the most important commercial and foreign trade cities in China. Located on the Pearl River within close proximity to Hong Kong and Macao, Guangzhou is a key national trading hub and trading port in South China. It is also seen as a manufacturing powerhouse with approximately 500 wholesale centers selling various commodities, such as apparel, electronic appliances, and cosmetics (Zhang, 2008). Its location and burgeoning manufacturing economies created abundant business opportunities for international trade (Zhang, 2008). Additionally, the availability of direct flights between Guangzhou and major African countries enhanced the connectivity, attracting many small-scale African businessmen and entrepreneurs travelling to the city in search for employment (Cisse, 2013).

Guangzhou is now home to an estimated 20,000 documented African residents, with an unknown number of undocumented residents and short term visitors on tourist visas (Bodomo, 2012; Li, Ma, & Xue, 2009). Several areas within the city are clustered with Africans for which the locals have coined as 'little Africa' or 'Africa Town' (Watts, 2013). Africans in Guangzhou are predominantly businessmen or traders, with a small number of housewives and teachers (Bodomo, 2012). Previous research has mainly focused on the economic and social roles of this newly emerging population (Bodomo, 2012; Li et al., 2009; Zhang, 2008); their health care experiences while in China have been relatively little studied. Our previous work showed that African migrants<sup>1</sup> in China face barriers to health care access, including affordability, legal issues, language barriers, and cultural differences (Lin et al., 2014). As part of a larger study of health care needs assessment among African migrants in Guangzhou, China, this study aimed to: (1) examine strategies that African migrants in Guangzhou have adopted in response to health care barriers; and (2) explore their perceptions of how to address their health care needs as their numbers continue to grow.

## Methods

This study utilized a qualitative research design to develop a holistic understanding of health care experiences among African migrants living in Guangzhou, China. Inclusion criteria for this study were individuals who originated from an African country and were at least 18 years of age. Participants were recruited through local community-based organizations. All participants provided verbal consent and were offered a meal in exchange for their participation in the study. The study protocol was approved by the Institutional Review

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<sup>1</sup>Our use of the term African here is meant to include all citizens of countries on the African continent, most of whom are members of the African Union, or anybody who considers themselves to be of African origins. In so doing we do not claim cultural homogeneity across this group of people. Indeed, cultural differences, if any, between these nationalities indicated do not have any major implications in the way they are treated with regards to health care delivery in China. In fact, Chinese, whether at the government level or at individual levels tend to treat and interact with Africans as a homogenous group, especially with regards to health care (non)-delivery.

Board of the Guangdong Provincial Centre for Skin Diseases and Sexually Transmitted Infection Control and the University of Hong Kong.

Data were collected over three consecutive weeks in July 2011 in two phases. The first phase consisted of formative work focused on building rapport with the African community leaders and identifying appropriate interview questions. Researchers conducted two key informant interviews with three local African community leaders. The community leaders provided information about the health care needs of the local African community, identified the most appropriate recruitment methods, and assisted in the selection of interview questions. The second phase involved participant recruitment through local community-based organizations. Community leaders from the two largest African organizations represented in Guangzhou were asked to notify their community of the recruitment meeting. At the meeting, researchers distributed recruitment pamphlets that included a description of the study and the contact information of research study personnel. Those willing to participate provided contact information in order to schedule an individual interview at a later date.

Two researchers (LL and KB) conducted 25 semi-structured interviews and two focus groups. Semi-structured interviews were used to allow flexibility and identify key issues. Our semi-structured interview guide was adapted from the interview guide developed by Harari et al (2008) and modified based on the feedback from community leaders. It consisted of open-ended questions on participants' local health care experiences. Examples of questions included "What did you do in Guangzhou when you have had health care concerns?" and "What is important to you when looking for a clinic in Guangzhou?" Each semi-structured interview ranged from 30 to 60 minutes and was conducted in English. The interviews occurred at locations preferred by the interviewees, such as restaurants or work offices. Those who participated in the interview were not asked to take part in focus groups in order to gain multiple perspectives. The two focus groups were stratified by gender such that one group consisted of five men, and the other consisted of five women. Each focus group discussion was approximately 50 to 60 minutes and followed an interview guide similar to that of the semi-structured interviews. All interviews and focus groups were audio-recorded and transcribed verbatim.

## Data Analysis

All names and identifying information were removed during transcription and each transcript was given a number. A team of five researchers conducted the data analysis. One team member took the role of "code keeper" and developed a codebook. The remaining team members coded the transcribed interviews. The code keeper used axial coding in the multiple readings of the transcripts to identify common strategies and suggestions on health care barriers raised by participants themselves. All data were double coded and compared by each team member coding independently to ensure consistency. Team members, including the principle investigators, met regularly to discuss coding discrepancies, review each code and definition in the codebook, and reach a consensus. Data were analyzed using MAXQDA 10 software (VERBI GmbH, 2011).

## Results

Demographic characteristics of all participants (N=35) are summarized in Table 1. Twenty-five participants completed semi-structured interviews, and 10 participants attended one of the two focus groups, stratified by gender. Twenty-five participants were male and 16 were married. The mean age of the participants was 33.7 years. Thirteen participants were originated from Nigeria and five from Uganda. Twenty-six participants were businessman and had a mean length of stay in Guangzhou of 4.4 years. A majority of the participants (n=28) obtained a legal residency permit and visa. Thirty participants reported English as their primary language for communication and most of them could not speak Chinese (n=28).

### Strategies to Overcome Barriers to Health Care Access

**Ad hoc Interpreters**—Nineteen participants reported that they relied on their Chinese friends, wives, and colleagues as interpreters, to help them communicate with medical staff during their health care visits. They noted these individuals were mostly proficient in English but had no training in medicine or medical interpretation. As a Nigerian man put it:

If you want to go somewhere here you need a Chinese-speaking [person] to help you. You need [to find] a way for them to understand you.

Two participants, however, did not feel comfortable with the presence of a third person during their medical visit because of privacy limitations and concerns about incorrect interpretation. A Nigerian man felt that he lost his patient's right to intimacy and confidentiality when an interpreter was present:

I cannot tell what's wrong with me to the doctor because of the language, so I went back to the hospital to see the doctor with my Chinese friend. But you know many of us want to keep our problem [private]... when you are going with a friend, it's not confidential anymore. Everything should be between the doctor and me, but now I have to tell my friend and I don't want him to know about my problem.

The other Nigerian man was afraid of missing important information during the translation process:

The doctor is not talking to you direct[ly]. When you are doing the translation, there will be some omissions along the line. It's not exactly what the person said.

**Self-medicating**—Thirteen participants indicated that they contacted their friends or relatives in their home country regularly to send them medicines. These medications were used for cold, cough, headache, and high blood pressure. Seven participants reported that they used home remedies when they encountered medical problems. For example, a Sierra Leonean woman took herbal medicine when she felt her blood pressure was high, and a Nigerian man 'treated' himself with red wine when he felt anxious. Six participants noted that they usually bought medicines when travelling to other countries because medications dispensed in the Western countries are often different or unavailable in China. As a Nigerian man explained:

Sometimes they [China] have the drug and sometimes they don't. I have to call a friend in Hong Kong to buy the drug for me.

Most participants practiced self-medication for common cold or flu-related symptoms; however, some reported that use of over-the-counter medicines for sexually transmitted infections was practiced among their peers. A Nigerian man expressed his concern:

Self-treatment is bad. Some people contracted with gonorrhoea will self-medicate. It might help initially but the problem will come back later and cause damages to the body.

**Personal Medical Connections**—Eight participants reported using personal connections to African medical doctors to solve their health problems. For example, a Togolese man consulted his doctor in his home country over the phone:

When I am not feeling well, I will call my doctor in my home country. He will ask about my symptoms and tell me what medicine to get over the phone.

A Malian man consulted an African medical student who was completing his training in Guangzhou:

I have one African friend who used to study here [Guangzhou]. He is a doctor. [During] that time, any information any problem we had I just called him. He helped us so much and we didn't have any problems. Since he left we have problems. He speaks Chinese; he writes Chinese. He can also speak French.

**Medical Tourism**—Eight participants reported that they sought health care services outside of mainland China due to communication problems and costs. Six participants indicated that they obtained health services during visits to their home country. Ten participants echoed this sentiment that they would rather delay their care until returning to their home country. As a Nigerian man explained:

The reason I went back to Nigeria because they didn't give me what I want when I visited the hospital [in China]. I decided to go back. I went back and explained to my doctor. I got my medicine and everything is okay.

Three participants reported that they travelled to countries that offer English-speaking doctors for health care. A Nigerian man said:

Hospitals in Hong Kong are way better than those in China because they treat you as a foreigner. They are able to speak English and interact with you.

A Togolese man shared his health care experience in Bangkok:

If you go there [Bangkok], they can understand any language you speak. The doctors come from many countries and speak many languages like Arabic, French, Spanish, English, and German.

This strategy was discussed within the local African community. Five participants reported that they know of someone who travels elsewhere for medical treatments. A Sierra Leonean woman recounted:

Lots of people go to Bangkok, Malaysia, or Indonesia for treatments.

### **Suggestions to Overcome Barriers to Health Care Access**

**Better Communication with Health Care Providers**—Eighteen participants stated that better communication with doctors could improve health care. They hoped the doctors in China were more proficient in English or French. As a Malian man explained that good communications can establish trust between doctors and patients:

If there is good communication, I will trust you and I will explain to you what I'm feeling.

Several participants reported that they preferred talking to doctors directly over using a medical interpreter. As a Nigerian man asserted:

I want a Chinese [doctor] who can speak English. This is very important. Sometimes the translator doesn't accurately translate what the person says. It is a problem.

**Culturally Competent Training to Health Care Providers**—Three participants suggested that doctors in China could receive cultural competence training to understand the nuances of their cultural heritage. They felt that doctors in China did not recognize that some diseases are more prevalent in their ethnic groups – for example, malaria and typhoid fever are more prevalent in Western Africa. A Nigerian man suggested inclusion of common health problems among ethnic minority groups into the China medical curriculums:

It is not easy for a foreigner to cure our diseases. The Chinese... when they go to school, they don't teach them about African sicknesses. But in Africa, [we] teach foreigner problems.

Six participants mentioned that the doctors did not understand their cultural beliefs, values, and practices and that impede the patient/doctor relationship. As a Malian man explained:

To understand a disease, it's more important to understand how a patient feels.

Participants hoped the doctors in China could show more empathy and be 'more friendly' to patients. A Ghanaian woman emphasized that African patients tend to require more psychological support from their health providers:

Doctors must have more empathy for sick persons... to support him/her.

**Health Insurance for Foreigners**—Two participants suggested incorporating health insurance programs for foreigners into the current health care system because most African migrants in Guangzhou have such financial difficulty that they cannot afford health care services. A Sierra Leonean man stated:

There are very few, about 20 to 30%, can afford good medicine but the majority [can]no[t].

A Ghanaian woman stressed the importance of health insurance programs to help reduce medical expenses, as some doctors in China would refuse service to those who could not pay the fee:



Health insurance will be much appreciated because when you go to a hospital with no insurance or money to pay, the doctors won't see the patient.

## Discussion

To our knowledge, this is one of few studies that assessed health care experiences among African migrants in Guangzhou, China. This study utilized a qualitative study design to examine strategies that the African migrants use to overcome health care barriers and explore their perceptions of how to best address their health care needs. This work builds on our previous study, documenting that African migrants have limited access to local health services due to a combination of linguistic and cultural barriers (Lin et al., 2014). Our finding suggests that participants have adopted a number of strategies in response to these barriers. These included: using Chinese friends or partners as interpreters, self-medicating, obtaining medical information through personal connections to medical doctors, and returning to their home country for medical care or travelling to countries that offer English-speaking doctors. Although helpful in providing short-term solutions, these strategies are a suboptimal and unsustainable approach to access health care.

First, interpreters without formal training can lead to misunderstanding and extended dialogues in a triangular conversation between physicians, patients and interpreters. Ad-hoc interpreting has been shown to result in clinical errors (Flores, Abreu, Barone, Bachur, & Lin, 2012). Similar to other studies (Garcia, Roy, Okada, Perkins, & Wiebe, 2004; Lee, Batal, Maselli, & Kutner, 2002), our participants who utilized ad-hoc interpreters reported low satisfaction with their care and had little desire to return for health services. Second, self-medicating can lead to direct adverse effects and complications secondary to medication interactions. As noted by one participant, it can also be an inadequate approach to treat infections, increasing the risk for further medical complications. Third, delaying care until international travel arrangements can be made may lead to increased morbidity and mortality. These findings point to the need for effective interventions that meet migrants' local health care needs in South China.

Our participants in this study suggested that health care providers in China could improve their communication skills and medical training to better serve the international populations. Given that the massive presence of African migrants in Guangzhou is a recent phenomenon in China, it is reasonable to assume that the existing medical services in Guangzhou are not accustomed to the needs of African migrant population and have not yet acquired cultural competence. To our knowledge, Guangzhou has a wide assortment of generalized and specialized hospitals that are either government or privately-owned. The public hospitals in Guangzhou, though available to foreigners, are not tailored to the needs and cultural practices of the foreigner community (Lin et al., 2014). One concern raised by our participants is the lack of formal medical interpreter services in such settings. The actual quality of communications between doctors and patients is unknown, although our previous study reported that African migrants were not satisfied with the Chinese doctor's second language skills (Lin et al., 2014). These hospitals are mainly attended by local patients and use of languages other than Chinese is minimal; therefore, doctors in public hospitals may lack the second language skills needed to communicate with international patients. There are



private health centers in Guangzhou that adopt international medical standards for its services and performance. Health care personnel in these centers are highly trained to meet the language and cultural requirements of international patients. However, membership or documentation of medical insurance is required and the services are extremely expensive. As a result, migrants with low income or undocumented migrants may experience challenges in accessing health services offered by these centers.

Some potential approaches to improving health care access for marginalized African migrants include the implementation of formal interpreter services and cultural competence training for health care providers in communities concentrated with African migrants. Chinese health care providers can work with interpreters to enable them practice effectively in a diverse community. Professional interpreter services have been implemented in other Asian developing countries and have yielded favourable results (Jaroensawat & Wankijcharoen, 2013). In addition, Chinese health care providers can receive training and education in culturally competent care to provide them the skills to serve international patients. Culturally competent care modules have been designed to introduce health care trainees important issues in the care of racial and ethnic minorities, as well as their cultural traditions and social values in health promotion (Birch, Ruttan, Muth, & Baydala, 2009; Kelly, 2011; Kim-Godwin, Clarke, & Barton, 2001). These modules have been shown to improve health quality and outcomes in other context (Fernandez, Seligman, Quan, Stern, & Jacobs, 2012; Lie, Lee-Rey, Gomez, Berekenyei, & Braddock, 2011) and may be warranted as the international populations continue to grow.

Our participants suggested that incorporating health insurance programs for foreigners into the current China health care system might improve their access to care. A similar situation has been observed among internal migrants in China, with more than 80 percent lack health insurance (Scheineson, 2009). China's health care system is currently undergoing major reforms, with the goal to expanding its coverage for both urban and rural residents. The current health insurance system in China generally falls into three categories: the urban employee basic medical insurance scheme for urban employees from both public and private enterprises; the urban resident basic medical insurance scheme for unemployed urban residents; and the new rural cooperative medical scheme for rural residents (Wang, Zheng, He, & Jiang, 2014). These programs are subsidized by government funding and based on residents' registration. Even so, the current health insurance system is not well adapted for internal migrants due to imbalance in accessibility and affordability of medical services (Wang et al., 2014). As such, African migrants might face even greater difficulties in gaining health insurance and adequate medical services because of their foreigner status. In 2011, China's Ministry of Human Resources and Social Security mandated Chinese employers to provide social insurance schemes to their international employees (Ku, 2012). This rule, however, did not apply to our participants, because most of them were self-employed and were not associated with any local employers. It may be advisable for African migrants to obtain travel insurance if they were staying temporarily in Guangzhou. African local community organizations may also collaborate and work with private medical centers in Guangzhou to develop affordable health insurance programs for those who plan to have a long-term stay. With respect to the increasing number of international migrants in China,

China Public Health Services may coordinate with central and provincial health agencies to examine whether it is feasible to promote basic medical insurance for international migrants.

This study has several important limitations. Participants in this study may not represent all migrants in Guangzhou, China. Migrants in the current study all self-selected to be interviewed. We cannot know whether important barriers and potential solutions may have been missed. This study had missing demographic data because some participants did not wish to share personal information in light of their immigration status and/or experiences in the past with local authorities. Almost all of our participants reported their occupation as self-employed businessman and therefore, our findings do not convey differences in health service use according to their occupation. Nonetheless, the distribution of our study sample is similar to the distribution of African diaspora in China as shown in the literature (Bodomo, 2012). Future research may replicate the design of this study with foreigners who work in a local company, particularly those working with African migrants, to compare their health barriers and coping strategies with the African migrants. Additionally, this study focused only on the health care experiences of African migrants from patient perspectives. Further studies may involve the viewpoints and experiences of local human resources administrators from different firms, health care providers, and immigration authorities to better understand the challenges related to health care access by international patients. In China, hospitals are classified into primary, secondary and tertiary institutions. Due to this complex system, further research is needed to assess at which level of services should be targeted. Quantitative research on international migrants' health seeking behaviors and outcomes would also be useful.

## Conclusion

This is one of few studies that examined health care experiences among African migrants in Guangzhou, and it contributes to the literature by exploring issues of access to care through the lens of foreigners residing in China. This study highlights that African migrants have limited access to health services in Guangzhou and have adopted a number of suboptimal and unsustainable strategies in response to barriers to health care. With the growing international migration to China, it is essential to develop sustainable approaches to improving health care access for international migrants, particularly those who are marginalized.

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**Table 1**

Demographic Characteristics of Participants (N=35)

Characteristics	No. or Mean (SD)
Gender	
Male	25
Female	10
Country of origin	
Nigeria	13
Uganda	5
Ghana	3
Sierra Leone	3
Togo	2
Congo	1
East Africa	1
Liberia	1
Mali	1
Gambia	1
Guinea	1
Unknown	3
Marital status	
Single	9
Married	16
Unknown	10
Immigration status	
Legal permanent resident	3
Legal visa holder	25
Undocumented migrant	2
Unknown	5
Primary language of communication	
English	30
French	5
Able to speak Chinese	
Yes	7
No	28
Occupation	
Businessman	26
Student	2
Housewife	1
English Teacher	1
Unknown	5
Age	33.7 (3.1)
Number of years in China	4.4 (7.1)