Journal of Current Chinese Affairs

China aktuell

Topical Issue: Foreign Lives in a Globalising City: Africans in Guangzhou
Guest Editor: Gordon Mathews

Bork-Hüffer, Tabea (2015),
Healthcare-Seeking Practices of African and Rural-to-Urban Migrants in Guangzhou, in: *Journal of Current Chinese Affairs*, 44, 4, 49–81.

URN: http://nbn-resolving.org/urn/resolver.pl?urn:nbn:de:gbv:18-4-9140

ISSN: 1868-4874 (online), ISSN: 1868-1026 (print)

The online version of this article and the other articles can be found at:
<www.CurrentChineseAffairs.org>

Published by
GIGA German Institute of Global and Area Studies, Institute of Asian Studies and Hamburg University Press.

To subscribe to the print edition: <ias@giga.hamburg>
For an e-mail alert please register at: <www.CurrentChineseAffairs.org>

The *Journal of Current Chinese Affairs* is part of the GIGA Journal Family, which also includes *Africa Spectrum*, *Journal of Current Southeast Asian Affairs* and *Journal of Politics in Latin America*: <www.giga-journal-family.org>.

Healthcare-Seeking Practices of African and Rural-to-Urban Migrants in Guangzhou

Tabea BORK-HÜFFER

Abstract: Taking the examples of Chinese rural-to-urban migrant and African migrant businesspeople in Guangzhou, this article inquires into the commonalities and differences in the health status and healthcare-seeking practices of both groups. While both populations of migrants are diverse and heterogeneous, there are many commonalities with regard to the challenges they face compared to the Chinese local population. Mixed-methods research frameworks and qualitative and quantitative methods were applied. While existing publications emphasise lacking financial access to healthcare, further individual and social factors account for migrants' healthcare choices. Their access to healthcare can be improved only by introducing insurance schemes with portable benefits, providing localised and culturally adequate health services adapted to migrants' specific needs and health risks, and enhancing patient orientation and responsiveness by health professionals.

■ Manuscript received 15 October 2014; accepted 22 June 2015

Keywords: China, Guangzhou, healthcare, health, international migration, rural-to-urban migration, public health policy

Dr. Tabea Bork-Hüffer is an Alexander von Humboldt Foundation Fellow at the Asia Research Institute of the National University of Singapore. Her research interests centre around the changing geographies of internal and international migration, migrant health, health governance, and the role of new media in migrants' place perception and place-making with a regional focus on China, Singapore, and Germany.
E-mail: <aritbh@nus.edu.sg>

Introduction

This paper[1] looks at the nexus of migration and health in urban China, with a particular focus on internal and international migrants' health status and their healthcare-seeking practices. I bring together results of two different research studies conducted in the southeastern city of Guangzhou, of which one focused on rural-to-urban migrant and the other on African migrant businesspeople.

There are a substantial number of publications that have analysed Chinese internal rural-to-urban migrants' health and their access to healthcare (including some that are relevant in the context of this article are presented in later sections), but there are very few that focus on international and African migrants in China (Hall et al. 2014; Lin et al. 2014; McLaughlin et al. 2014) and none that compare both groups. Yet, as will be shown, these populations face similar challenges in China, especially in regards to limited access to local health-insurance schemes, low social status, discrimination, and insecure legal status, which all affect their interaction with the healthcare system. While rural-to-urban migrants work in various occupations in the manufacturing, construction, and services sectors, the great majority of Africans in Guangzhou are traders, with many having their own businesses. Work regimes produce different health risks (cf. Gransow 2010) and substantially affect migrants' ability to use the healthcare system. For example, factory employees might be bound to see factory-employed health personnel, not be allowed to leave factory compounds, or be threatened with loss of job when ill or taking off time to see a doctor (cf. e.g. Pun 2005; Bork-Hüffer 2012; Hartmann 2013). Thus, in order to allow a comparison between Chinese rural-to-urban and African migrants, I selected individual busi-

1 Both research projects on which this paper is based were part of the German Research Foundation's programme 1233 "Megacities – Megachallenge: Informal Dynamics of Global Change" (DFG; KR 1764/8-1 and KR 1764/8-2). I would like especially to thank Frauke Kraas, Birte Rafflenbeul, Li Zhigang, Xue Desheng, Bettina Gransow, Yuan Yuan-Ihle, Heiko Jahn, M. M. H. Kahn, and Alexander Krämer for their contributions during all stages of the research. In addition I am grateful to the Alexander von Humboldt Foundation in Germany and the Asia Research Institute of the National University of Singapore, both of which supported my fellowship during which this article was written. Finally I would like to express my gratitude to the two anonymous reviewers for their thoughtful and helpful comments.

nesspeople – those who are self-employed and/or employ others in their businesses – out of the larger samples that were collected as part of both studies.

The specific research question of this article is: What are the commonalities and differences in the health status, healthcare-seeking practices, and barriers to receiving care experienced by rural-to-urban and African businesspeople in Guangzhou? Based on the results, I make recommendations for improvements in healthcare provision that can benefit both groups. On a broader level, the paper contributes to research that integrates and compares international and internal migrant populations, which has been repeatedly called for (e.g. by Skeldon 2006; DeWind and Holdaway 2008; King and Skeldon 2010; Smith and King 2012).

I start out by discussing and comparing existing insights into the migration background, livelihoods, and respective migration regimes in which both populations are embedded as well as insights into their access to healthcare. Healthcare-seeking is then used to conceptually frame migrants' healthcare decision-making. Mixed-methods research approaches that combine qualitative and quantitative data-collection methods were applied under similar conditions for both groups under analysis. The findings section presents results of both research studies before they are contrasted and discussed in relation to existing publications and the conceptual approach. The final section comprises policy recommendations.

Commonalities and Differences between Rural-to-Urban and African Migration

Internal and international migration in China was enabled by the changes in migration law and regulations released in the reform period (cf. Liu 2009). Rural-to-urban migration jumped after the introduction of the opening reforms and grew to a total of 221 million people in 2010, according to the latest population census (National Bureau of Statistics 2011: 59–61; this number includes subjects who crossed at least county borders and stayed for more than six months in a place other than that of their permanent residency). African migration to China increased substantially only after the country's entry into the World Trade Organization in 2001. The majority of Africans are involved in the trading businesses, and Guangzhou has more African

migrants than any other city in China (Li et al. 2008; Li, Ma, and Xue 2009, 2013; Müller and Wehrhahn 2011, 2013; Bodomo 2012; Bredeloup 2012; Lyons, Brown, and Li 2012; Bork-Hüffer et al. 2015). Being the location of the China Import and Export Fair, the city has become a hub for traders from all over the world involved especially in the export of Chinese goods. Many African traders in China are highly mobile and spend varying periods of time in China and their home country and/or other countries (cf. Bork-Hüffer et al. 2015). Nevertheless, they are defined as migrants in the context of this article, based on definitions of migrants that take the growing transnational and translocal movements of mobile subjects into account (cf. Castles 2000; UNESCO 2010).

The existing regulatory frameworks treat both groups of migrants as temporary elements in the cities or the country, respectively (Wang and Fan 2012). Despite there being a few places where internal migrants were able to obtain urban household registration, in most cities they are required to register and obtain a series of other documents to officially be granted the right to stay (Zhao 2003), even though these procedures were relaxed under the leadership of Hu Jintao and Wen Jiabao (Holdaway 2008). Treating rural-to-urban migrant workers as temporary elements in the urban fabric serves to legitimise the disregarding of this group in urban planning and the provision of urban infrastructure and services (Qi, Kreibich, and Baumgart 2007). Suda (cf. 2014) has shown how also those who are employed in the highly skilled sectors, but who do not manage to obtain a local urban household registration, are systematically excluded from the provision of urban services and from urban society. While there are visa types allowing for international migrants to stay for longer periods of time and apply for permanent residency, by default only a very small group of them are able to achieve this status. Individual businesspeople are only able to apply for an M visa (formerly an F visa), which needs to be regularly renewed. Based on prevailing political interests at any given time, visa-issuance policy has been known to change at the drop of a hat, resulting in a constant state of insecurity for international migrants in China (cf. Liu 2009, 2011; Bork-Hüffer and Yuan-Ihle 2014).

Aside from the institutional-administrative discrimination they face, both groups of migrants are socially stigmatised and marginalised. Rural-to-urban migrants are blamed by urban locals for increas-

ing criminality and prostitution in the cities (Friedmann 2007). In public discourse, Africans are associated with the three illegalities (illegal entry, stay, and employment), the drug trade, and other criminal activities, and they are blamed for spreading diseases (cf. Haugen 2012; Bork-Hüffer and Yuan-Ihle 2014; Hall et al. 2014). Frequent controls of passports, visas, work permits, housing registration, and other official documentation by the police cause stress and anxiety for the migrants (cf. Bork-Hüffer and Yuan-Ihle 2014; Hall et al. 2014). Black Africans are even more affected by racism against foreigners in China than any other international migrant group (cf. Callahan 2013). While many rural-to-urban migrants usually have the advantage of speaking Mandarin, most do not speak Cantonese, and studies have shown that language differences between the Cantonese-speaking local population and migrants exacerbate social distance (Chang 1996). Xu and Liang (2012) pointed out that only a small percentage of Africans speak a sufficient level of Mandarin or Cantonese, which makes communication with locals and the integration into the host society difficult. Many studies have underlined significant negative effects of discrimination and social exclusion on migrants' socio-psychological well-being (e.g. Li et al. 2006; McGuire, Li, and Wang 2009; Wang et al. 2010).

Commonalities and Differences between Rural-to-Urban and African Migrants' Access to Healthcare

As a result of the economic and health system reforms after the introduction of the open door policy, disparities between healthcare provision in rural and urban areas in China have widened tremendously (Ma, Lu, and Quan 2008; Treiman 2012). In the quickly developing and economically booming cities of China's eastern provinces, like Guangzhou, healthcare supply has expanded and diversified greatly over the last three decades; aside from public and public-private facilities, it has grown to include an ever-greater number of private-only facilities, as well (Gu and Zhang 2006; Ramesh and Wu 2009; Tam 2010). Due to its status as capital of Guangdong and regional centre of Southeast China, available healthcare includes specialised municipal-, provincial-, and national-level healthcare institutions, alongside basic medical care facilities. Responding to the grow-

ing number of international migrants in China, further international health facilities have opened, which mainly serve highly skilled migrants working in international companies or embassies that provide insurance for their staff and are very expensive. Hall et al. (2014) and Lin et al. (2014) have pointed out that staff in Chinese facilities is not trained in culturally adequate care and the management of specific ailments that their African clients may face. At the same time, unregistered practitioners have mushroomed due to the increased demand for low-cost treatment especially by rural-to-urban migrants. Some of these practitioners have received some training – for example, as former village or military doctors – but were not able to get accreditation in Guangdong. Others are charlatans who have never received any education or training (cf. Bork-Hüffer and Kraas 2015).

Overall, the potential availability of healthcare is much higher for rural-to-urban migrants in Guangzhou compared to their places of origin. Because the African migrants' places of origin are too diverse and include rural and urban areas, it is not possible to directly compare healthcare availability along the same lines. Due to the general increase in healthcare provision and the availability of high-level healthcare institutions, however, it can be assumed that, on average, the availability and quality of healthcare is higher in Guangzhou than in the African traders' places of origin. Nevertheless, the adequacy of health services (cf. Butsch 2011) is a concern for both groups, who might expect healthcare services to be provided by traditional or alternative practitioners that will not be available in the cities they move to.

Both groups have limited access to health insurance. Rural-to-urban migrants fall into the gap between rural and urban health insurance systems, and while pronouncements have been made that this group will be included in social insurance schemes in the future, this policy has not yet been implemented sufficiently (Xiang 2004; Holdaway 2008). An official scheme that seeks to integrate foreign workers into China's social insurance system, which includes health insurance, was only introduced and implemented in 2011. It is restricted to international migrants in China who are employed by companies or public and registered non-governmental institutions and thus does not cover individual businesspeople (cf. Bork-Hüffer and Yuan-Ihle 2014). The only way for them to be covered by insurance is if they obtain private health insurance individually.

Overall, migrants in both groups are disadvantaged in terms of their financial access to healthcare, they face social and institutional discrimination in the cities, and many are socially excluded and face insecurity in terms of their legal right of stay.

Health- and Healthcare-Seeking Practices

Definitions of the concept of "health" have varied across time and cultures (cf. Blaxter 2004). The World Health Organization (WHO 1946: preamble of the 1946 Constitution of the WHO) defined health as embracing physical health and social and mental well-being. Following this conceptualisation, Blaxter put forth that health is a "positive state of wholeness and well-being, associated with, but not entirely explained by, the absence of disease, illness or physical and mental impairment" (Blaxter 2004: 19). In a previous work, I defined health(care)-seeking as

> the process in which an individual perceives, evaluates, and takes action or does not take action as [a] response to a perceived physical or mental health problem (illness) with the aim of getting well. This process may include no action, self-care – defined as self-diagnosis, self-treatment, and self-medication including care by members of the individual's social network – and/or the utilisation of formal and/or informal healthcare services. (Bork-Hüffer 2012: 68)

Health(care)-seeking is a complex process (MacKian, Bedri, and Lovel 2004) that involves a variety of influences that I framed using Archer's (1995) morphogenetic approach and Giddens' (2000) structuration theory (cf. for the detailed approach Bork-Hüffer 2012). Among these influences are, first, individual factors such as mental and physical health status, predisposing circumstances (e.g. age, sex), type of health problem, perception of the health problem and of the opportunities to take action to get well, past experiences (recall [cf. Giddens 2000: 44–51]) with the health system, all types of knowledge (memory [cf. Giddens 2000: 49]) relevant for health-seeking, and personal intentions. Second, other agents and individuals' relations to them (cf. Archer, 1995) influence health-seeking. Among them are, for example, health practitioners and pharmacists, members of social networks, government and administrative bodies, and civil society organisations. As individuals are always embedded in a social context,

relations and societal rules affect their opportunities to respond to a health problem. Relations between agents define their positions, social status, and level of power in society. Third, material structures (cf. Giddens 2000) affect health-seeking in the form of economic resources, locational resources, healthcare, and medical resources. I postulate that in opposition to the prevailing notion that health-seeking behaviour is a reflexive response to a trigger, individuals deliberately and reflexively consider their options and constraints and play an active part in shaping their health-seeking decision-making (Bork-Hüffer 2012).

Given restrictions with regard to the data collected that is comparable across both research studies, the following analysis will focus on individuals' healthcare-seeking practices – meaning, their utilisation of formal and/or informal healthcare services in Guangzhou and elsewhere; it is not possible here to evaluate self-care and other alternative strategies. In addition, I focus especially on individual factors, the social context, and economic resources in the analysis of migrants' healthcare-seeking practices. It is not possible to dissect the influence of societal rules based on the data.

Research Approaches and Comparability of the Data

Both research projects on which this paper is based were part of the German Research Foundation's programme (1233) "Megacities – Megachallenge: Informal Dynamics of Global Change." One focused on the linkages between urbanisation, health governance, and rural-to-urban migrant health in the Pearl River Delta (PRD) (hereafter: research project I); data was collected between 2006 and 2008. Research was undertaken in so-called "villages-in-the-city" in Guangzhou, which are marginal settlements characterised by very high housing and building densities and insufficient supply and disposal infrastructure. They are one of the main residential areas for migrants in the PRD – especially self-employed businesspeople (Gransow 2007, 2012; Wehrhahn et al. 2008; Bork-Hüffer 2012). The other project dealt with China's management of its international migrant population and the migrants' access to social services and infrastructure, with a special focus on African migration into the PRD (hereafter: research project II); data was collected between 2006 and 2010.

The studies took similar research approaches and mixed-methods research frameworks. They were characterised by an inductive-deductive interplay and the combination of qualitative and quantitative research methods, which were given equal importance in the research process and integrated at various stages. Each research approach started out with an initial empirical and explorative research phase, in which emphasis was given to qualitative methods. In-depth interviews were conducted with migrant subjects as well as with experts. In the research study on rural-to-urban migrants, a theory-development phase followed. The theoretical approach that was developed during the overall process of research project I also informed the design, data collection and analysis, and interpretation phases of research project II. Both projects underwent a second empirical research phase that included the concurrent conduct of a quantitative survey with migrant subjects as well as in-depth interviews with migrant subjects and experts that were more structured and focused than those in the initial empirical phase. Wherever possible, questions in the quantitative survey that were related to health-seeking in project II were aligned with those in research project I, making the results comparable across both samples. SPSS 21 was used for the statistical analysis of the quantitative surveys.

Qualitative interviewees were selected through theoretical sampling (cf. Lamnek 2005) with the aim of integrating migrants from various backgrounds and perspectives who experienced different health problems. The unavailability of a frame covering either the rural-to-urban or African migrant target population made random sampling impossible for both populations. This is particularly due to the fact that unregistered rural-to-urban and undocumented African migrants were included in the sample. The share of each among the total migrant populations is unclear, though Taubmann (2002: 81) once estimated that up to 50 per cent of the rural-to-urban migrants living in Guangzhou are not registered. As a consequence, local migrants were recruited in the street and other public spaces, in their businesses and in restaurants. In order to cover as many different areas of the villages-in-the-city as possible, each interviewer conducted interviews in a certain strategic location (we covered main intersections, main streets, and entrances and exits of the villages-of-the-city, and a few interviewers were instructed to also interview in side streets). Consequential under- and over-coverage was discussed in

Bork-Hüffer (2012). The African entrepreneurs were interviewed in the two most important business areas for African traders in Guangzhou: Guangyuanxi and Xiaobei. Interviews took place in the street, in African businesses (restaurants, cafés, and hair salons), interviewees' offices or stalls, and in the hallways of the buildings in both locations.

As pointed out in the introduction, in order to be able to compare rural-to-urban migrants with the African traders who reside in Guangzhou, this article focuses on those interviewed migrant subjects who work as businesspeople: those who are self-employed or who employ others in their own business. Hence, of the overall data collected in the frame of research project I, this article is based on qualitative interviews with 11 rural-to-urban migrant businesspeople (selected from the overall sample of 39 migrants) and a quantitative survey of 145 rural-to-urban migrants (selected from the total sample of 450 migrants; the survey was conducted in March 2008). The interviewees that were excluded were those working as employees and unemployed subjects. Those interviewees included work, for instance, as owners of stores, restaurants, hairdresser's shops, or small handicraft workshops located in villages-in-the-city. As part of research project II, 10 migrants were interviewed qualitatively and 161 quantitatively (out of the overall sample of 269; the survey was conducted between April and May 2010). Those excluded were employees or migrants that resided in other Chinese cities (the original survey also included migrants living in Foshan). All qualitative interviews with rural-to-urban migrants were recorded and transcribed. Only some of the African interview partners agreed to an audio recording of their interview as it also covered more sensitive questions related to their legal status. Thus, most of the interviews could only be recorded in writing and were not taped or transcribed.

Two standardised indicators were used in both quantitative surveys to measure and compare physical and mental health status. These are item 1 of the 36-Item Short-Form Health Survey from the RAND Medical Outcomes Study (hereafter SF-36) (cf. Ware and Sherbourne 1992) and the 1998 version of the WHO-Five Well-Being Index (hereafter WHO-5) (WHO 1998: 25). Item 1 of the SF-36 reflects perceptions of physical health status rather than of mental health status (according to a study conducted by Ware, Kosinski, and Keller 1996 cited from Ware n.y.). The WHO-5 is an indicator of

positive psychological well-being (Bech et al. 2003) and has further been found to perform well as a depression-screening tool (e.g. by Primack 2003). A raw score below 13 indicates poor well-being and high risk for depression (WHO 1998: 25).

Table 1. Comparison of Basic Socio-Demographic and Socio-Economic Characteristics between African and Rural-to-Urban Businesspeople in Guangzhou

		African businesspeople	Rural-to-urban businesspeople
Share of men in the sample		94.4%	51.7%
Age	average age	34 years	34 years
	50 and older	1.2%	8.7%
Educational level	no education or only primary school	4.4%	16.7%
	high school or above	73.0%	28.5%
Length of stay in Guangzhou: less than 3.5 years		70.3%	34.5%

Table 1 compares basic socio-economic and socio-demographic characteristics of the migrant samples. Due to the dominance of men in African trading in China, the number of males is much higher in the survey of African businesspeople than in that of rural-to-urban migrants. Migrants in both samples had a similar average age of 34 years; however, there was a comparatively larger share of migrants 50 or older in the sample of rural-to-urban migrants. Rural-to-urban migrants who reside in villages-in-the-city are on average slightly older than the general rural-to-urban migrant population in Chinese cities (cf. Fan 2008, this matches the findings of Zheng et al. 2009). Further, private businesspeople and employers were in general older than other occupational groups in the overall rural-to-urban migrant sample. African migrants had on average much higher levels of education than their rural-to-urban counterparts. The great majority of African interviewees stemmed from West African countries (cf. also Bodomo 2012). Rural-to-urban migrants stemmed from various provinces in China, with higher numbers (above 5 per cent) coming especially

from other parts of Guangdong (29.7 per cent), Hunan (22.1 per cent), Guangxi (8.3 per cent), Henan (7.6 per cent), Sichuan (6.9 per cent), and Jiangxi (5.5 per cent). Following the comparatively more recent increase in African migration to China, 70.3 per cent had migrated to China in the three and a half years prior to the survey (since 2007). In comparison, only 34.5 per cent of the rural-to-urban interviewees had migrated to Guangzhou in the three and a half years prior to the survey (since 2005); 84 per cent had arrived somewhere in the ten and a half years prior to the survey (since 1998).

Findings: Health Status and Healthcare-Seeking Practices

Before analysing factors that account for migrants' choice of healthcare and the problems they encountered when seeking care, I will outline their general health status and their patterns of healthcare utilisation.

Physical and Mental Health Status

According to item 1 of SF-36, African interviewees had in general a good physical health status and on average a better physical health status than their rural-to-urban counterparts (cf. Table 2), although both migrant samples ranked rather well. At the same time, a significant number of interviewees from both samples had a WHO-5 raw score below 13 (cf. Table 2), which indicates poor well-being and high risk of depression.

The qualitative interviews point to some self-reported causes that account for poor psycho-social well-being, and they evinced some differences between the populations. Rural-to-urban migrant interviewees complained especially about stress caused by long working hours, the pressure to earn money and pay for the living costs of their families and their children's tuition fees, as well as institutional barriers. An owner of a grocery store from Hunan reports:

> I feel a lot of pressure because of the high cost of living. My children are learning at school, I must take care of four parents, my wife is in poor health. I call my parents twice a week by telephone to get some information about their living conditions, which makes me a little lighter of heart. (Anonymous 1 2008)

Table 2. Comparison of Basic Indicators of Physical and Mental Health Status of African and Rural-to-Urban Migrant Businesspeople

		African business-people (%)	Rural-to-urban busi-nesspeople (%)
SF-36, item 1	Poor	1.9	3.5
	Fair	1.9	11.2
	So-so	8.7	26.6
	Good	50.9	42.0
	Excellent	36.6	16.8
WHO-5 raw score below 13		24.5	21.3

Those African migrants who complained about burdens they faced in the qualitative interviews were more often undocumented migrants who did not have a valid visa and/or passport (cf. also next section), and their precarious and insecure situation alongside their ever-present fear of being discovered by the police were prominent topics. Others pointed to the profound social discrimination and racism they faced, which affected Black Africans more than others. As a Nigerian businessman pointed out:

> See, the issue is this: Once we are in China we are never happy. We cannot be happy unless we go back home. [...] All life is like this, life is painful for us. You know, first of all we are Africans. Life is hard. Because we are Blacks, man, life is fucked up, do you understand this? I am a Black man, everywhere I go, people look at me like I am an animal. (Anonymous 2 2010)

Utilisation of and Satisfaction with Healthcare Services

Ninety out of 161 African interviewees had visited a health professional when they came down with an illness in mainland China before. Of these, 81.1 per cent had consulted one based in mainland China, 14.4 per cent one in their home country and 4.4 per cent one in Hong Kong. Of those who chose to see a doctor in mainland China, 76.5 per cent had gone to a hospital, in comparison to 23.5 per cent who consulted a practitioner in a lower-level facility (cf. Table 3). Strikingly, 36.5 per cent of the Africans had not been aware of the status of the facility they had visited – of those who were able to tell,

42.6 per cent had gone to a Chinese private facility, 12.8 per cent a private international healthcare facility and 44.7 per cent a Chinese public facility.

Table 3. Comparison of Health-Insurance Coverage, Utilisation, and Satisfaction with Healthcare in Guangzhou between African and Rural-to-Urban Businesspeople

		African businesspeople (%)	Rural-to-urban migrant businesspeople (%)
Enrolled in health insurance	that can be used in Guangzhou	13.3	5.6
	that can be used in places of origin	42.4	13.3
Utilisation of	higher-level facilities (e.g. hospitals and outpatient departments)	76.5	62.7
	lower-level facilities (e.g. community health services stations, community health services centres, clinics)	23.5	37.3
Satisfaction with health services received	very satisfied or satisfied	66.2	28.2
	neither satisfied nor dissatisfied	21.1	29.6
	dissatisfied or very dissatisfied	12.7	42.3

Sixty-six out of 145 interviewees in the quantitative survey of rural-to-urban migrants had used a health facility in Guangzhou in the six months prior to the survey; 62.7 per cent had seen a health professional in a hospital, in comparison to 37.3 per cent who had consulted one working in a lower-level facility (cf. Table 3). The quantitative survey with rural-to-urban migrants also inquired into the types of health problems interviewees had faced in the six months prior to the survey and the respective decisions they made, including their choice of healthcare. The survey showed that the majority of interviewees who decided to seek care consulted hospitals, independent of the severity of the medical problem faced – that is, even in cases of minor illnesses such as colds and other upper-respiratory-tract infections. This tendency was also evinced by the population holding an

urban household registration, according to Li (2006: 93) and Liu and Yi (2004: 50, 55).

Rural-to-urban migrants who had visited a hospital were not able to identify whether it was a state-owned or a private facility. Thus it is only possible to identify the share that had used private clinics: 18.7 per cent. The overall share of private facilities used might be even higher. Nevertheless, in comparison, only 12.2 per cent of the Chinese overall population had sought treatment at private facilities in 2008 (MoH 2009), showing that migrants are more likely to use these facilities. In addition, rural-to-urban migrants were asked whether they knew if the facility they had visited was licensed (this concerns only private clinics, as all others are licensed) and almost all were not able to tell.

Strikingly, African migrants tended to be much more satisfied with the health services they had received in mainland China than the rural-to-urban migrants (cf. Table 3).

Factors Influencing the Choice of Healthcare and Problems Encountered

There are both commonalities and differences in terms of the health barriers and healthcare-seeking practices between the two populations, as revealed through the quantitative survey (cf. Figure 1) and qualitative interviews. Strikingly, despite the much higher satisfaction of African interviewees with the care they had received when compared to the internal migrant interviewees (cf. Table 3), a much larger number of the former named actual problems they had encountered when consulting health professionals in Guangzhou (cf. Figure 1). The most prominent challenge for Africans by far when seeking care was language problems (cf. Figure 1), a challenge that does not affect rural-to-urban migrants as greatly. Among the Africans, 11.3 per cent rated their Mandarin proficiency as good or excellent, and 2.5 per cent rated their Cantonese the same, meaning that the remaining share, in turn, had a level that was insufficient to communicate with doctors who only spoke Mandarin or Cantonese. Among the African interviewees, 43.9 per cent spoke English, 21.3 per cent French, 17.4 per cent Igbo (a language spoken by the Igbo ethnic group based in southeastern Nigeria) and 17.4 per cent other languages as their first language.

Both migrant populations raised issues related to the organisation of health facilities, such as long waiting times in facilities, which a substantial number of migrants from both groups named as challenge, along with inconvenient opening hours (cf. Figure 1). One-third of the African migrants and one-fifth of the rural-to-urban migrants also said that they had faced problems taking time off from work in order to see a health professional (cf. Figure 1), making long waiting times and inconvenient hours an even larger problem. However, the qualitative interviews with rural-to-urban migrants revealed a lack of knowledge on the availability of off-hour emergency services in hospitals. In addition, these services require extra charges that might deter migrants from using them. Further, African and rural-to-urban interviewees complained about inscrutable and complicated administrative procedures, especially in larger facilities, as the following excerpt from an interview with an internal migrant indicates:

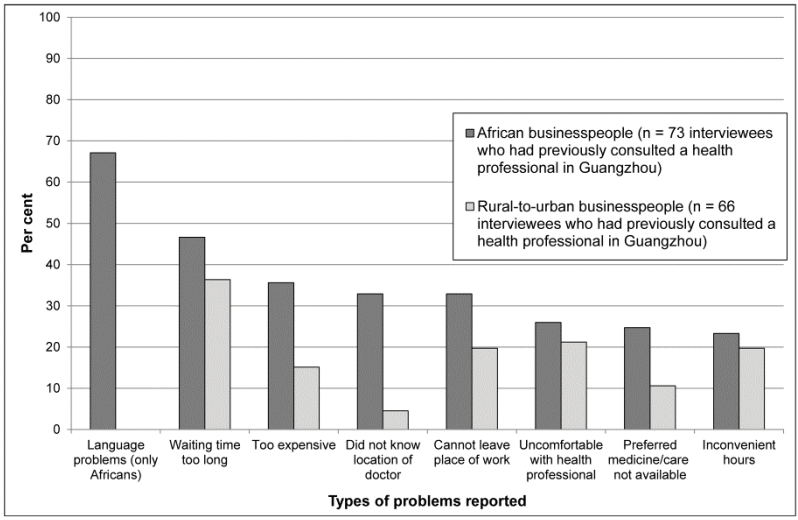
> If you go to a good hospital of a higher grade, then you have to queue half an hour, or even hours; you cannot find the health professional, you do not know who the doctor is. Some hospitals now have a guide, a hospital guide. That is a little better. Otherwise you do not know where to go and have to find out for half a day. (Anonymous 3 2008)

Along these lines, they criticised the lack of transparency of the pricing of services and having to pay before seeing a doctor. The qualitative interviews also showed that migrants' different experiences and expectations and the fact that they are not familiar with procedures in health facilities in Guangzhou could result in confusion and dissatisfaction. One-fourth of the African migrants but just one-tenth of the rural-to-urban migrants said that the type of care they needed was not available in Guangzhou or in China, respectively (cf. Figure 1).

Another issue raised was lack of knowledge on healthcare options and the location of doctors, which was much more a challenge for the African migrants than for the rural-to-urban migrants (cf. Figure 1). The qualitative interviews with migrants from both populations made clear that unfamiliarity with the urban healthcare system and available healthcare in Guangzhou was a problem. In addition, rural-to-urban migrants' limited radius of everyday movement in the city meant that they were not aware of the sites and variety of facilities located outside of this area. For African migrants, communication problems made it more difficult to evaluate which facility might

be the appropriate address for the health problem they faced. Migrants from both groups told us they often followed recommendations made by members of their social network.

Figure 1: A Comparison of Problems that African and Rural-to-Urban Businesspeople Encountered When Seeking Care in Guangzhou



A remarkable number of interviewees from both groups reported having felt discomfort with health professionals when seeking care (cf. Figure 1). Qualitative interviews revealed different reasons for this evaluation. Internal migrant interviewees often profoundly distrusted doctors and had doubts about the pricing, the quality of care and doctors' competency. As a consequence, some migrants said they prefer public hospitals with some mentioning they preferred "big" hospitals. In stark contrast, African interviewees in the qualitative interviews usually showed a remarkable openness towards and trust in the Chinese healthcare system and Chinese health professionals.

Another aspect of feeling uncomfortable with health professionals that was named by members of both migrant populations in the qualitative interviews was related to their low social status in Chinese society. Internal migrant interviewees said that they felt doctors would not listen to their problems and would not treat them as well

as locals. As a result, some of these interviewees preferred to consult unregistered practitioners, most of whom are migrants themselves, or they preferred to buy medicine at a pharmacy rather than to see a doctor. Similarly, some Africans, all of them Black, complained about disrespectful, sometimes racist, treatment from doctors.

As pointed out earlier, migrants' low social status is further cemented by the temporary status they are ascribed by authorities because they have not been able to register or obtain/renew visas. Unregistered and overstaying migrants were among our interviewees in the qualitative interviews and quantitative survey. Determining the share of migrants who had not registered in the city (internal migrants) or did not have a valid visa or passport (international migrants) is not possible, as it is unlikely that all would admit being in the city illegally in quantitative surveys and this is not the point of discussion here. Those migrants who openly talked about their illegal status in the qualitative interviews were asked if it affected whether they sought care and their choice of care. Interestingly, migrants from both groups said that their illegal status had not kept them from consulting health services. They said they knew that they did not need to show their registration or passports at health facilities, and no one in our sample had ever been asked to do so.

Lacking financial access to healthcare was named as a problem by members of both migrant groups (cf. Figure 1). However, with roughly one-third of the African and only 15.2 per cent of the rural-to-urban migrants saying that the cost of services was a problem, this issue ranked surprisingly low in comparison to other problems named. Further questions about migrants' economic resources showed that 13.3 per cent of the Africans had a health insurance plan that they could use in China, and another 42.4 per cent had a plan they could use in their home country (cf. Table 3). In comparison, overall only 30.1 per cent of the rural-to-urban migrants had health insurance. Of these, 13.3 per cent had health insurance plans that they had bought in their hometowns (New Cooperative Medical Scheme [NCMS]) and that they could use only there (cf. Table 3). Of those who could effectively use their insurance in Guangzhou, 3.5 per cent were members of the Basic Insurance Scheme (BIS) and 2.1 per cent had private insurance. However, 9.8 per cent of those saying they had insurance did not know what type of insurance they held, and one person said that he had a different type of insurance from

the abovementioned ones. Qualitative interviews revealed that several rural-to-urban migrants did not know the terms and conditions of their insurance schemes and thus did not know when and how to use it. One of the explanations that interviewees gave was that their parents or spouses had signed them up, and they had never learned the details.

Looking at incomes, African interviewees earned on average much higher salaries than their rural-to-urban counterparts; however, their incomes per month varied widely, with a few migrants who earned very high salaries: Approximately one third had an income of less than 5,000 CNY, roughly another third earned between 5,001 to 14,000 CNY, and the remainder made more than 14,000 CNY. One quarter of the rural-to-urban migrants earned less than 1,000 CNY. Roughly half of them earned between 1,001–2,000 CNY, and the remaining approximate quarter more than 2,000 CNY. Interviewees who had said that costs of care were a problem for them in the qualitative interviews said that as a result they had either not sought care, had delayed seeking care or, in the case of some rural-to-urban migrants, had consulted unregistered practitioners because their services are cheaper (they can be as low as 50 per cent of the cost in registered facilities, cf. Bork-Hüffer and Kraas 2015).

Another aspect not covered in the problems encountered but which appeared in both the quantitative and qualitative surveys was the supportive role played by members of their social networks and of particular organisations. Regarding their utilisation of healthcare, some interviewees were accompanied to the doctor by members of their social network. These people had also often been the source of knowledge about facilities and sometimes had shared their good or bad experiences as the following quote from an interviewee with an African trader showed:

> You know, in most cases you have to have the experience first, before you can recommend it. I have a problem with a broken leg, and so when I came in they said, "Oh, there is a hospital very close here and there should you go." They will treat you the Chinese way. At first I objected to it. I said, "Why don't you just put on plaster, POP [plaster-of-Paris bandages], etc." And then, one of my friends told me, "No, POP have cost and side effects, it is not good." I listened and then I go in with the Chinese medicine and I found that the leg would be healed in time, faster and with-

> out any side effects. So I trusted the traditional medicine. (Anonymous 4 2010)

At the same time, especially rural-to-urban migrants complained in the qualitative interviews that pressure from their social networks, especially with regard to the need to provide money, was one of the things that kept them from taking off time from work to see a doctor.

Regarding support offered by organisations, a few rural-to-urban migrants who had suffered from occupational illnesses had received help from migrant worker NGOs (cf. for a detailed analysis: Gransow et al. 2014). Otherwise, however, internal migrants are not organised and thus cannot rely on any other type of support group. African interviewees reported having received advice on health and healthcare options in Guangzhou and China from, among other organisations, home-country unions, which are primarily economic associations. However, only a small portion of them were members of the unions (cf. Bork-Hüffer et al. 2015).

Past experiences played an important role in subsequent healthcare-seeking practices for respondents from both migrant groups. If they were satisfied with the service, they stuck to the same facility or doctor independent of the health problem faced; if they had bad experiences they would not give it another try. Bad experiences could keep them from seeking care at all or lead to substantial delays in seeking treatment.

Discussion, Conclusions, and Policy Recommendations

This study compared the health status and healthcare-seeking of rural-to-urban and African migrant businesspeople in Guangzhou. Following the theoretical framework introduced earlier in the article, a variety of influences that can be differentiated into individual factors, other agents, the social context, and economic resources affected both migrant populations' engagement with the healthcare system, their satisfaction with it, and problems they encountered. As I discuss in detail below, these factors partly account for different healthcare-seeking practices, varying expectations, and contrasting levels of satisfaction with the services received in Guangzhou. At the same time, the two groups of migrants display substantial commonalities with regard to their health status, the health barriers they face and their

choice of care in Guangzhou when compared to the general Chinese population. For that reason, at the end of this section I introduce shared recommendations for practice for improving access to healthcare for both populations.

Regarding individual factors, the data showed that interviewees of both migrant samples had on average a good physical health status, with a substantially lower number of Africans who rated their health as poor or fair. While migrants usually tend to be physically healthier than the local population, because it is usually the younger and healthier individuals who migrate, the available data does not allow us to draw conclusions about the difference in perceived physical health status between the two migrant populations. At the same time, poor mental well-being was a concern for a substantial share of interviewees from both migrant populations, and qualitative interviews indicate that social exclusion and an insecure legal situation are especially pertinent here, in addition to high social pressure, which affected rural-to-urban migrants in particular. With respect to predisposing factors, interviewees from both populations are on average much younger than the Chinese general population; moreover, there are very few above the age of fifty, who would have a higher risk of aging-associated diseases. At the same time, the much larger number of females among the internal migrant populations means that female-specific health risks are more a concern for this group.

Concerning individuals' perception of healthcare, internal migrants proved to be much more critical of the healthcare system and the quality of care than African interviewees, despite the fact that the latter had much more frequently encountered problems when seeking care. Most members of both migrant populations are not familiar with the Chinese urban healthcare provision system when they first arrive in Guangzhou or China, making it more difficult for them to find the appropriate type of care. With regard to memory (knowledge), it must be noted that a much larger share of African migrants compared to rural-to-urban migrants reported having had problems identifying an appropriate healthcare provider, as they have generally spent less time in the city and thus had less time to get acquainted with the healthcare infrastructure. Concurrently, it is more difficult for them to orientate themselves in an organisational setting so different from their places of origin and in which they are often not able to read or speak the local language. As a result, Africans' on-

average higher levels of education did not help them to navigate through the Chinese healthcare system. Yet, the Africans were better informed about the health-insurance schemes they had enrolled in, while a significant number of rural-to-urban migrants could not tell what type of insurance they held and when and how to use it.

Individual recall (past experiences) substantially influenced the future choice of care and general attitude towards the healthcare system of interviewees from both populations. Having had bad experiences with health professionals was a factor that kept migrants from seeking care at all or substantially delayed it. Experiences with the healthcare systems in their places of origin likewise moulded their expectations and satisfaction with health services in Guangzhou. African migrants' much higher satisfaction with the healthcare services in Guangzhou – despite the many problems they encountered when making use of the system – is most likely due to their experiences (recall) with much less developed healthcare systems in their places of origin.

The analysis of migrants' healthcare utilisation patterns showed similar tendencies regarding the choice of care in mainland China among both migrant populations when compared to the Chinese general population: migrants more often visited private facilities and were more likely to visit hospitals than the general Chinese population. Simultaneously, they were less likely to visit lower-level, state-owned healthcare facilities: community health services centres and stations, which are intended to be the state-owned units providing basic and preventive healthcare. Interview results show that it is most likely social factors and the relations between doctors and migrant patients characterised by mistrust that explain the high rate of visits to hospitals. Zheng, Faunce, and Johnston (2006) and Ma, Lu, and Quan (2008) found that lack of trust in the quality of private facilities and lower-level facilities is one of the factors that accounts for the high utilisation rate of public facilities and especially public hospitals among the Chinese general population. Our interviews with internal migrants hint at a similar phenomenon, as these individuals were on average quite sceptical about the quality of treatment, and many, despite higher costs and even for the treatment of minor ailments, preferred to use public hospitals. The tendency of some to look for "big" hospitals shows how, due to their lack of other means to evaluate the quality of the facility, they take the physical size and appear-

ance of the hospital buildings as an indicator for the success and thus the quality of the services of a facility. Africans did not show the distrust that the local migrant interviewees had towards lower-level and private facilities – once again most likely due to the generally better-developed healthcare system in Guangzhou compared to their places of origin. Non-availability of specific traditional and alternative health services and medicine was much less frequently named as problem by the rural-to-urban migrant interviewees. This could be due to the fact that traditional Chinese medicine is offered in Chinese rural and urban areas, while some alternative services that meet African interviewees' health beliefs and cultural norms are commonly not available in China (cf. also Lin et al. 2014). Further, other types of alternative medicine in China were nearly eradicated during the Mao era (cf. Fruehauf 1999), which contributed to a declining demand for such care.

A substantial share of migrants from both groups felt discriminated against by health professionals related to the low social status they are ascribed in Chinese society. Negative experiences with disrespectful behaviour of practitioners influenced their attitude towards the healthcare provision system and with that their healthcare-seeking. It resulted in not seeking care and in treatment being delayed. Additionally, it led some internal migrants to rely on unregistered practitioners; because most of these are migrants themselves, internal migrant patients felt they were more open towards them and treated them with more respect. It has to be noted that Black Africans in China are subjected to particularly harsh discrimination by the general public, and some interviewees also complained about racist treatment by health professionals. It can be assumed that other groups of foreigners will not experience such strong stigmatisation or even any at all. Further, language barriers substantially aggravated the communication difficulties between African migrants and doctors. Nevertheless, only a small number of African interviewees chose international facilities where the personnel speak English. Lack of knowledge on options is one factor that most likely accounts for this discrepancy, alongside the higher prices for services in these facilities.

Agents who played a role other than health professionals were members of the social network who, according to interviewees from both migrant populations, enabled healthcare-seeking by accompanying ill individuals to the doctor or by giving recommendations to

migrants who had not previously sought care in Guangzhou. However, particularly rural-to-urban migrants complained about the constraining effect of their social embeddedness that derived mostly from the need to keep earning money and caring for family members, which kept them from seeking care themselves. Help offered by migrant organisations played a minor role for both Africans and rural-to-urban migrants. Given restrictions on formal organisation in China, migrants have a very low power level and a marginalised position within urban health governance overall (cf. Bork, Kraas, and Yuan 2011).

Tight economic resources are a challenge for both migrant populations, but, as pointed out above, cannot alone explain migrants' choice of care. When comparing the incomes of the two groups, Africans on average have much more money to pay for health services; however, if they are in need of more costly care, pharmaceuticals or longer treatment periods, they also face substantial problems paying for these out of pocket. Given the very low incomes of some rural-to-urban migrants, it can be expected that this group might be more likely than African migrants to delay or skip even low-cost medical treatments. In the international literature on Chinese internal migrants' access to healthcare, the primary challenge that is pronounced is migrants' lacking financial access to care as they do not have insurance. Yet, my findings show that the problem for both migrant populations is not only that they do not have insurance, but that many migrants have insurance they can use only in their hometowns (NCMS for rural-to-urban migrants) or home countries, respectively. Buying a train ticket home could consume a substantial amount of rural-to-urban migrants' low incomes. Travelling home, especially to remote areas, can be drawn out and even take more than 24 hours. Further, migrants making trips home might have to close their businesses, which many might not be able or willing to afford. Thus, going home to seek care would not be a viable solution in most cases. Rural-to-urban migrants usually travel home only once a year, generally during the spring festival, to visit their families. A much larger percentage of the African interviewees were members of an insurance scheme in their home countries. For them, travelling back to seek care is also very costly and time-consuming. Nevertheless, 14.4 per cent of the interviewees who had come down with an illness in China and sought care had done so in their home countries. As

many African traders are quite mobile and commute between China and their home countries for business purposes (cf. Bork-Hüffer et al. 2015), their frequent trips home offer them the opportunity to combine business trips with seeing a doctor in their countries of origin. Next to financial considerations, the availability of services that are adapted to their health beliefs and expectations can help account for this phenomenon. Yet, despite the high mobility of many Africans (there are others who are rather immobile, especially undocumented migrants and those who are less successful with their businesses, cf. especially Haugen 2012), the great majority had seen a health professional in China. When facing acute ailments or certain health issues that do not allow them to travel, going back home is not an option – for example, in the case of an illness that requires quick medical care, such as an injury. In addition, the great satisfaction of African interviewees with the better-developed Chinese healthcare system can further explain why most consulted a health professional in China.

The results of this study point to the need to intervene and undertake targeted measures to improve internal and international migrants' access to healthcare in China (cf. for a more detailed description of measures targeting internal migrants: Bork-Hüffer 2012). First, the immobility of social protection schemes is a general problem in times of increasingly mobile capital and labour. That Chinese health insurance schemes are bound to places of origin stands in stark contrast to the increasing mobility of its people – whether manifested in rural-to-urban, urban-to-urban, or (though to a lesser extent) rural-to-rural movements, many of which are circular in nature. Schemes with portable benefits must be introduced; otherwise, both internal and international migrants will be unable to take advantage of an integration into the social insurance system.

Second, migrants' specific healthcare needs and demands need to be met through the provision of targeted healthcare services. As both migrant populations examined here are concentrated in specific areas of the city – villages-in-the-city in the case of internal migrants, specific business locations in the case of African migrants – it is advisable to provide targeted services in these places. They can be offered through the basic urban medical care facilities that already exist: community health services stations and community health services centres. Many of these are already located in or near areas with high

concentrations of migrants. In these facilities, contact points represented by personnel that are especially trained with regard to migrants' needs and health risks should be established. Personnel should be instructed in how to provide culturally sensitive and respectful counselling. Lin et al. (2014) suggested that professional interpreter services should be introduced for African migrant patients. Given the concentration of migrants in certain locations, I argue that it makes most sense to provide these services localised in the above-named contact points for migrants. Based on the results presented above, these should at least be available in English, French, and Igbo. At the same time, information campaigns in areas with high concentrations of migrants are needed that make these types of services known to potential patients. Popularisation through major online platforms (for instance, African countries' embassies and other webpages frequented by the given communities) would help to further spread knowledge on the services. Local African migrant organisations (especially home-country unions and church groups, cf. Xu and Liang 2012; Xu 2013; Bork-Hüffer et al. 2015) should be involved in the establishment of the services to ensure their cultural adequacy and to help spread the word among the relevant populations.

Third, the findings emphasise the importance of improving patient orientation and responsiveness to migrant patients' needs in Chinese healthcare provision. Lack of both ranked among the most frequently named challenges migrants encountered in both quantitative surveys, and they included long waiting times, restricted opening hours of healthcare facilities, and a feeling of discomfort with doctors. The above-recommended establishment of localised, targeted, and culturally adequate health services that are provided by doctors that are specifically employed and trained to serve this population group would also help to enhance patient orientation and responsiveness. The services should also be offered in off-hours for the same prices so that migrants can afford to go there after work. At the same time, the profit-driven behaviour of health professionals must be further contained and health facilities better controlled (cf. e.g. Yip and Mahal 2008), which will ensure quality and in the long run also a higher trust of patients in health professionals and the health system.

Overall, the comparison revealed a significant number of shared barriers to health that can be tackled with similar intervention measures for both groups. As such, the findings of this paper support

calls for more comparative research on internal and international migrant groups. Simultaneously, the data sets analysed in this article allowed a comparison of only a restricted number of factors. Further studies are needed that consider self-care as a health-seeking strategy and that distinguish responses to an illness based on the specific health problems the migrants faced. Moreover, analyses are urgently required that differentiate the highly heterogeneous African population in China and more closely examine how different cultural traditions and local health systems in migrants' places of origin shape their expectations, health-seeking practices, and satisfaction with healthcare services in China. Further research gaps are the health status and health-seeking practices of highly skilled internal migrants and international migrant employees working for national or transnational companies in China, as public health-related research on internal migrants has almost solely focused on rural-to-urban migrants working in the low-skilled services, construction, and manufacturing sectors, and research on international migrants' healthcare-seeking has just scratched the surface.

References

Anonymous 1 (2008), interview, from Hunan province, businessman in Guangzhou, 20 January.

Anonymous 2 (2010), interview, Nigerian trader in Guangzhou, 4 April.

Anonymous 3 (2008), interview, from Hunan province, businessman in Guangzhou, 21 January.

Anonymous 4 (2010), interview, Ghanaian trader in Guangzhou, 26 April.

Archer, Margaret Scotford (1995), *Realist Social Theory: The Morphogenetic Approach*, Cambridge, New York, Melbourne: Cambridge University Press.

Bech, Per, Lis Raabaek Olsen, Mette Kjoller, and Niels Kristian Rasmussen (2003), Measuring Well-Being Rather than the Absence of Distress Symptoms: A Comparison of the SF-36 Mental Health Subscale and the WHO-Five Well-being Scale, in: *International Journal of Methods in Psychiatric Research*, 12, 2, 85–91.

Blaxter, Mildred (2004), *Health*, Cambridge, UK, Malden, MA: Polity Press.

Bodomo, Adams (2012), *Africans in China. A Sociocultural Study and Its Implications on Africa-China Relations*, Amherst, NY: Cambria Press.

Bork, Tabea, Frauke Kraas, and Yuan Yuan (2011), Governance Challenges in China's Urban Health Care System – The Role of Stakeholders, in: *Erdkunde*, 65, 2, 121–135.

Bork-Hüffer, Tabea (2012), *Migrants' Health Seeking Actions in Guangzhou, China. Individual Action, Structure and Agency: Linkages and Change*, Stuttgart: Franz Steiner Verlag.

Bork-Hüffer, Tabea, and Frauke Kraas (2015), Health Care Disparities in Megaurban China: The Ambivalent Role of Unregistered Practitioners, in: *Tijdschrift Voor Economische En Sociale Geografie*, 106, 3, 339–352.

Bork-Hüffer, Tabea, and Yuan Yuan-Ihle (2014), The Management of Foreigners in China: Changes to the Migration Law and Regulations during the Late Era Hu/Wen and Early Era Xi/Li and their Potential Effects, in: *International Journal of China Studies*, 5, 3, 571–597.

Bork-Hüffer, Tabea, Birte Rafflenbeul, Zhigang Li, Frauke Kraas, and Desheng Xue (2015), Mobility and the Transiency of Social Spaces: African Merchant Entrepreneurs in China, in: *Population, Space and Place*, doi: 10.1002/psp.1900.

Bredeloup, Sylvie (2012), African Trading Post in Guangzhou: Emergent or Recurrent Commercial Form?, in: *African Diaspora*, 5, 1, 27–50.

Butsch, Carsten (2011), *Zugang zu Gesundheitsdienstleistungen. Barrieren und Anreize in Pune, Indien*, Stuttgart: Steiner Verlag.

Callahan, William A. (2013), *China Dreams*, New York, NY: Oxford University Press.

Castles, Stephen (2000), International Migration at the Beginning of the Twenty-first Century: Global Trends and Issues, in: *International Social Science Journal*, 52, 165, 269–281.

Chang, Sen-dou (1996), The Floating Population: An Informal Process of Urbanisation in China, in: *International Journal of Population Geography*, 2, 3, 197–214.

DeWind, Josh, and Jennifer Holdaway (2008), *Internal and International Migration and Development: Research and Policy Perspectives*, Geneva: International Organization of Migrant and Social Science Research Council.

Fan, Cindy C. (2008), *China on the Move. Migration, the State, and the Household*, London, New York: Routledge.

Friedmann, John (2007), Reflections on Place and Place-making in the Cities of China, in: *International Journal of Urban and Regional Research*, 31, 2, 257–279.

Fruehauf, Heiner (1999), Chinese Medicine in Crisis: Science, Politics and the Making of "TCM", in: *Journal of Chinese Medicine*, 61, 6–14.

Giddens, Anthony ([12]2000), *The Constitution of Society*, Cambridge, Malden: University of California Press.

Gransow, Bettina (2012), *Internal Migration in China – Opportunity or Trap?*, IMIS Policy Briefs, 19, December.

Gransow, Bettina (2010), Body as Armor: Health Risks and Health Consciousness among Rural Migrants in Urban China, in: Bettina Gransow and Daming Zhou (eds), *Berliner China-Hefte*, 38, Berlin: LIT Verlag, 9–27.

Gransow, Bettina (2007), „Dörfer in Städten" – Typen chinesischer Marginalsiedlungen am Beispiel Beijing und Guangzhou, in: Dirk Bronger (ed.), *Marginalsiedlungen in Megastädten Asiens*, Münster: LIT Verlag, 343–377.

Gransow, Bettina, Guanghuai Zheng, Apo Leong, and Ling Li (2014), *Chinese Migrant Workers and Occupational Injuries, A Case Study of the Manufacturing Industry in the Pearl River Delta*, UNRISD Working Paper, 1, Geneva, Guangzhou: United Nations Research Institute for Social Development Sun Yat-sen Center for Migrant Health Policy.

Gu, Edward, and Jianjun Zhang (2006), Health Care Regime Change in Urban China: Unmanaged Marketization and Reluctant Privatization, in: *Pacific Affairs*, 79, 1, 49–71.

Hall, Brian, Wen Chen, Carl Latkin, Li Ling, and Joseph D. Tucker (2014), Africans in South China Face Social and Health Barriers, in: *The Lancet*, 383, 9925, 1291–1292.

Hartmann, Pamela (2013), *Flexible Arbeitskräfte: Eine Situationsanalyse am Beispiel der Elektroindustrie im Perlflussdelta*, Stuttgart: Franz Steiner Publishers.

Haugen, Heidi Ø. (2012), Nigerians in China: A Second State of Immobility, in: *International Migration*, 50, 2, 65–80.

Holdaway, Jennifer (2008), Migration and Health in China: An Introduction to Problems, Policy and Research, in: *The Yale-China Health Journal*, 5, 7–23.

King, Russell, and Ronald Skeldon (2010), "Mind the Gap!" Integrating Approaches to Internal and International Migration, in: *Journal of Ethnic and Migration Studies*, 36, 10, 1619–1646.

Lamnek, Siegfried ([4]2005), *Qualitative Sozialforschung*, Basel: Beltz Verlag.

Li, Weiping (2006), Institutional Reform and Governance of Public Hospitals, in: *Social Sciences in China*, Special Issue: Reform of the Public Health System, 85–97.

Li, Xiaoming, Bonita Stanton, Xiaoyi Fang, and Danhua Lin (2006), Social Stigma and Mental Health among Rural-to-urban Migrants in China: A Conceptual Framework and Future Research Needs, in: *World Health Population*, 8, 3, 14–31.

Li, Zhigang, Laurence J. C. Ma, and Desheng Xue (2013), The Making of a New Transnational Urban Space: The Guangzhou African Enclave, in: Peijin Li and Laurence Roulleau-Berger (eds), *China's Internal and International Migration*, Abingdon, UK, New York, NY: Routledge, 150–173.

Li, Zhigang, Laurence J. C. Ma, and Desheng Xue (2009), An African Enclave in China: The Making of a New Transnational Space, in: *Eurasian Geography and Economics*, 50, 6, 699–719.

Li, Zhigang, Desheng Xue, Michael Lyons, and Alison Margaret B. Brown (2008), The African Enclave of Guangzhou: A Case Study of Xiaobeilu, in: *Acta Geographica Sinica*, 63, 2, 207–218.

Lin, Lavinia et al. (2014), Health Care Experiences and Perceived Barriers to Health Care Access: A Qualitative Study among African Migrants in Guangzhou, Guangdong Province, China, in: *Journal of Immigrant and Minority Health*, doi: 10.1007/s10903-014-0114-8.

Liu, Guofu (2011), *Chinese Immigration Law*, Farnham, Burlington: Ashgate.

Liu, Guofu (2009), Changing Chinese Migration Law: From Restriction to Relaxation, in: *Journal of International Migration and Integration*, 10, 3, 311–333.

Liu, Xingzhu, and Yunni Yi (2004), *The Health Sector in China: Policy and Institutional Review*, Worldbank Background Paper, online: <www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2006/01/27/000160016_20060127165524/Rendered/PDF/345250CHA0poli1tutionalreview1final.pdf> (24 June 2014).

Lyons, Michael, Alison Brown, and Zhigang Li (2012), In the Dragon's Den: African Traders in Guangzhou, in: *Journal of Ethnic and Migration Studies*, 38, 5, 869–888.

Ma, Jin, Mingshan S. Lu, and Hude Quan (2008), From a National, Centrally Planned Health System to a System based on the Market: Lessons from China, in: *Health Affairs*, 27, 4, 937–948.

MacKian, Sara, Nafisa Bedri, and Hermione Lovel (2004), Up the Garden Path and Over the Edge: Where Might Health-Seeking Behaviour Take us?, in: *Health Policy and Planning*, 19, 3, 137–146.

McGuire, James, Xiaoming Li, and Bo Wang (2009), Social Stigma and Quality of Life among Rural-to-urban Migrants in China: A Comparison with their Rural Counterparts, in: *World Health Population*, 11, 2, 30–41.

McLaughlin, Megan M., Margaret C. Lee, Brian J. Hall, Marc Bulterys, Ling Ling, and Joseph D. Tucker (2014), Improving Health Services for African Migrants in China: A Health Diplomacy Perspective, in: *Global Public Health*, 9, 5, 579–589.

Ministry of Health of the People's Republic of China Ministry of Health of the People's Republic of China (2009), 2009 年中国卫生统计提要 (*2009 nian Zhongguo weisheng tongji tiyao, China Health Survey 2009*), online: <www.moh.gov.cn/publicfiles/business/html files/mohbgt/s8274/200905/40765.htm> (17 September 2009).

MoH see Ministry of Health of the People's Republic of China

Müller, Angelo, and Rainer Wehrhahn (2013), Transnational Business Networks of African Intermediaries in China: Practices of Networking and the Role of Experiential Knowledge, in: *Die Erde*, 144, 1, 82–97.

Müller, Angelo, and Rainer Wehrhahn (2011), New Migration Processes in Contemporary China – The Constitution of African Trader Networks in Guangzhou, in: *Geographische Zeitschrift*, 99, 2+3, 104–122.

National Bureau of Statistics (2011), *Major Figures on 2010 Population Census in China*, compiled by the Population Census Office under the State Council, Beijing: Statistics Press.

Primack, Brian A. (2003), The WHO-5 Wellbeing Index Performed the Best in Screening for Depression in Primary Care, in: *ACP J Club*, 139, 2, 48.

Pun, Ngai (2005), *Made in China. Women Factory Workers in a Global Workplace*, Durham and London: Duke University Press.

Qi, Changqing, Volker Kreibich, and Sabine Baumgart (2007), Informal Elements in Urban Growth Regulation in China – Urban Villages in Ningbo, in: *Asien*, 103, 23–44.

Ramesh, M., and Xun Wu (2009), Health Policy Reform in China: Lessons from Asia, in: *Social Science & Medicine*, 68, 12, 2256–2262.

Skeldon, Ronald (2006), Interlinkages between Internal and International Migration and Development in the Asian Region, in: *Population, Space and Place*, 12, 1, 15–30.

Smith, Darren P., and Russell King (2012), Editorial Introduction: Re-making Migration Theory, in: *Population Space and Place*, 18, 127–133.

Suda, Kimiko (2014), A Room of One's Own: Highly-educated Migrants' Strategies for Creating a Home in Guangzhou, in: *Population, Space and Place*, doi: 10.1002/psp.1898.

Tam, Waikeung (2010), Privatising Health Care in China: Problems and Reforms, in: *Journal of Contemporary Asia*, 40, 1, 63–81.

Taubmann, Wolfgang (2002), Urban Administration, Urban Development and Migrants Enclaves: The Case of Guangzhou, in: Kwan-Yiu Wong and Jianfa Shen (eds), *Resource Management, Urbanization, and Governance in Hong Kong and the Zhujiang Delta*, Hong Kong: Chinese University Press, 79–96.

Treiman, Donald J. (2012), The "Difference between Heaven and Earth": Urban-rural Disparities in Well-being in China, in: *Research in Stratification and Mobility*, 30, 1, 33–47.

UNESCO (2010), *Migrant/Migration*, Paris: UNESCO.

Wang, Bo, Xiaoming Li, Bonita Stanton, and Xiaoyi Fang (2010), The Influence of Social Stigma and Discriminatory Experience on Psychological Distress and Quality of Life among Rural-to-urban Migrants in China, in: *Social Science and Medicine*, 71, 1, 84–92.

Wang, Wenfei Winnie, and Cindy C. Fan (2012), Migrant Workers' Integration in Urban China: Experiences in Employment, Social Adaptation, and Self-identity, in: *Eurasian Geography and Economics*, 53, 731–749.

Ware, John E. Jr. (n.y.), *SF-36 Health Survey Update*, online: <www.sf-36.org/tools/sf36.shtml> (15 March 2011).

Ware, John E. Jr., and Cathy Donald Sherbourne (1992), The MOS 36-item Short-Form Health Survey (SF-36). Conceptual-framework and Item Selection, in: *Medical Care*, 30, 6, 473–483.

Wehrhahn, Rainer et al. (2008), Urban Restructuring and Social and Water-related Vulnerability in Megacities – The Example of the Urban Village of Xincun, Guangzhou (China), in: *Erde*, 139, 3, 227–249.

WHO (1998), *Wellbeing Measures in Primary Health Care. The DEPCARE Project*, WHO Meeting, Stockholm, 12–13 Feburary.

WHO (1946), *Constitution of the World Health Organization*, online: <www.who.int/governance/eb/who_constitution_en.pdf> (24 June 2015).

Xiang, Biao (2004), *Migration and Health in China: Problems, Obstacles and Solutions*, online: <www.populationasia.org/Publications/RP/AMCRP17.pdf> (12 May 2007).

Xu, Tao (2013), The Social Relations and Interactions of Black African Migrants in China's Guangzhou Province, in: Peijin Li and Laurence Roulleau-Berger (eds), *China's Internal and International Migration*, Abingdon, UK, New York, NY: Routledge, 133–149.

Xu, Tao, and Zai Liang (2012), The Reconstruction of Social Support Systems for African Merchants in Guangzhou, China, in: Zai Liang, Steven F. Messner, Cheng Chen and Youpin Huang (eds), *The Emergence of a New Urban China. Insiders' Perspectives*, Lanham, MA: Lexington Books, 123–140.

Yip, Winnie, and Ajay Mahal (2008), The Health Care Systems of China and India: Performance and Future Challenges, in: *Health Affairs*, 27, 4, 921–932.

Zhao, Shukai (2003), Peasant Migration: Order Building and Policy Rethinking, in: *Social Sciences in China*, 24, 4, 160–167.

Zheng, Pingan, Thomas Faunce, and Kellie Johnston (2006), Public Hospitals in China: Privatisation, the Demise of Universal Health Care and the Rise of Patient-doctor Violence, in: *J Law Med*, 13, 465–470.

Zheng, Siqi, Fenjie Long, Cindy C. Fan, and Yizhen Gu (2009), Urban Villages in China: A 2008 Survey of Migrant Settlements in Beijing, in: *Eurasian Geography and Economics*, 50, 425–446.

Contents

Foreign Lives in a Globalising City: Africans in Guangzhou

Editorial

Introduction

Research Articles

Research Articles