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Exploring health care experiences and access challenges: A qualitative study of African migrants in Guangzhou, China

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Abstract

This study analyzes the health care experiences and barriers of African migrants in Guangzhou, China, employing the Cultural-Ecological Access Framework (CEAF). Using 35 participant in-depth interviews, the study describes the challenges of accessing health care as multi-dimensional: the participants faced language barriers, legal and financial discrimination, culturally inappropriate care, and lack of competent clinicians. The results explain how migrants' interactions with health providers and the services, as well as the community and policy, enable or disable their abilities to receive—and sometimes to seek—their medical needs. Support networks served participants as both a coping strategy and as an important informant to aid in navigating the health system. At the institutional and structural level, unfamiliar workflows, insufficient interpreting resources, and exclusionary health policy severely impede access. Utilizing CEAF, the study highlights how different forms of power, including culture and structural relations, bind together explaining the care of Africans in China. The findings call for inclusive and responsive African migrant health policies in China. *(Afr J Reprod Health 2025; 29 [8]: 40-50).*

Keywords: African migrants; Guangzhou; Health care access; Cultural-Ecological Access Framework (CEAF); Language barriers; Legal status, Health disparities

Résumé

Cette étude analyse les expériences et les obstacles rencontrés par les migrants africains en matière de soins de santé à Guangzhou, en Chine, à l'aide du Cadre d'accès culturel et écologique (CEAF). À partir d'entretiens approfondis menés auprès de 35 participants, l'étude décrit les difficultés d'accès aux soins comme étant multidimensionnelles : barrières linguistiques, discrimination juridique et financière, soins culturellement inappropriés et manque de cliniciens compétents. Les résultats expliquent comment les interactions des migrants avec les prestataires de santé et les services, ainsi qu'avec la communauté et les politiques, favorisent ou entravent leur capacité à recevoir – et parfois à solliciter – les soins dont ils ont besoin. Les réseaux de soutien ont constitué pour les participants une stratégie d'adaptation et une source d'information importante pour les aider à s'orienter dans le système de santé. Aux niveaux institutionnel et structurel, des flux de travail inhabituels, des ressources d'interprétation insuffisantes et une politique de santé exclusive entravent gravement l'accès. S'appuyant sur le CEAF, l'étude met en évidence comment différentes formes de pouvoir, notamment culturelles et structurelles, s'articulent pour expliquer la prise en charge des Africains en Chine. Les conclusions plaident en faveur de politiques de santé inclusives et adaptées aux migrants africains en Chine. *(Afr J Reprod Health 2025; 29 [8]: 40-50).*

Mots-clés: migrants africains; Guangzhou; accès aux soins de santé; cadre d'accès culturel et écologique (CEAF), barrières linguistiques; statut juridique; disparités en matière de santé

Introduction

The broadened economic connectivity between China and Africa is of concern for both regions as to what the impact will be in the long run. As of 2010, the amount of trade that was happening between China and Africa reached an astonishing 126.9billion along with 20 billion in development aid funds promised (China Africa Research Initiative, 2021). This economic diplomacy easily made it possible for a large number of Africans to move to China, especially to Guangzhou that is a trade center and is a city in the Guangdong Province, which has a GDP of $423 billion (2022).[1] There has been a massive increase in the African population: in comparison to having only 2000 registered African in 2003, the number has shot to 20,000. That estimate is however expected to be 10,000-15,000 migrants who have not been registered and these numbers are increasing at an

astonishing estimated 30-40 percent every year.[2] Xiaobei is now home to 1200 African businesses which have led to the formation of two names for the suburb; Chocolate city and ''little Africa''.[3] Most of the studies conducted concerning this trans action haven't focused on the public health implications which is an integral issue. So much focus has been placed on the Austrian economics aspects around these migrants that very little attention is directed towards how these migrants interact with the Chinese structure of healthcare where 72% of them face language barriers and 56% cite race in discrimination as major obstructions to care.[4] Additionally, 89% of these people do not have any form of health insurance[5] which makes them delaying treatment a much bigger problem when it comes to public health policies.[6]

The availability of healthcare services for migrant groups presents a steep challenge that goes well beyond the provision of healthcare facilities and services. The case of African migrants in China is illustrative of this issue when they are faced with merging constraints such as legal status ambiguities, discrimination, finances, language, culture, systemic racial prejudice, and anatomy.[7] These factors are structural and socio-cultural in nature and lead to a design of health care seeking behavior referred to as "postponement", where migrants defer treatment until their health issues become critical. This postponement not only deteriorates individual health, but also entrenches inequitable patterns of resource and service availability and erodes the effective control of chronic conditions among these vulnerable populations. The main objective of this study is to fill in the gap by focusing on the health care access barriers and experiences of African migrants living in Guangzhou. To do so, we apply the Cultural-Ecological Access Framework (CEAF)[8] a model with multiple layers including the individual, social, institutional, community, and policymaking levels which interact in a community to shape the access to care a person has. The strength of CEAF lies in the explanation of the interaction of systemic and cultural determinants of health, particularly as it relates to disadvantaged mobile populations.

While much of the existing literature highlights the need for a framework to evaluate healthcare efficiency, there remains a significant gap in understanding the quantitative relationship between resource inputs and user adoption in healthcare systems. Specifically, prior studies have separately emphasized the development of evaluation frameworks and comparative analyses of healthcare systems, as well as the quantification of efficiency in causal relationships. However, these concerns are closely interlinked, and the distinction between them is minimal. By consolidating these two aspects, this study aims to offer a more cohesive and comprehensive analysis of how resource allocation directly influences user adoption behaviors, especially in the context of migrant populations in Guangzhou. This unified approach allows for a clearer understanding of how various factors—such as legal status, systemic barriers, and socio-cultural influences—impact healthcare access and utilization. Ultimately, the research will provide a more streamlined framework to assess the efficiency of healthcare systems and their capacity to address the needs of vulnerable populations.

Theoretical framing

This research is conducted using the Cultural-Ecological Access Framework (CEAF),[8] which is a model developed to assess how individuals from different cultures and socioeconomic strata access health care services. It incorporates culture, society, and structure elements into behavior theories which was previously neglected.[9] These factors are particularly relevant when analyzing the experiences of African migrants residing in nations like China because the system and culture is quite different from what they are accustomed to.

The CEAF model examines five integrated determinants that affect health care access.[10] These include the individual level where a person is considered; their ability to communicate using the local dialect, their legal status, their level of health knowledge, and their personal beliefs about sickness and care. These also include interpersonal relationships where one gets support from family, friends, members of the community, and how well patients and doctors interact. On a broader scope, it considers how a hospital is organized, whether the services offered are acceptable to the target culture, and the friendliness of the health care personnel. It also incorporates how the society perceives and treats migrants in relation to their acceptance in the community. Lastly, it incorporates rules and policies like the governing laws on immigration and the availability of health coverage.

Methods

Study design

This study employed a qualitative exploratory design to understand the health care experiences and perceived obstacles to accessing services among African migrants living in Guangzhou, China. The approach was selected because scant literature exists on this population and issue. Using qualitative method helped capture participants' experiences and perspectives regarding the health care system as well as appreciate their culture.

Participant recruitment

Using convenience sampling, participants were recruited from among adults (aged 18 or more) from African countries living in Guangzhou during the time of the research. As the study was conducted in English, participants had to possess at least minimal knowledge of the language. Participants were recruited with the help of two important African community organizations based in Guangzhou. Community leaders set up a preliminary session with 38 members interested in learning more about the study. Interested participants were allowed to give their contact information, and out of these, 25 participants were chosen for the interviews. Ten additional participants (5 males and 5 females) participated in two focus group discussions.

Data collection

Data were collected in **July 2024** through **semi-structured interviews** and **focus group discussions**. The interviews were guided by a question set adapted from Harari et al., and refined with input from local community representatives to ensure cultural relevance. Core interview questions focused on participants' experiences with health care in Guangzhou and comparisons with health services in their home countries, as well as the specific barriers they encountered.

Interviews lasted 30–60 minutes and were conducted in locations chosen by participants, such as restaurants or workplaces.

Focus groups included individuals who did not participate in the interviews, providing additional insights and validating themes across gender lines.

Verbal informed consent was obtained from all participants, and each was offered a meal in appreciation. Ethical approval was granted by both the Guangdong Provincial Centre for STI and Skin Diseases Control and the University of Hong Kong.

Data analysis

Every interview and focus group conducted was recorded for audio and later transcribed word for word. This was then analyzed through thematic analysis. Health care access, cultural perceptions, and systemic challenges in the context of relevant literature were cross-sectional and thematically analyzed at the policy level using CEAF, Cultural-Ecological Access Framework. The transcript was coded in a manual fashion and arranged by levels from individual to policy broader frameworks. This analytic approach yielded understanding of the nuanced, systemic barriers encountered by African migrants in Guangzhou.

Respondents profile

Figure 1 presents the demographic characteristics of the 35 participants involved in the study. The majority of participants were male (71.4%), with females representing 28.6% of the sample. We use the term *African* to refer to all people from countries on the African continent, most of which are members of the African Union, as well as anyone who identifies as being of African origin. This does not mean we see all African people as culturally the same. We recognize that there are cultural differences among these nationalities. However, these differences do not significantly affect how they are treated when it comes to health care in China. In reality, both the Chinese government and individuals often view and interact with Africans as one single group, especially in the context of health care.

Participants originated from a range of African countries, with the largest representation from Nigeria (40.6%), followed by Uganda (15.6%), Ghana and Sierra Leone (each 9.4%), and smaller numbers from Togo, Congo, East Africa, Liberia, Mali, Gambia, and Guinea. In terms of marital status, 64% of the participants were married, while 36% were single.

English was the primary language of communication for the vast majority (85.7%), with

a smaller proportion speaking French (14.3%). Only 20% of participants reported being able to speak Chinese, while the remaining 80% could not. Regarding occupation, the majority were businessmen (86.7%), followed by students (6.7%), and one participant each working as a housewife and an English teacher (3.3% respectively).
The average age of participants was 33.7 years (SD = 3.1), and the mean number of years they had lived in Guangzhou, China, was 4.4 (SD = 7.1). Note that the number of responses may vary slightly due to missing data for some variables.

Results

This research pinpointed eleven specific themes (presented in table 1,2) regarding African migrants' access to healthcare in Guangzhou, China. Among 35 respondents, the most prevalent challenges included dominating language gaps (89%) and immigration policy loopholes (77%) alongside social network dependency (80%) for navigation. Other hindering factors included racial bias (69%), poor health knowledge (71%), cultural insensitivity towards care (57%), which reveals deeper inequivalences within China's health framework.

1. Personal knowledge and health beliefs

This theme concerns what people know about health in relation to people's beliefs, and how it impacts their choices. Many African migrants in China have different perceptions of health and illness.[11] Some have faith in traditional medicine from their countries, whereas others prefer modern biomedical treatment. Health literacy e.g., how a person comprehends information about health, is crucial. A person who does not know when to visit a doctor or how to adhere to the advice given is bound to have problems. There are also those who will not seek help for an illness that is perceived as serious due to deeply entrenched cultural views. Some people will choose to place their trust in herbs or prayers instead of modern hospitals. While these beliefs can sometimes be useful, they can also hinder people from obtaining necessary treatment. Understanding how health systems operate in China can enable migrants to make better decisions. Tailored health education designed to address these gaps is critical.

"As one African migrant expressed, 'Back home, we trust in herbs and prayers for healing. Here in China, I find it difficult to trust hospitals because they don't understand our ways. Health education that respects our beliefs could help us make better choices and seek care when needed".

2. *Language and communication*

One of the most significant challenges for African migrants in China is language. A great deal of them do not understand Chinese, and most of the hospitals do not offer any form of translation services.[12] These factors limit patients' ability to narrate their ailments and doctors' ability to adequately instruct them. Even with basic command of the Chinese language, or a translation application, comprehension issues arise. The lack of understanding, fear or confusion, is further complicated by certain medical terminology and its usage. In many cases, patients do not understand the instructions from the doctor and end up not following them or taking the wrong medication. Communication problems may also result in feeling mistrusted and unwelcomed. As a result, people tend to avoid going to the hospital, unless it is a dire situation. Providing bilingual assistance in hospitals, along with an increase of staff willing to speak other languages, would make communication better. This increase would make African migrants visit health facilities without reservations.

"As one African migrant shared, 'When I visit the hospital, I struggle to understand the doctor, even with a translation app. Sometimes, I leave without fully knowing what the doctor said or how to take the medication. It makes me hesitant to seek care unless I'm really sick.'"

3. Legal and immigration status

An individual's visa or immigration status in China impacts the extent to which they may access health care services in the country.[13] A number of African migrants seem to have short-term visas, or are in the country undocumented.

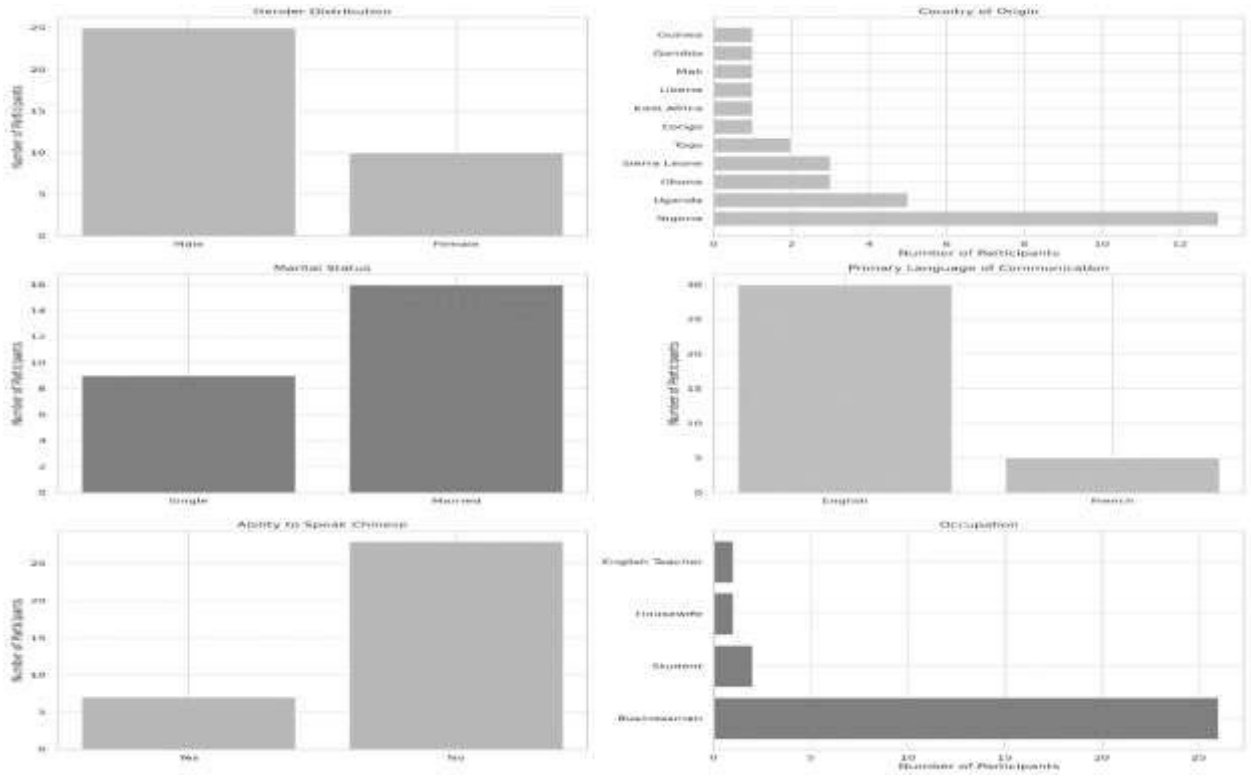

Figure 1: Demographic characteristics of the 35 participants

Some are fearful of deportation or being interrogated if they present themselves at hospitals. Such fears tend to prevent migrants from utilizing public services— regardless of their medical conditions. It is also likely that persons without appropriate documents are excluded from availing health insurance, or are subjected to exorbitant fees. Furthermore, prior to receiving treatment, hospitals may demand some form of identification, or legal documents, and this in itself creates anxiety and further restricts access to medical care. Even those with legal documents face challenges if their visa is nearing expiration. The majority of migrants lack adequate information on the rights they possess or the services accessible to them. This lack of information leads to delayed attempts at obtaining medical attention. In regard to solving these problems, it is crucial to provide information in English and assist immigrants in understanding the services available to them.

"As one migrant explained, 'I'm scared to go to the hospital because my visa is about to expire, and I don't know if they will ask for my documents. I've heard of people being deported just for seeking treatment. I don't even know what rights I have here, so I avoid going unless it's an emergency."

4. Social Networks and Support

Social networks, which include family, friends, and the community of African migrants, were fundamental in determining how participants navigated and interacted with the healthcare system in Guangzhou.[14] Respondents appeared to utilize such informal social networks for emotional and practical assistance. In the case of health problems, family and friends often served as the first point of contact, providing suggestions on medical facilities and often visiting the clinics or hospitals with patients.

Such assistance was essential for transcending the language barriers and the lack of familiarity with the local healthcare system. Some community members who had been to the hospital were, for some, informal interpreters and even guides, which made the interaction less daunting. Being reassured and accompanied through the illness also helped to diminish the emotional struggles of stress and loneliness in the foreign land.

Table1: Barriers to healthcare access among African Migrants in Guangzhou

CEAF Level	Theme	Subthemes
Individual	1. Personal Knowledge and Health Beliefs	- Health literacy - Illness perception - Traditional vs. biomedical care
	2. Language and Communication	- Lack of Chinese proficiency - Translation difficulties - Miscommunication
	3. Legal and Immigration Status	- Visa insecurity - Fear of deportation - Limited-service access
Interpersonal	4. Social Networks and Support	- Role of friends/family - Emotional/practical support
	5. Patient–Provider Relationships	- Trust and rapport - Discrimination - Communication with providers
Institutional	6. Hospital/Clinic Environment	- Unfamiliar systems - Wait times - Availability of English-speaking staff
	7. Cultural Competency of Care	- Lack of cultural sensitivity - Misunderstood needs
Community	8. Community Integration and Belonging	- Social isolation - Local community support - Cultural organizations
	9. Public Perception and Racism	- Stereotypes - Racial profiling - Avoidance of public spaces
Policy/Structural	10. Immigration and Health Policies	- Health insurance barriers - Policy limitations - Exclusion from services
	11. Systemic Inequities	- Bureaucratic challenges - Lack of migrant-inclusive policies

Table 2: Percentage distribution of healthcare access challenges faced by African Migrants in Guangzhou

Theme	Key Findings	Percentage of Respondents Affected
1. Personal Knowledge & Health Beliefs	Reliance on traditional medicine; low health literacy delays care.	71% (25/35)
2. Language & Communication	Language barriers hinder diagnosis/treatment adherence.	89% (31/35)
3. Legal & Immigration Status	Fear of deportation; exclusion from insurance.	66% (23/35)
4. Social Networks & Support	Dependence on informal networks for navigation/translation.	80% (28/35)
5. Patient–Provider Relationships	Discrimination/poor communication reduce trust.	74% (26/35)
6. Hospital/Clinic Environment	Complex bureaucracy; long wait times.	63% (22/35)
7. Cultural Competency of Care	Providers lack cultural awareness.	57% (20/35)
8. Community Integration	Isolation; reliance on ethnic/religious groups.	51% (18/35)
9. Public Perception & Racism	Racial profiling in clinical settings.	69% (24/35)
10. Immigration & Health Policies	Insurance barriers for undocumented migrants.	77% (27/35)
11. Systemic Inequities	Policies exclude migrants' needs.	63% (22/35)

In the absence of formal support structures from one's country, these networks easily filled the gaps.

"As one participant shared, 'Whenever I have a health problem, I always turn to my friends and family first. They help me find the right clinic, and sometimes, they even come with me to the hospital. It's easier with someone who speaks the language and knows how things work here. It makes me feel less alone and more confident.'"

5. Patient–Provider relationships

The interactions that the participants had with the patient and healthcare provider were important predictors for their willingness to interact with the healthcare system.[15] Trust and rapport were identified as key themes, with some participants reporting satisfaction when they felt that they were treated with courtesy and respect by the medical personnel. On the other hand, a lot of other participants reported negative encounters which were filled with bias and discrimination stemming from their race or ethnicity. This often resulted in the patient feeling alienated, reluctant to actively seek medical attention, and in some cases, completely refraining from the system altogether. Furthermore, inadequate communication due to language barriers led to gaps in understanding concerning diagnoses, medications, and overall treatment. This deficiency in communication strained patient-provider relations, further deteriorating confidence in the received healthcare services.

"As one participant noted, 'When the doctor treats me with respect, I feel comfortable and confident in seeking care. But when I sense discrimination or bias because of my race, I feel unwanted and avoid going to the hospital. It's hard to trust the system when there's no proper communication.'"

6. Hospital/Clinic environment

The participants often reported difficulties accessing care of high quality in hospitals and within clinic settings.[16] Participants, especially those with limited knowledge of Mandarin, often described the health system in China as complex and hard to make sense of. Waitlisted patients often had to cope with treated conditions only to miss exacerbated symptoms because of prolonged treatment alleviation delays, receiving care much later than needed. People also cited the lack of personnel that can speak English as a major problem which improved inability but also

confusion regarding billing, medical procedures, and even follow-up care leads. All of these issues aggregate Sapere patients on a perceived notion of disempowerment against advanced healthcare services worsening patient frustration. This deepens patient dependency not on the system formally, but in informal networks bypassing navigated resources.

"As one participant shared, 'It's so frustrating. The wait times are long, and by the time I get treated, my condition has worsened. Not understanding Chinese or having anyone to explain things to me makes everything more complicated, from the bills to the medications. I rely more on my friends to help me navigate the system, because I don't feel supported by the hospital.'"

7. Cultural competency of care

An ongoing issue has been identified as the lack of culturally appropriate care. Several provided reports indicating that health care workers did not want to respect or did not know how to adapt culturally appropriate care practices. Incorrect assumptions regarding some symptom's meaning, food preferences, and other individual's disregard often resulted in care that appeared and felt bland. Ethnic backgrounds were not taken into account which resulted in feeling misapprehended and hence decreased the willingness to access health services in the future. Such ignorance of culture also added to the perception of African migrants that care is inadequate or unfit for their expectations.

"As one participant explained, 'The doctors don't understand our culture. They think I'm just being difficult when I say I can't eat certain foods, or when I mention symptoms that don't fit their usual assumptions. It makes me feel like they don't really care about my needs, and I start to doubt the quality of the care they provide.'"

8. Community integration and belonging

The lack social contact seemed to affect many Africans migrants, especially those who had recently arrived to Guangzhou or did not speak Chinese. Still, some were able to receive aid and relief from cultural groups as well as religious organizations that provided a sense a belonging. These support networks gave them emotional aid and, in some cases, offered them practical assistance like translating medical documents and giving referrals to reliable clinics. Not all of the participants were connected to these support networks, which left them exposed to the emotional strain that comes from living in a foreign country with no community connections.

"As one migrant shared, 'When I first arrived, I felt lost and isolated. But through my church group, I was able to find support—someone translated my medical papers, and they even recommended a good clinic. Without these connections, I would have struggled much more, especially dealing with everything alone in a new country.'"

9. Public perception and racism

Racism, along with misinformed public perception, emerged as significant barriers to healthcare access on a community level. Respondents described being racially profiled in both public and clinical settings. These forms of prejudice fueled anxiety about attending public spaces, including hospitals, where patients often feel that the care they receive is substandard. Some patients bypassed the seeking care entirely due to the expectation of indifference or scorn. The mental constructs and actual experiences of racism restricted, both in distance and willingness, engaging with the local healthcare services.

10. Immigration and health policies

Policies regarding immigration and health care created structural barriers that directly impacted the availability of services. Numerous participants underscored the challenge of obtaining health care coverage because of their visa status, severely restricting their access to affordable care. Those who could obtain insurance also faced complicated administrative procedures that many did not have the means to overcome, oftentimes through inadequate guidance. Thus, some migrants placed themselves on the bludgeon of self-medication or limited their recourse to emergency situations, postponing treatment and increasing the risk of complications. These migrants were made to feel as though health services completely ignored them.

11. Systemic Inequities

Lack of policies that are inclusive of migrants were noted as the most important barriers concerning health care access. Participants reported that these policies capture the unique migratory stories of people which leads to complicated paperwork, excessive service denials, or unnecessary registration timelines. Such incompetence deepened the perception of not belonging to the society and therefore, most people are unwilling to obtain medical assistance until it is absolutely critical. Without fundamental changes designed to acknowledge the needs, rights, and situations of African migrants, these imbalances are bound to continue causing deeper divides regarding access to health care services

Discussion

This research sheds light on the healthcare access experiences of the African migrants living in Guangzhou, China. Following the Cultural-Ecological Access Framework (CEAF),[8] we demonstrated how individual, institutional, community, and policy/structural factors shape and influence access to health care.[17] These patterns illustrate the complexity of issues African migrants confront while simultaneously deepening insights on their perceptions, obstacles, and demands in the Chinese health system.[18]

Social networks and need relationships facilitated access to care, but alongside social networks, their relationships with care providers also shaped accessibility.[19] Fewer social contacts meant less community support which led a number of them to feel lost and utterly isolated in a health system and confused as to how to access the needed services. Furthermore, the quality of patient-provider interactions also surfaced as a significant issue. Participants described doctors as uncaring and unfeeling and as being overworked and in a hurry which led them to neglect patients' needs.[20] Most patients were dissatisfied and did not feel that they could freely communicate with their doctors and so could not trust that they would be treated well and have their needs addressed. Language challenges also made some of these interactions even more complex. Migrants who could not speak Mandarin or did not have anyone to help them with medical care did not have any control over the medical decisions about them that were made.[21]

At the institutional level, multiple factors within the hospital and clinic setting hindered health care access. Participants reported feeling navigationally stranded due to intricate administrative procedures, combination of unfamiliar administrative steps, long wait times, and long periods of inaction. Unsurpassed English language barriers created problems for patients in knowing where to go, what services were offered on the appointment, and how to follow the medical directions step given.[22] The lack of staff who could communicate in English added problems for patients enabling them to.

Public health specialists and social workers were reported to have little appreciation of care that was culturally different, which was reported as another overarching concern.[23] Migrants shared misconceptions regarding African illnesses such as malaria or typhoid were unacknowledged by chinese doctors, for example. Patients expressed concern with several Chinese medical practices like the routine application of IV drips. This resulted in distrust and fear of misdiagnosis as patients felt there was disconnect with their prior healthcare experiences and expectations.

These healthcare experiences were further contextualized by the community for migrants. These migrants reported having little access to the local community describing social isolation. [24] Although some migrants were helped through religion or supporting a cultural group, these networks did not mitigate the absence of broader community belonging. The existing negative social image of the group, including stereotypes and racism compounded the burden facing some migrants. A number of participants recounted experiences of being discriminated against like in public places or even within the hospital which weakened their willingness to seek care and amplifed their feelings of disenfranchisement.

Lastly, policies and structural barriers greatly restricted access to care. For example, many African migrants, particularly those with irregular legal status, had little to no access to health insurance. The expensive cost of care—alongside the risk of exposure due to immigration policies—prevented many from receiving treatment even in dire situations. Moreover, participants faced other

systemic barriers like convoluted bureaucratic pathways, absence of adequate information in accessible languages, and exclusion from relevant health programs ailed by nationalism. All of this was even worse because of China's harsh enforcement of immigration controls, which exacerbated the insecurities of undocumented migrants

As with all academic work, this research considered Cultural-Ecological Access Framework (CEAF)[8] and its relevance to the multifaceted obstacles African migrants encounter in accessing healthcare services in Guangzhou, China. This analysis confirmed the applicability of CEAF in addressing the tension between personal experiences and the broader level systemic, cultural, and policy dynamics. The migrants' struggles were largely the consequence of institutional, sociolinguistic, cultural incompetence, and restrictive public health and immigration policy framework. The integrative approach of CEAF provided the comprehensive understanding needed to analyze these barriers on multiple levels: individual, organizational, systemic community participation, and socioeconomic disparities. In applying CEAF, we argue that equity analyses must incorporate cultural and ecological features in examining health access. These findings point to the necessity of developing culturally competent, inclusively framed healthcare systems and policies that strategically respond to migrants' realities in non-Western settings such as China.

Limitation

While this study provides valuable insights into the healthcare barriers faced by African migrants in Guangzhou, there are several limitations. First, the sample size of 35 participants may not fully capture the diversity of experiences within the broader African migrant community in China. As a result, the findings may not be generalizable to all African migrants across China. Additionally, the study relies on self-reported data from interviews, which may be subject to biases such as social desirability or recall bias. The focus on a single city, Guangzhou, also limits the applicability of the findings to other regions of China, where migrants may face different challenges. Furthermore, the study does not account for the potential influence of gender or other intersectional factors, which could provide a more nuanced understanding of the barriers to healthcare access. Despite these limitations, the study offers crucial insights into the health-related struggles of African migrants in China.

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