

UNDERSTANDING THE ROLE OF CULTURE IN HEALTH-SEEKING BEHAVIOURS OF
CHINESE INTERNATIONAL STUDENTS IN CANADA

Master's Thesis

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Abstract

In the 21st century, the mobility of world population has posed greater challenges to healthcare practitioners, since they are facing an increasingly diverse patient population from all over the world. At the same time, patients also find it difficult to access and utilize quality health care services in a culturally diverse context.

This study examines the role of culture in Chinese international students' health-seeking behaviours in Canada. The study explores any barriers/perceived barriers that Chinese international students may confront when accessing health care which can prevent them from obtaining quality health care services in Canada. To this end, an intercultural health communication model was employed as a theoretical framework, and semi-structured interviews were used as a data collection tool.

While contributing to existing literature on health communication and culture, this study also hopes to contribute to providing Canadian universities and institutions important information regarding Chinese international students' access to and utilization of health care services with the hope of enhancing the quality of ethnic health care and promoting better health outcomes.

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Chapter 1: Introduction

With an increasingly globalized economy, advanced educational expertise, and diverse ethnic backgrounds, Canada has been one of the most popular destinations for international students, steadily attracting a large influx of students from all over the world (Higginbotham, 1979; Khawaja & Dempsey, 2008; Mori, 2000). According to reports from Citizenship and Immigration Canada (CIC, 2008), about 130,000 students come to Canada every year and even more come to learn English and/or French. As of December 2008, there were 178,227 long-term (staying for at least six months) international students pursuing their formal education in Canada (Roslyn Kunin & Associates, Inc., 2009). More than half of these students were from East Asian countries: primarily China, South Korea, and Japan (Lin & Yi, 1997; Roslyn Kunin & Associates, Inc., 2009; Vestal, 1994).

International students present a range of benefits to Canada (Roslyn Kunin & Associates, Inc., 2009). For instance, they alleviate the Canadian labour-market shortage (Asanin & Wilson, 2008; Roslyn Kunin & Associates, Inc., 2009); promote the tourism industry (Roslyn Kunin & Associates, Inc., 2009); increase intercultural understanding (Sam, 2001); and most importantly, they contribute substantially to Canada's economic growth (Asanin & Wilson, 2008; Brown, Edwards, & Hartwell, 2010; Khawaja & Dempsey, 2008; Roslyn Kunin & Associates, Inc., 2009; Vestal, 1994). As such, international students are important economic, social, and cultural

“assets to their host countries” (Asanin & Wilson, 2008, p. 1271; Sam, 2001); therefore, ensuring the benefits of international education is equally important (Asanin & Wilson, 2008).

Burmaster (2010) has argued that what students need today is to “travel, explore, and be creative in a culture other than their own” (p. 4). Since international students must adapt to new environments (Khawaja & Dempsey, 2008; Mori, 2000), often quite different from their home cultures, these students face many problems, academically, culturally, financially, and socially (Lin & Yi, 1997). The process of adjusting to a new environment may be fraught with numerous difficulties (Khawaja & Dempsey, 2008), potentially resulting in psychological distress and physical discomfort (Khawaja & Dempsey, 2008). Hence, access to health care services is an issue of great concern to international students.

According to existing literature, Chinese immigrant groups in developed countries “experience much difficulty in receiving entitled social benefits” (Asanin & Wilson, 2008, p. 1272), such as health care services (Asanin & Wilson, 2008; Bollini & Siem, 1995). In recent years, a growing number of scholars have researched on how Chinese people access and utilize health care services in a multicultural setting, where multiple cultural orientations intertwine with human communication (Ahmed, 2007; Kreps & Kunimoto, 1994). It has been noted that given the presence of differing cultural orientations, health care practitioners need to be culturally sensitive when providing health services in a multicultural health care setting (Ahmed,

2007; Ahmed & Bates, 2007). Existing literature show that scholars have studied Chinese-American restaurant workers' experiences with occupational injury and illness (Tsai, 2009), Chinese-American elders' use of health resources (Chesla, Chun, & Kwan, 2009; Chiang & Sun, 2009; Pang et al., 2003), the health-seeking attitudes and behaviours of Chinese-American adolescents (Chen & Mak, 2008; Ching et al., 2009; Ting & Hwang, 2009), and of Chinese-American women (Cheng & Pickler, 2009; Liang et al., 2009; Straughan & Seow, 2000), and Chinese-Canadian immigrants' perceptions of access to healthcare (Asanin & Wilson, 2008; Lai & Surood, 2009; Simich et al., 2009; Wang, Rosenberg, & Lo, 2008). Scholars have found that Chinese immigrants often "face multiple barriers when attempting to access health care services" (Asanin & Wilson, 2008, p. 1272), such as barriers relating to language (Blignault et al., 2008; Chesla, Chun, & Kwan, 2009; Garrett et al., 2008; Hwang, Myers, Abe-Kim, & Ting, 2008; Tsai, 2009), cost (Tsai, 2009), location and transportation (Derose, Escarce, & Lurie, 2007), and cultural sensitivity (Chesla, Chun, & Kwan, 2009; Kagawa-Singer & Kassim-Lakha, 2003; Blignault et al., 2008). Scholars have argued that such barriers to health care services can be pivotal for immigrants when choosing their destination countries (Asanin & Wilson, 2008).

However, unlike permanent immigrants (Mori, 2000), international students comprise a more mobile population. While some international students plan to return to their home countries after completing their studies (Aubrey, 1991; Mori, 2000), others may still be in their

decision-making process - that is to say, they may be in a transitional stage while residing in a foreign country in order to achieve their academic objectives (Mori, 2000). With the steady rise in the number of international students, recent years have witnessed a growth in research devoted to issues relating to the sojourn experience of international students (Brown, Edwards, & Hartwell, 2010; Russell, Thomson, & Rosenthal, 2008), for instance, mental health (Mori, 2000); psychological distress (Khawaja & Dempsey, 2008); dietary practices (Brown, Edwards, & Hartwell, 2010); adjustment-related stressors (Aubrey, 1991; Chen, 1999; Lin & Yi, 1997; Tavakoli et al., 2009); cross-cultural counselling (Barletta & Kobayashi, 2007); university and counselling services usage (Russell, Thomson, & Rosenthal, 2008); and medical communication between native English-speaking medical professionals and international students (Frank, 2000). It has been found that the transition to a new culture can possibly lead international students to substance abuse, a high alcohol intake, and altered dietary practices (Brown, Edwards, & Hartwell, 2010). Moreover, international students, particularly those who come from China, India, and the Middle East (Tavakoli et al., 2009), underutilize both health and counselling services (Aubrey, 1991; Russell, Thomson, & Rosenthal, 2008; Tavakoli et al., 2009), as do Chinese immigrants in developed countries (Asanin & Wilson, 2008).

Although a number of studies point to the many difficulties encountered by international students when residing in foreign countries, few studies have examined how Chinese

international students in particular seek medical treatment in Canada, and even fewer studies have linked aspects of Chinese culture to Chinese international students' attitudes and behaviours in their search for health care services. Due to the rapidly rising number of this group in Canada, and their contribution to Canada's culture, educational environment, and economy (Khawaja & Dempsey, 2008), developing an understanding of access to health care services among Chinese international students in Canada is an important and timely research issue.

To bridge the gap in the literature referenced above, this thesis will focus on understanding how Chinese international students in a multicultural society like Canada access and utilize health care services. Chinese international students, in this study, are defined as Chinese citizens who temporarily reside in Canada in order to pursue their international education as students (Barletta & Kobayashi, 2007; Lin & Yi, 1997). As such, the purposes of this thesis are: 1) to examine the ways in which Chinese international students seek medical treatment in Canada; 2) to investigate barriers/perceived barriers, if any, which Chinese international students may face during their health-seeking process; and 3) to understand the influences of Chinese culture on Chinese international students' search for medical treatment. It is also important to look into Chinese international students' major health concerns, risky behaviours, prevention of sexually transmitted diseases, and mental health problems in a multicultural setting; however, it is beyond the scope of this study, which leaves space for future research.

Significant benefits may accrue from conducting such research: on the one hand, it can assist universities and institutions in identifying and addressing some of the problems confronted by Chinese international students during their health-seeking process (Khawaja & Dempsey, 2008); on the other hand, Chinese international students, in being acknowledged and accommodated, may feel that their needs have been satisfactorily addressed, thus enhancing the reputation of Canadian universities (Khawaja & Dempsey, 2008).

Overview of the Thesis

In order to explore the health-seeking experiences of Chinese international students in Canada, this thesis is divided into six main sections. The present chapter provides a background and context for understanding Chinese international students' health-seeking experiences in a multicultural setting. The next chapter examines more closely existing literature pertinent to the current study, and outlines the theoretical framework and research questions posed. Chapter three defines the methodological approach employed in this study; the collection and analysis of data are then discussed in detail. In chapter four, the findings of this study are reported, followed by discussions in light of the theoretical framework used. Finally, chapter six presents conclusions and implications of the findings, closing with suggestions on potential directions for future research.

Chapter Summary

In the present chapter, the researcher has introduced the subject matter serving as the focus of this study, that is, Chinese international students' health-seeking experiences in Canada. This chapter has provided a brief summary of the difficulties confronted by the Chinese population in receiving entitled social benefits in foreign countries, while underscoring the importance of examining Chinese international students' health-seeking experiences in Canada. More specifically, the researcher proposed to investigate the difficulties, if any, encountered by Chinese international students when accessing and utilizing health care services in Canada, and to examine the role of Chinese culture on Chinese international students' search for medical treatment.

In chapter two, the researcher will review related literature on health communication and culture, ethnicity and utilization of health care services, barriers/perceived barriers to health care services, traditional Chinese medicine (TCM) and Chinese cultural beliefs, sojourn experience and health, and pose research questions to help guide the study.

Chapter 2: Literature Review

This literature review examines the relationship between health communication and culture, while paying special attention to the experiences of ethnic groups seeking health care services within a multicultural context. Reviewing relevant literature provides context and background when examining the health-seeking behaviours of Chinese people living abroad, and establishes a foundation for further exploration of the barriers/perceived barriers confronted in their health-seeking process within a multicultural setting. Accordingly, the literature review is divided into six sections: an overview of health communication and culture, ethnicity and utilization of health care services, barriers/perceived barriers to health care services, traditional Chinese medicine (TCM) and Chinese cultural beliefs, sojourn experience and health, and theoretical framework. The review develops from general ideas which provide a conceptual background to specific areas affecting ethnic health care today.

An Overview of Health Communication and Culture

Health communication is the study of human interactions between participants in the health care process, including the dissemination of health-related messages by individuals and groups, to other individuals, organizations, and the general public, and how these messages are interpreted (Ahmed, 2007; Jackson & Duffy, 1998; Kreps & Thornton, 1984; Ray & Donohew, 1990; Thomas, 2006). Witte and Morrison (1995) have argued that, “the goal of most health

communication specialists is to improve the health status of individuals, groups, and society through effective communication strategies” (p. 244).

Today, health care practitioners from varying socio-cultural backgrounds “find themselves serving an increasingly diverse patient population” (Rao, 2006, p. 310). Witte and Morrison (1995) have posited that “communication problems are exacerbated and understanding between people is reduced when patients and practitioners are from different cultures” (p. 217). Scholars have recognized the importance of constructing and negotiating health communication in relation to culture (Abdulrahim & Baker, 2009; Ahmed, 2007; Allen et al., 2007; Dutta & Basu, 2008; Gadd et al., 2005; Kreuter & McClure, 2004; Larkey & Hecht, 2010; Liang et al., 2009; Rao, 2006; Uiters et al., 2010; Yehya & Dutta, 2010). Moreover, scholars have argued that, in order to guarantee the effectiveness of health communication programs (Kreuter & McClure, 2004), cultural needs should be integrated into health messages (Dutta, 2007; Kreuter et al., 2005; Larkey & Hecht, 2010). Culturally appropriate health information is believed to be more effective for its target audience than information which disregards culture (Kreuter & Haughton, 2006). Thus, to employ effective health communication strategies, the concept of culture must first be understood (Ahmed, 2007).

Culture is a popular and widely used term in contemporary society. Culture has been tied to such fields as advertising (Cheong, Kim, & Zheng, 2010), health care (Dutta, 2007; Gao, Burke,

Somkin, & Pasick, 2009; Kreuter et al., 2005), marketing (Cheong, Kim, & Zheng, 2010), and food (Bruss et al., 2005; Cheong, Kim, & Zheng, 2010).

Generally, culture can be defined as the intergenerationally learned, shared, and transmitted arts, beliefs, values, customs, norms, practices, patterns of communication, and other conventions existing within a community which guide members' thinking and decisions (Anderson et al., 2003; Dutta, 2007; Kreuter & Haughton, 2006; Kreuter & McClure, 2004; Purnell & Paulanka, 1998; Salman & Zoucha, 2010; Ulrey & Amason, 2001).

Samovar, Porter, and McDaniel (2006) have defined culture as “the rules for living and functioning in society” (p. 10). Culture specifies the rules by which individuals can “function and be effective in a particular society” (p. 10). The rules are mostly unconscious enabling individuals to respond to familiar situations automatically (Samovar, Porter, & McDaniel, 2006). Similarly, Larkey and Hecht (2010) have defined culture as code, which also represents “a system of rules and meanings” (p. 115), where the rules and meanings make sense within the context provided by that culture (Yehya & Dutta, 2010). As Samovar, Porter, and McDaniel (2006) have argued, it is when one enters another culture having different rules for functioning that problems begin to arise. Culture plays a significant role in health communication (Gao, Burke, Somkin, & Pasick, 2009). Culture generates and forms “a unique pattern of beliefs and perceptions” of health and illness, which influences how people interpret symptoms and

attributions, and how and when to seek health services (Anderson et al., 2003, p.69). It is when people hold differing definitions of a given word or concept that miscommunication and misunderstandings ensue, which in medical encounters can result in adverse health outcomes (Witte & Morrison, 1995).

In fact, Rao (2006) has argued that the physician-patient interaction is “inherently an intercultural encounter even when the two parties perceive they are from the same culture” (p. 309). The reasons can be attributed to their differing socioeconomic status, education, and cultures – patients’ and physicians’. Kleinman, Eisenberg, and Good (2006) have explained that while patients consult a doctor due to “*illness* (the human experience of sickness)” (p. 141; emphasis in original), physicians “diagnose and treat *diseases* (abnormalities in the structure and function of body organs and systems)” (p. 141). For instance, Castillo-Carniglia et al. (2010) found that in Andean communities in Bolivia, health professionals and patients’ mothers held differing attitudes towards traditional medicine. The mothers believed that traditional Andean medicine and public health systems are complementary and not contradictory, while health personnel indicated that only biomedicine is acceptable.

Besides the inherent intercultural differences between patients and physicians, communication problems can be aggravated when the two parties come from differing sociocultural backgrounds (Rao, 2006). A growing body of literature has found that culture, as

an important variable (Ahmed, 2007; Dutta, 2007), exerts a powerful influence on people's interpretations of and responses to health-related decisions and behaviours (Kreuter & McClure, 2004; Purnell & Paulanka, 1998). Scholars have also argued that culture, broadly defined, includes "people's health values and beliefs," such as how they perceive health and illness, explain symptoms, and seek care (Dong, Loignon, Levine, & Bedos, 2007, p.1340). For example, for Asian-Americans, including Japanese, Chinese, Filipino, Asian Indian, and Koreans, having mental illness is considered to be shameful. The mentally ill person will be hidden by the family at home rather than seeking medical treatment (Purnell & Paulanka, 1998). Scholars have argued that with an awareness of the cultural characteristics of specific groups, health communication programs and services can be tailored to better satisfy patients' needs (Kreuter & McClure, 2004). Against such a backdrop, this study aims to understand the influence, if any, of Chinese culture on Chinese international students' health-seeking attitudes and behaviours. Health behaviour can be broadly defined as "any activity undertaken by individuals who see themselves as healthy for the purpose of preventing disease or detecting it at an asymptomatic stage" (Ward, Mertens, & Thomas, 1997, p. 21). Conversely, health-seeking behaviour has been defined as "any activity undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy" (Ward, Mertens, & Thomas, 1997, p. 21). Thus, in this study, health-seeking behaviour typically refers to any behaviour undertaken by

Chinese international students who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy. As Ward, Mertens, and Thomas (1997) have argued, health-seeking behaviours cannot be isolated from socio-cultural factors. Therefore, socio-cultural and other factors related to health will be considered when examining Chinese international students' health-seeking experiences in Canada.

Ethnicity and Utilization of Healthcare Services

Conflicts, natural disasters, and technological changes have brought another round of global population movement (Garrett et al., 2008). Diversity is an asset to a society (Anderson et al., 2003), while also presenting challenges (Copeland, 2005). How to satisfy the needs of patients of diverse cultural backgrounds while providing quality health care has become a crucial topic for both health care practitioners and scholars.

Health disparities, as a priority concern in the health care field (Ball & Kettner, 2010; Kreps, 2006; Larkey & Hecht, 2010), are defined as any significant disparity within a particular group, in the overall rates of disease, incidence, prevalence, morbidity, mortality, disability, or death, as compared to the population at large (Harrison & Falco, 2005; Safran et al., 2009; Walker & Chesnut, 2010). Ethnic minority groups include American Indians, African Americans, Hispanic Americans, Asian Americans, Aboriginal peoples, refugees, immigrants, those within lower socioeconomic classes, and other distinct populations (Ball & Kettner, 2010; Safran et al., 2009).

To date, much evidence indicates that ethnic minorities endure higher rates of incidence, prevalence, disease, disability, mortality (Anderson et al., 2003; Copeland, 2005; Hwang, Myers, Abe-Kim, & Ting, 2008; Kreps, 2006; Mallinger & Lamberti, 2010). Ethnic minorities “tend to receive a lower-quality health care,” and have worse health outcomes than the majority population (Anderson et al., 2003, p. 68). For example, African Americans, particularly those who are poor and those working without health care insurance, are less likely to have usual sources of health care, compared with their White counterparts (Copeland, 2005), while African-American women are more likely than White women to develop late-stage breast cancer at diagnosis, with less favourable outcomes (Bradley, Given, & Roberts, 2002). Similarly, African Americans, Asians, and Hispanics are found to have higher rates of late-stage colorectal cancer than non-Hispanic Whites (Gao, Burke, Somkin, & Pasick, 2009). Black (2002) has also found that African Americans, Hispanic Americans, Native Americans are quite likely to have diabetes.

Health disparities also exist in the diagnostic and therapeutic arenas (Groeneveld, Heidenreich, & Garber, 2003; Harrison & Falco, 2005). For instance, Harrison and Falco (2005) have noticed that, in the emergency department, Hispanic and Black patients with extreme fractures received analgesics less frequently than did White patients. Similarly, compared with their White counterparts, Blacks (aged 66 to 74 years) have a significantly lower probability of

receiving an implantable cardiac defibrillator, a procedure considered to be life-saving (Groeneveld, Heidenreich, & Garber, 2003).

The existence of health disparities within ethnic minority groups is of concern to patients, health scholars, administrators, and policy-makers (Copeland, 2005; Walker & Chesnut, 2010), and represents “a major burden for both individuals and groups” (Ball & Kettner, 2010, p. VI). For individuals, poor health prevents them from fully participating in a society; at the group level, health disparities can be a burden on the national economy (Ball & Kettner, 2010).

In recent years, a growing body of scholars have raised awareness of the ineffective utilization of health care services among Chinese people (Asanin & Wilson, 2008; Blignault et al., 2008; Constantine et al., 2005; Liang et al., 2009; Ting & Huang, 2009; Wang, Rosenberg, & Lo, 2008). Scholars have found that Asian-Americans tend to underutilize health care services compared with their White counterparts (Ting & Huang, 2009). For instance, Ting and Huang (2009) have found that less than a third of Asian-Americans requiring professional mental help actually receive treatment. Asian-Americans tend to underutilize mental health services compared to other groups. Likewise, Liang et al. (2009) have found that Chinese-American women above fifty years of age have a lower mammography-screening rate than do White women (45.8% vs. 57.4%), despite the fact that women over forty are advised to take mammograms every one to two years to detect early signs of breast cancer. Moreover,

Chinese-American women have “an even lower rate of screening than do their Asian counterparts, such as Filipino, Japanese, and Vietnamese women” (Wang et al., 2008).

In fact, most Asians in North America have the tendency to delay or even avoid seeking health treatment altogether until their condition is very serious and all other resources have been tried (Abe-Kim et al., 2007; Chen & Mak, 2008; Hsu & Alden, 2008; Meyer et al., 2009). For example, the underutilization of health care services is also true of Chinese-Canadian immigrants. Wang, Rosenberg and Lo (2008) have found that despite Canada’s publicly-funded health care system, Chinese immigrants within Canada underutilize health services as well. Moreover, mainland Chinese immigrants in the Toronto area exhibit an overwhelming preference for Chinese-speaking family physicians. Scholars have also found that Chinese immigrants in Canada tend to underutilize mental health services even when they suffer from severe depression (Chen, 2011; Fang, 2011). For instance, Fang (2011) has found that some Chinese immigrants in Toronto hold a negative attitude toward seeking counselling help.

However, some scholars have already noted that it is inappropriate to equate Asian-Americans who are foreign-born with those who are U.S. born (Abe-Kim et al., 2007; Meyer et al., 2009) as the two groups differ greatly in their health-seeking patterns (Abe-Kim et al., 2007). Scholars have also found that U.S.-born Chinese sought mental health treatment more frequently than did immigrants (Abe-Kim et al., 2007; Chen & Mak, 2008), who displayed

reluctance to seek professional help on these issues. Therefore, it has been argued that when immigrants make a better acculturation into American society, their health can be improved evidently (Abdulrahim & Baker, 2009; Allen et al., 2007). These examples bring scholars to realize that it is culture which influences immigrants' health-related attitudes and behaviours (Allen et al., 2007).

Among ethnic minority groups, another Asian subgroup, international students, also experience much difficulty in accessing and utilizing health care services. Coming to another country in pursuit of quality high education, international students are faced with unfamiliar academic, social, and cultural environments (Khawaja & Dempsey, 2008; Mori, 2000). Having less social support in contrast to domestic students (Khawaja & Dempsey, 2008; Mori, 2000), international students experience many difficulties adjusting to their new environment. For instance, in Shik's (2011) study, international students in Canada were found to have three most important problems, including financial concerns, heavy workload, and stress and pressure. Scholars have argued that these changes can result in psychological distress and physical discomfort (Chen, 1999; Khawaja & Dempsey, 2008; Maundeni, 2001; Mori, 2000; Rosenthal, Russell, & Thomson, 2008; Shik, 2011; Tavakoli et al., 2009). Nevertheless, despite the fact that international students (and especially Asian international students) tend to experience more problems than do domestic students, they still underutilize health care services (Barletta &

Kobayashi, 2007; Mori, 2000; Rudowica & Au, 2001; Russell, Thompson, & Rosenthal, 2008; Shik, 2011; Tavakoli et al., 2009).

In previous studies, Chen and Mak (2008) compared the attitudes towards professional help-seeking among four groups: European-Americans, Chinese-Americans, Hong Kong Chinese, and Mainland Chinese. European-Americans were greatly influenced by Western values, while Chinese-Americans subscribed to both Western and Eastern cultural values. In the other two Chinese groups, Hong Kong Chinese were more westernized than Mainland Chinese, who were deeply rooted in traditional Chinese culture (Chen & Mak, 2008). Scholars have found that European-Americans and Chinese-Americans seek professional help more frequently than do Hong Kong Chinese, while Mainland Chinese are least likely to seek help. Moreover, Asian-Americans who are more inclined to traditional Chinese culture are also less likely to seek professional help. Consequently, Chen and Mak (2008) have argued that the degree of students' willingness to seek help is associated with cultural influences, that is, individuals influenced by Western cultures are more positive in seeking professional help and use more mental health services. Scholars have posited that culture influences how one perceives health and illness, and also plays an important role in shaping help-seeking attitudes and behaviours (Chen & Mak, 2008; Mori, 2000; Rudowicz & Au, 2001; Russell, Thompson, & Rosenthal, 2008).

Against such a backdrop, an important question worth considering is: why do Chinese students fail to seek help when it is needed? Russell, Thomson, and Rosenthal (2007) have identified two reasons: firstly, students tend to believe their condition does not warrant medical treatment; secondly, students lack information regarding the existence of health care services, locations, fees, or even the mechanics of scheduling an appointment. In other words, on the one hand, Chinese international students are influenced by traditional Chinese cultures on their perceptions of health and illness; on the other hand, there are barriers/perceived barriers for Chinese international students to access and utilize health care services.

Existing studies of ethnic minority groups' access to health care in Canada mainly draw from the general Asian population (Asanin & Wilson, 2008), or from Chinese-Canadian immigrants (Wang, Rosenberg, & Lo, 2008); few insights have been gained into the lack of accessibility to health care for a special subpopulation group, Chinese international students. Hence, despite the increasing growth of this group in Canada, relatively little is known about Chinese international students' access to health care, which should constitute an important concern for the host country. Therefore, examining issues of accessibility and utilization of health care services among Chinese international students is significant and necessary.

Barriers/Perceived Barriers to Healthcare Services

Ethnic populations in developed countries often face multiple barriers when attempting to access health care services. Accordingly, much research has focused on examining issues among the Chinese population, noting that their low utilization of health care services may be attributed to structural and cultural factors (Copeland, 2005; Pang et al., 2003). Structural factors include affordability (Copeland, 2005; Tsai, 2009), availability of services (Wang, Rosenberg, & Lo, 2008), lack of knowledge of services, transportation and health care system (Blignault et al., 2008; Copeland, 2005; Derose, Escarce, & Lurie, 2007; Mori, 2000), and citizenship status (Tsai, 2009). Cultural factors include language (Blignault et al., 2008; Chesla, Chun, & Kwan, 2009; Garrett et al., 2008; Hwang, Myers, Abe-Kim, & Ting, 2008; Tsai, 2009), health beliefs (Hsu & Alden, 2008; Straughan & Seow, 2000; Tsai, 2009), and low levels of cultural competence among health care practitioners (Blignault et al., 2008; Chesla, Chun, & Kwan, 2009; Kagawa-Singer & Kassim-Lakha, 2003).

Regarding structural barriers, Tsai (2009) has found that Chinese immigrant restaurant workers in the U.S. are reluctant to report occupational injuries, seek medical assistance, or take sick leave from work due to their concerns with health insurance coverage, their low-income status and other structural and cultural factors. Similarly, Mori (2000) has determined that the reason why international students tend to delay or even avoid seeking health care services altogether is partly due to their financial concerns, not knowing that most health care services are

free of charge or ask for only a small fee. Scholars have posited that education, employment, and financial status directly and indirectly influence people's access to health care resources (Derose, Escarce, & Lurie, 2007). And most of the Chinese immigrants in the U.S. have a lower educational background, work in service industry, and live in poverty compared to their U.S.-born counterparts (Derose, Escarce, & Lurie, 2007; Tsai, 2009). As a result, most Chinese immigrants in North America choose self-diagnosis and self-treatment when injured or ill (Tsai, 2009; Wang, Rosenberg, & Lo, 2008).

Lack of knowledge of services, transportation, and health care system is another major structural barrier to Chinese populations in developed countries. For instance, existing studies reveal that immigrants in Canada experience "lack of meaningful multilingual information about health issues, knowledge of where to find the right health care or how to access preventive health care services" (Simich, 2011, p. 18). Most international students in the U.S. are also found to have no idea of available campus resources (Mori, 2000). Even if they are told of such health services, international students tend to consider the services to be provided exclusively for domestic students (Mori, 2000). Moreover, Mori (2000) has argued that the physical locations of health care services are closely related to international students' utilization of health care services. Scholars have found that in some cultures, mental health problems are considered to be 'losing face' for both patients and their families; therefore, patients and their families will avoid

going to counselling services where they may confront acquaintances (Mori, 2000; Purnell & Paulanka, 1998). Moreover, Chinese families with mentally ill members tend to deny the existence of mental illness because of their fear of ‘losing face,’ which in turn “prevents individuals with mental health needs from receiving timely and appropriate assessment and treatment” (Fang, 2011, p. 71).

Another major determinant of immigrants’ access to health care services is legal status (Derose, Escarce, & Lurie, 2007). In Derose, Escarce, and Lurie’s (2007) study, immigrants had consistently lower rates of health insurance coverage compared with their U.S.-born counterparts. Moreover, sixty-five percent of undocumented immigrants in the U.S. did not have any health insurance, compared with thirty-two percent of permanent residents. The lack of health insurance leads Chinese immigrants to seek a less regular source of health care.

Among the cultural factors, language has been one of the most challenging issues for the Chinese to search for medical treatment (Blignault et al., 2008; Constantine et al., 2005; Derose, Escarce, & Lurie, 2007; Lin & Yi, 1997; Mori, 2000; Wang, Rosenberg, & Lo, 2008). Scholars have found that about thirty-two percent of Chinese immigrants in Canada cannot speak English (Wang, Rosenberg, & Lo, 2008), and those who have limited English proficiency (LEP) are often reluctant to seek Western health care services (Wang et al., 2008). Moreover, previous studies have indicated that immigrants with limited English proficiency are much less likely to

have health care insurance, have fewer physician visits, and receive less preventive care than those who can speak English (Derose, Escarce, & Lurie, 2007; Liang et al., 2009). For international students, language barrier is also a major problem (Lin & Yi, 1997; Mori, 2000).

Although most of the Chinese international students take English language tests, such as TOEFL and IELTS, before they go abroad, it is not enough to ensure sufficient English communication skills (Mori, 2000). Language differences can create significant problems and barriers when trying to access medical services, and affect the quality of physician-patient communication (Derose, Escarce, & Lurie, 2007; Dohan & Levintova, 2007; Lin & Yi, 1997), which can cause patient dissatisfaction and adverse health outcomes (Derose, Escarce, & Lurie, 2007). For example, Wang, Rosenberg and Lo (2008) have found that in the Toronto area, most Chinese immigrants thought it was difficult to comprehend English medical terminologies; they could not communicate with Western doctors effectively; as a result, those Chinese immigrants turned to seek Chinese-speaking family doctors since they could better understand their Chinese doctors' diagnosis and instructions. To bridge linguistic gaps between limited English proficiency patients and providers, scholars have argued to solve the problem by turning to interpreters (Barone, 2010; Derose, Escarce, & Lurie, 2007; Dohan & Levintova, 2007; Willgerodt, Kataoka-Yahiro, Kim, & Ceria, 2005).

Health beliefs are also found to have influences on Chinese people's health-seeking attitudes and behaviours (Blignault et al., 2008; Gao, Burke, Somkin, & Pasick, 2009; Hsu & Alden, 2008; Liang et al, 2009; Mori, 2000; Straughan & Seow, 2000; Tsai, 2009). Patients rely on their different cultural beliefs to support their health-related decisions (Gao, Burke, Somkin, & Pasick, 2009). For instance, Liang et al. (2009) have found that Chinese American women who hold a more Chinese cultural view, such as believing in karma or fatalism (Gao, Burke, Somkin, & Pasick, 2009), are significantly less likely to have had regular mammograms than those having a more western cultural view. Mori (2000) has argued that people's perceptions of health determine their use of health services. For instance, in many cultures, mental illnesses are considered as 'losing face' to both individuals and their families (Mori, 2000; Purnell & Paulanka, 1998). In existing literature, scholars have noted that in Hong Kong, the majority of people held a stereotypic attitude towards mental illness and associated it with "craziness and insanity" (Shik, 2011, p. 1). Chinese culture, particularly, emphasizes self-control to maintain the harmony of the group (Rudowicz & Au, 2001). Therefore, people influenced by these cultures tend to be unwilling to seek mental health care (Mori, 2000). Similarly, Hsu and Alden (2008) have found that immigrants who have greater Chinese cultural heritages face more cultural barriers that prevent them from seeking mental health services, compared with those who are more acculturated to Western cultures. Consequently, scholars have suggested that one's

perception of health and illness are related to his/her health-seeking attitudes and behaviours (Copeland, 2005; Straughan & Seow, 2000), and these perceptions directly and indirectly determine one's interpretation of illness (Copeland, 2005).

Another cultural factor, low levels of cultural competence among health care practitioners, also influences Chinese people's health-seeking behaviours (Blignault et al., 2008; Chesla, Chun, & Kwan, 2009; Kagawa-Singer & Kassim-Lakha, 2003). In the past decades, scholars have argued that increasing cultural competence in health care professionals is a vital component of multiple strategies to eliminate ethnic health disparities, improve the quality of services and health outcomes, and increase the efficiency of health care practitioners (Ahmed, 2007; Anderson et al., 2003; Axtell, Avery, & Westra, 2010; Barone, 2010; Frank, 2000; Ulrey & Amason, 2001).

Cultural competence, also known as cultural awareness (Perkins et al., 2002), cultural sensitivity (Frank, 2000; Ulrey & Amason, 2001), and culturally and linguistically appropriate services (Barone, 2010; Cioffi, 2003), is indispensable in providing quality health care (Anderson et al., 2003). Cultural competence refers to the ability of health care practitioners and systems to effectively provide care to patients with diverse cultural backgrounds (Axtell, Avery, & Westra, 2010; Betancourt, Green, & Carrillo, 2010). In other words, health care practitioners

“not only possess cultural knowledge and respect, but can apply that knowledge effectively”

within cultural contexts as well (Barone, 2010, p. 454).

Cultural competence in the health care industry carries great importance. For both international students and immigrants, low levels of cultural competence among health care practitioners and organizations have been an obstacle to their utilization of health care services (Blignault et al., 2008; Chesla, Chun, & Kwan, 2009; Kagawa-Singer & Kassim-Lakha, 2003; Mori, 2000). Frank (2000) has found some problems in the medical communication between international students and the Student Health Programs (SHP) staff. These problems included the content of the speech, the manner of speaking, pragmatic aspects of the interactions, and different expectations and understanding of the American health care system. On the one hand, medical terminologies made the international students unable to express their symptoms and medical problems to health care providers; moreover, with a lack of knowledge of the American health care system, international students were unfamiliar with problems, such as making appointments and paying bills, and were unsure of the communication patterns with health care practitioners. On the other hand, health care practitioners appeared to lack culturally competent health care practices in their delivery of care. For instance, while being unsure of communication patterns, international students appeared to take some time to respond to questions, yet, some health care practitioners tended to show impatience towards these patients.

Traditional Chinese Medicine (TCM) and Chinese Cultural Beliefs

Each year thousands of international students come to Canada to pursue a quality high education (Lin & Yi, 1997; Khawaja & Dempsey, 2008), among which Chinese international students constitute a major part (Constantine et al., 2005; Lin & Yi, 1997; Roslyn Kunin & Associates, Inc., 2009; Vestal, 1994). As the number of Chinese international students who sojourn to Canada continues to rise, it becomes increasingly vital for scholars to look into issues and experiences of this population (Brown, Edwards, & Hartwell, 2010; Constantine et al., 2005). Some scholars tend to examine Asian groups as a whole, including Japanese, Korean, and Vietnamese. However, it is important to note that although Asian groups share certain similarities, they are different in their cultural values (Constantine et al., 2005). Kwan and Holmes (1999) have argued that “each culture has its own system of health beliefs, a collection of beliefs, perceptions and ideas about health and illness, which underpin health-related behaviours” (p. 453). Therefore, to provide culturally competent health care services to Chinese international students, it is crucial for Canadian health care practitioners to have a basic knowledge of Chinese culture and its health belief systems (Dong, Loignon, Levine, & Bedos, 2007; Kwan & Holmes, 1999; Ma et al., 2010).

Traditional Chinese Medicine (TCM)

Traditional Chinese medicine (TCM) can be traced back to a legend (Hoizey & Hoizey, 1993). In ancient China, there was a Yellow Emperor (*Huangdi*) who claimed to be the highest sovereign in the universe. His work *The Yellow Emperor's Classic of Internal Medicine* (*Huangdi Neijing*) contains many conversations between him and his physician Qi Bo (Hoizey & Hoizey, 1993).

The Yellow Emperor's Classic of Internal Medicine describes that men must ensure the perfect balance and harmony of *yin* and *yang*, since one's health depend on the equilibrium of these two opposing yet complementary forces (Hoizey & Hoizey, 1993; Kwan & Holmes, 1999; Quah & Bishop, 1996).

Originating in Taoism, *yin-yang* balance is the most essential aspect of Chinese culture and traditional Chinese medicine (Wang, Rosenberg, & Lo, 2008). It is important to note that *yin* and *yang* are not “two different types of energy,” rather they are “two opposite and complementary qualities of the same basic energies” (Reid, 1996, p. 24). *Yin* and *Yang* initially meant only “shaded side of a hill” (*yin*) and “sunny side of a hill” (*yang*) (Reid, 1996, p. 24; Unschuld, 1985, p. 55). They are in a “mutually transmutable relationship” (Reid, 1996, p. 24).

In traditional Chinese medicine, *yin* and *yang* represent the body and the spirit separately (Hoizey & Hoizey, 1993); together with *qi* (vital energy), these three determine the rules of universe and the relationship between people and the environment (Kwan & Holmes, 1999; Ma

et al., 2010). A balance between *yin* and *yang* results in good harmony and health; conversely, an imbalance in these two forces leads to poor health and diseases (Kwan & Holmes, 1999; Ma et al., 2010; Matocha, 1998; Quah & Bishop, 1996; Reid, 1996; Tsai, 2009; Wang, Rosenberg, & Lo, 2008). As a result, traditional Chinese medicine identifies that to keep one's wellness, a balanced state of mind, body, emotions and spirit must be ensured (Ma et al., 2010).

Health Beliefs

Traditional Chinese health beliefs are considerably different from those of Western medicine (Quah & Bishop, 1996). On the basis of the biomedical model, Western medicine views diseases as being mainly caused by “biochemical abnormalities or the result of disease-causing organisms or substances” (Quah & Bishop, 1996, p. 210); however, traditional Chinese medicine considers diseases a result of “internal disharmony and imbalance of body energies” (Quah & Bishop, 1996, p. 210).

Chinese perceptions of health and illness are greatly influenced by traditional Chinese medicine (Tsai, 2009). Generally, traditional Chinese conceptions of disease believe that the malfunction of the human body is caused by both internal and external factors (Bond, 1993). External causes are: wind, cold, heat, dampness, dryness, and fire (Bond, 1993; Reid, 1996; Tsai, 2009). These external causes do not mean physical temperature or wetness; rather, they are classified according to the imbalance of energy states (Quah & Bishop, 1996). For example,

conditions such as allergic skin, stomach troubles, sore throat, and hypertension are viewed as having an excess of heat in the body (Quah & Bishop, 1996; Wang, Rosenberg, & Lo, 2008); while asthma and diarrhoea are viewed as having an excess of cold (Quah & Bishop, 1996). Internal causes include human beings' seven emotions, which are "joy, anger, worry, contemplation, sorrow, apprehension, and fright, as well as fatigue and irregularity of food and drink" (Bond, 1993, p. 254). For instance, Chinese immigrant restaurant workers often could not have meals at regular hours due to the nature of catering services; therefore, the imbalanced and irregular eating habit was considered as the major cause of stomach aches in Chinese health beliefs (Koo, 1984; Tsai, 2009). Both internal and external factors can lead to an imbalance of an individual's body, which in turn engender hurt to a specific organ (Bond, 1993). For example, when one gets very angry, his/her liver may be affected; and if one becomes extremely joyful, his/her heart has to bear a lot of burden (Bond, 1993).

Another central concept in traditional Chinese medicine is *qi* (Matocha, 1998; Quah & Bishop, 1996). As a physical indicator of energy, *qi* is considered as "the source of life" (Koo, 1984, p. 757; Quah & Bishop, 1996, p. 211), including "air, breath, or wind and is present in all living organisms" (Matocha, 1998, p. 181). On the one hand, *qi* is inborn; on the other hand, it can be obtained from the outside environment, such as from food (Matocha, 1998). Therefore, food plays a crucial role in Chinese daily lives (Koo, 1984; Matocha, 1998). Scholars have found

that according to traditional Chinese medicine, to maintain good health, one should guarantee a sufficient accumulation and smooth flow of *qi* (physical energy) throughout his/her body (Koo, 1984; Quah & Bishop, 1996). Any “blockage or insufficiency of *qi*” can lead to illness, such as headache, stroke, diabetes, and tuberculosis (Quah & Bishop, 1996, p. 211).

These health beliefs are deeply rooted in the minds of Chinese people (Kwan & Holmes, 1999), and influence Chinese people’s health-seeking attitudes, behaviours, and knowledge (Chau & Yu, 2010).

Treatment

There are two health care systems in China: traditional Chinese medicine and Western medicine (Matocha, 1998). In China, the government consistently underlines that traditional Chinese medicine and Western medicine are complementary (Chau & Yu, 2010), and treats traditional Chinese medicine and Western medicine equally, both economically and politically (Cai, 1988). Therefore, Chinese people are used to employing “both Chinese and Western medicine in combination” for the treatment of their diseases (Chau & Yu, 2010, p. 386; Tsai, 2009). Matocha (1998) has found that younger Chinese people generally seek Western medicine the first time; if Western medicine does not cure their diseases, they will then turn to traditional Chinese medicine. However, Tsai (2009) has found that most of the Chinese American immigrants used Chinese medicine products and Chinese herbal patches for minor injuries or

pain. Chinese American immigrants only turned to Western medicine when their injuries or pain were too serious to be cured or eased by Chinese medicine or other means. For instance, a waiter who had got on-the-job sprains would rather stick to Chinese medicine wine for a month than go to see the Western doctor (Tsai, 2009). Moreover, scholars have found that most of the Chinese lay people believe that Western medicine can only cure superficial symptoms of diseases (Koo, 1984), while traditional Chinese medicine is competent in curing diseases at the root (Cai, 1988; Koo, 1984; Wang, Rosenberg, & Lo, 2008). Scholars have argued that Chinese people's attitude towards traditional Chinese medicine are associated with their age, education, and socioeconomic status (Quah & Bishop, 1996). For example, Quah and Bishop (1996) have found that in Singapore and Taiwan, older people and those with lower levels of education tend to particularly rely on traditional Chinese medicine.

Furthermore, Chinese people have a tendency to use various methods to manage their health (Chau & Yu, 2010), for instance, food remedies, herbal teas, acupuncture, massage, and other methods (Koo, 1984; Marino, Minichiello, & MacEntee, 2010; Quah & Bishop, 1996; Reid, 1996; Wang, Rosenberg, & Lo, 2008).

Food has always been seen as the "major source of energy that one absorbs every day" (Koo, 1984, p. 757). In fact, in traditional Chinese medicine, food and medicine are interconnected (Reid, 1996; Wang, Rosenberg, & Lo, 2008). To maintain good health and prevent illness, food

and nutrition must be taken seriously (Koo, 1984; Matocha, 1998; Reid, 1996). Koo (1984) has found that in Chinese culture, some food are deemed as tonic due to their high nutrition, for instance, meats, poultry, seafood, eggs, and animal organs. Food remedies are considered to be natural and balanced, and will cause very few negative effects to the human body (Koo, 1984).

Chinese people also classify food into hot and cold (Koo, 1984; Quah & Bishop, 1996; Reid, 1996). A cold-hot balanced dietary does good to health (Wang, Rosenberg, & Lo, 2008). Chinese people believe that diseases can be cured by using food and medicine with an opposite attribute, and thus, the imbalance inside one's body can be restored (Koo, 1984). For instance, to treat diseases caused by excessive heat, such as cough, nose bleeds, hypertension, and nightmares, people are supposed to have more cooling food and medicine, such as cooling herbal tea (Koo, 1984; Kwan & Holmes, 1999); while for illness engendered by excessive cold, for instance, colds and diarrhoea, people are supposed to have more heating food and medicine (Koo, 1984; Quah & Bishop, 1996).

As such, with diverse methods of health care management, Chinese people, especially Chinese immigrants, have a tendency to resort to self-diagnosis and self-treatment rather than seek help from health care practitioners when they are ill (Chau & Yu, 2010; Matocha, 1998; Wang, Rosenberg, & Lo, 2008). For instance, Wang, Rosenberg, and Lo (2008) have found that most of the Chinese Canadian immigrants manage their health by taking traditional herb-based

Chinese medicine (*Zhong Cheng Yao*) brought from China and eating hot-cold balanced homemade meals. Similarly, Chinese immigrants believe that Western medicines can cure the symptoms of disease easily, whereas only traditional Chinese medicine can treat the root of the disease completely (Cai, 1988; Koo, 1984; Wang, Rosenberg, & Lo, 2008). This belief partly explains why Chinese immigrants underutilize health care services in foreign countries.

Sojourn Experience and Health

With a large influx of international students into Canadian universities and colleges (Higginbotham, 1979; Khawaja & Dempsey, 2008; Mori, 2000), scholars have argued that great attention must be paid to meet the needs of this group (Higginbotham, 1979).

International students, on the one hand, are considered as “cultural carriers and resources” (Sam, 2001, p. 315); on the other hand, they are characterized by academic, socio-cultural, and health problems (Sam, 2001). Scholars have indicated that not only do international students have problems similar to local students such as academic competence, but they also have uniquely culture-based problems, such as adjustment to new “climate, food, living conditions and standards, social values, ways of behaving, styles of learning, and modes of communication” (Westwood & Baker, 1990, p. 251). All of these differences may bring increasing stress to international students (Church, 1982; Higginbotham, 1979; Westwood & Baker, 1990).

A number of scholars have conducted research on the sojourn experience of international students in a multicultural setting (Adler, 1975; Brown, 2009; Church, 1982; Higginbotham, 1979; Sam, 2001; Westwood & Baker, 1990). The concept of sojourner is very important in understanding the experience of Chinese international students in foreign countries (Yang, 2000). Scholars usually view sojourners as temporary residents in a foreign country with specific purposes, such as education (Jandt, 1998). Sojourners are “temporary between-society contact for a duration of six months to five years” (Brown, 2009, p. 504), they uphold “the culture of their own group” (Yang, 2000, p. 235), and live in a foreign country for many years “without being assimilated by it” (Yang, 2000, p. 235; Woon, 1983). For instance, early Chinese immigrants in America were considered as those who “intended to make and save money and then return to their home villages for a better life” (Yang, 2005, p. 235). Sojourners include “immigrants, refugees, business executives, students, and tourists” (Begley, 2000, p. 401).

Church (1982) has noticed early on that there may be a difference between short-term sojourners and potential permanent settlers in their adjustment experience, and thus in his study he dealt mainly with relatively short-term international students. People who plan a short-term sojourn are different from those who plan to settle permanently while adapting to a foreign culture (Begley, 2000). Those who spend a one-week tour only need to know some phrases in the local language, while those who plan a long-term settlement need to master more cultural

knowledge and communication patterns in the dominant culture (Begley, 2000). Begley has also posited that short-term sojourners are “characterized by more uncertainty, confusion, or mistakes concerning appropriate communication behaviour and practices” (p. 402), but long-term sojourners are more adaptive to the dominant culture.

Furthermore, Yang (2005) has argued that the sojourning experience must be understood both from the sojourner’s perspective and the environment of acceptance in the country of his/her sojourn. As Woon (1983) has pointed out, “the Chinese did not go to Canada to sojourn, but rather to settle permanently” (p. 673). Therefore, sojourners in this study are defined as Chinese international students who come to Canada to pursue a high quality education, including those who plan to return to China at the conclusion of their study, those who plan to settle permanently in Canada, and those who are still in their decision-making process of whether to stay or not (Aubrey, 1991; Mori, 2000; Yang, 2005).

In previous studies, scholars have found that international sojourners confront many personal and medical problems (Brown, 2009). Specifically, scholars have argued that immigrants in Canada who come from Asia and Africa may confront adjustment challenges since their cultural backgrounds are distinctive from those of Canada, which may have an influence on the mental wellbeing of immigrants (Ng & Omariba, 2011). However, international sojourners from many cultures are reluctant to seek health care services, especially psychiatric

and psychological services (Higginbotham, 1979; Westwood & Baker, 1990), and they will turn to these health care services “only as a desperate last resort” (Higginbotham, 1979, p. 57). For example, Zheng and Berry (1991) have found that Chinese sojourners actually experience more problems, such as “lower English fluency, lower ease of making friendships, lower subjective adaptation, and more adaptation and communication problems” (p. 451), compared with non-Chinese Canadians and Chinese-Canadian students. In addition, some Chinese international students even have to go back to their home country due to personal health crisis (Fong, 2008), giving up the possibility of obtaining a permanent residence status in their study destinations. In Fong’s (2008) study, a Chinese international student got chronic back pain due to his part-time job as an assembly line worker. The pain was so severe that the student could not maintain sufficient school and job attendance rates, which resulted in his failure to continue his studies. Later, he had to go back to China, without gaining any degree.

Scholars have found that the difficulties international students confront when accessing and utilizing health care services are associated with their sojourn experience (Sam, 2001); moreover, the duration of sojourn is very important in understanding the health status of international students (Neto, 2002).

Most previous studies on sojourners’ health have focused on international undergraduate students (Zheng & Berry, 1991). While national reports on international students in Canada have

revealed that there is an increasing trend in international graduate students which account for 42.5% of all international students in 1989; Chinese international students from Mainland China were the largest group of international graduate students in Canada from 1985 to 1989 (Zheng & Berry, 1991). Accordingly, scholars have called for studies with a focus on Chinese graduate students from Mainland China to better understand these sojourners' experience (Zheng & Berry, 1991). Moreover, Zheng and Berry (1991) have also indicated that Chinese international students from Mainland China may preserve more traditional Chinese culture than those in Hong Kong and Taiwan; therefore, there is a necessity to conduct further theoretical and empirical studies to look into how Chinese sojourners from Mainland China interpret health, and how traditional Chinese cultures influence their health beliefs and practices, which leaves space for this study. Hence, this study aims to examine how traditional Chinese culture influences the way Chinese international students access and utilize health care services in Canada.

The following section is a discussion of the theoretical framework that this study used to understand Chinese international students' health-seeking attitudes and behaviours in Canada.

Theoretical Framework

A growing number of scholars have developed different theoretical frameworks to understand communication between people with diverse cultural backgrounds (Wiseman, 1995). For instance, Gudykunst's (1995) Anxiety/Uncertainty Management (AUM) theory offers

explanations of intercultural effectiveness in various contexts; Baldwin and Hecht (1995) elaborate on the conceptualization of cultural intolerance (e.g., racism, sexism); Communication Accommodation Theory developed by Gallois et al. (1995) focuses on intercultural adjustment and adaptation; and Cross-Cultural Adaptation Theory (Kim, 1995) examines the process and structure of cross-cultural adaptation in which individuals adapt to a new and unfamiliar culture. However, scholars have posited that the complete application of these Western-based theories to other cultures is “inappropriate, and in some cases actually cause more harm than good” (Witte & Morrison, 1995, p. 217). Accordingly, Witte and Morrison (1995) have proposed an intercultural health communication model, which is employed as the theoretical lens in this study.

The intercultural health communication model developed by Witte and Morrison (1995) is based on five dominant health communication theoretical approaches – The Health Belief Model (HBM), Social Cognitive Theory (sometimes called Social Learning Theory), Fear Appeal Theory, Applied Behavioural Analysis, and Prochaska’s Stages of Change Model. Within these five health communication models, Witte and Morrison have identified three key general variables that influence people’s health-related attitudes and behaviours: (a) perceived threat, the degree to which one feels at risk for a severe threat (e.g., “I am vulnerable to the deadly HIV”); (b) perceived efficacy, consisting of self-efficacy (the degree to which one feels able to take a

recommended action to avoid a health threat, e.g., “I am able to use condoms to prevent AIDS”) and response efficacy (the degree to which one believes a recommended response effectively averts a health threat, e.g., “Using condoms prevents AIDS”); (c) barriers, or the perceived barriers of performing a recommended response, physiologically, physically, or financially (e.g., “Condoms cost too much, reduce sensation, and are difficult to obtain”) (p. 238). In addition, two cultural variables are added to the model: fatalism and family values. These two cultural variables are believed to interact with the above three variables and influence health-related decisions for non-Westerners.

The intercultural health communication model has been employed in existing studies to examine cultural influences on people’s health-related behaviours. For instance, Mullin, Cooper, and Eremenco (1998) have argued that in a non-Western context, health care providers need to “develop an awareness of traditional beliefs and how these may impede patients from following Western medical treatment” (p. 80).

The intercultural health communication model explains, in order to “effectively motivate health promotion behaviours, communication strategies should emphasize low barriers, high efficacy, and moderate to high levels of threat” (Witte & Morrison, 1995, p. 245). Accordingly, using this theoretical framework, this study assumes that the reasons why many Chinese and Chinese immigrants in North America delay or avoid seeking health treatment can be attributed

to: (1) low efficacy of health-related behaviours; (2) high barriers/perceived barriers to access and utilize health care services; (3) influences of traditional Chinese medicine and Chinese cultures. Moreover, Witte and Morrison (1995) have argued that cultural differences between health care practitioners and patients can result in “miscommunication, misunderstanding, and poorer health” (p. 246). All of these factors were taken into account in drafting the interview guideline and data analysis phase to facilitate the understanding of health-seeking attitudes and behaviours of Chinese international students in Canada.

It can be seen from the above literature review focusing especially on an overview of health communication and culture, ethnicity and utilization of health care services, and barriers/perceived barriers to health care services that, Chinese people confront multiple barriers and perceived barriers when attempting to access and utilize health care services in a foreign country. Chinese people may have language proficiency problems, financial concerns, and many other obstacles, all of which may hinder them from obtaining quality health care services.

However, in the existing literature, few studies have shed some light on Chinese international students in a multicultural setting like Canada. Clearly there is room for greater reflection on how Chinese international students access and utilize health care services and their perceived barriers to quality health care services in Canada. Accordingly, two research questions are posed:

RQ 1: What role does culture play in Chinese international students' health-seeking attitudes and behaviours in Canada?

RQ 2: What are Chinese international students' barriers/perceived barriers to quality health care services in Canada?

Chapter Summary

Chapter two provided a review of relevant literature on the topic of health-seeking experience of Chinese people in a multicultural setting. The literature review also discussed Witte and Morrison's (1995) model of intercultural health communication and explained the concepts in the theory, and argued for using it as a theoretical framework for this study. Based on the literature reviewed, the research questions guiding this thesis were posited.

In the following chapter, the methodology to carry out this study is described.

Chapter 3: Methodology

This study employed a qualitative approach, mainly, semi-structured in-depth interviews to understand Chinese international students' health-seeking attitudes and behaviours in Canada.

A qualitative approach enables the researcher to “study selected issues in depth and detail” (Patton, 1990, p. 13), which is particularly suited to understand “subjective experiences of health and disease;” structural and cultural influences on health-related behaviours; and patients' interactions with health care providers (Blignault et al., 2008, p. 182). In-depth interviews are usually used to seek deep information and understand people's experience and feelings, and how participants interpret that experience (Gubrium & Holstein, 2002; Patton, 1990; Seidman, 1998), which involves very personal matters such as “an individual's self, lived experience, values and decisions, occupational ideology, cultural knowledge, or perspective” (Gubrium & Holstein, 2002, p. 104). Semi-structured interviews also help explore the perceptions and opinions of individuals regarding “complex and sometimes sensitive issues and enable probing for more information and clarification of answers” (Barriball & While, 1994, p. 330). Thus, this study integrated semi-structured and in-depth interviews to better and further understand Chinese international students' health and illness experience and cultural influences on their health-seeking attitudes and behaviours in Canada.

Participants

Interview participants in this study were recruited by advertisements sent through the International Student Office of the University of Ottawa and the researcher's personal network (see Appendix A for the recruitment text). Snowball sampling technique (one participant leading to another) was also employed to select participants (Gubrium & Holstein, 2002; Seidman, 1998). Although fourteen Chinese international students were recruited, only twelve agreed to participate in the one-to-one interviews. Therefore, twelve Chinese international students studying in universities and colleges in the Ottawa area participated in the study. The participants' age ranged from 21 to 27 years, among whom, nine were female, and three were male. It has been found in existing research that "female students outnumbered male students" in most university disciplines in Canada (CAUT, 2011, p. 1). In 1998-1999, over 52% of the 22,000 graduate students in Canada who received their Master's degree that year were female (CAUT, 2011). Female students now comprise more than sixty percent of Canadian university students (CAUT, 2011). These facts may help to understand the gender distribution in this study.

The study was approved by the Research Ethics Board (REB) of the University of Ottawa. The participants were told that their participation was completely voluntary and that they would not receive any compensation. In case any of the participants experienced emotional or psychological discomfort caused by the study, the researcher provided the contact information of

the on-campus health clinic in order to minimize such a risk or at least to help the participants cope with such feelings.

Data Collection

Data reported in this study was generated through participants completing one-to-one semi-structured in-depth interviews, ranging from 14 to 54 minutes (see Appendix B for the interview guide). Upon REB approval, participants were assigned to interviews at their convenience. Informed consent forms were gained from each participant before conducting the interviews (Keyton, 2006) (see Appendix C for the informed consent form). All of the interviews were recorded by a digital voice recorder. Interviews covered general demographic information, participants' perceptions about health and illness, their interactions with health care providers and services, and the perceived barriers/barriers in their health-seeking process. Despite the use of a semi-structured interview protocol, the interviews applied mainly open-ended questions to access the perspectives of participants (Baxter & Babbie, 2004; Patton, 1990; Seidman, 1998). Since all of the participants and the researcher were from Mainland China, the interviews were conducted in Mandarin, the official language in People's Republic of China, to ensure the participants could feel free to express themselves. After conducting the interviews, the researcher transcribed the interviews verbatim using a computer-based word-processing program (Seidman, 1998). The researcher verified the transcripts against the recordings and translated them into

English (Keyton, 2006). The copies of transcriptions (both in Chinese and English) were sent to the participants to verify the accuracy through e-mail (Hesse-Biber & Leavy, 2008), and the participants could make revisions or exclude any part that made them feel uncomfortable (Seidman, 1998). To protect the anonymity of the participants, participants' identities were kept private, and pseudonyms were used in the final report (Hoffman, Novak, & Peralta, 1999; Seidman, 1998). During the data collection process, the researcher kept a journal of ideas and thoughts as an on-going log of the interview process.

Data Analysis

Data analysis consists of examining, coding, and recombining evidence to draw conclusions (Yin, 2009). In this study, thematic analysis was employed to analyze the interview data (Howitt & Cramer, 2008). As one of the “most commonly used methods of qualitative analysis,” thematic analysis can help the researcher to identify a certain number of themes which “adequately reflect their textual data” (Howitt & Cramer, 2008, p. 333).

After the researcher had completed data collection, the data were subjected to thematic analysis (Langdrige, 2004). The researcher examined the interview transcripts in detail by performing a thorough reading of the data several times to obtain a general sense of the information and its overall meaning (Baxter & Babbie, 2004; Creswell, 2009). Then, participants' responses that were related to research questions and interview questions were highlighted on the

computer with a different colour (Howitt & Cramer, 2008), and coded into categories and subcategories according to their different themes (Creswell, 1998; Deng, 2008; Seidman, 1998). After that, the researcher identified themes on the basis of those codes, for instance, perceptions of health and illness, barriers/perceived barriers, self-treatment, and sojourn experience and health. Direct quotations were employed to reflect participants' perceptions, thoughts, and experiences (Patton, 1990).

Validity

Validity, also known as credibility, is very important to qualitative research (Keyton, 2006). According to Creswell (2009), validity in qualitative research means that “the researcher checks for the accuracy of the findings by employing certain procedures” (p. 190). Accordingly, in this study, the researcher employed two methods to ensure validity.

The first method was data triangulation (Keyton, 2006). The researcher compared and cross-checked the consistency of data from different sources, interview transcripts and research journal, to assure consistency of the findings (Creswell, 2009; Keyton, 2006; Patton, 1990). The second method employed was member-checking, or member validation (Baxter & Babbie, 2004; Creswell, 2009; Keyton, 2006). Member-checking took the research findings or analysis back to the same participants (Baxter & Babbie, 2004; Creswell, 2009; Keyton, 2006). Interview

transcripts were shown to each participant to allow them an opportunity to verify the findings and interpretations (Baxter & Babbie, 2004).

Limitations

There are several limitations that need to be taken into consideration in assessing the study. First of all, the size of the sample is relatively small. All the participants are from specific universities and colleges in the Ottawa area and may not be representative of the population as a whole. Second, the participants' age ranged from 21 to 27 years, which is quite restrictive to the findings of the study. It is likely this study would not reflect other barriers/perceived barriers confronted by Chinese international students of different ages in Canada. Third, in this study, participants' health-seeking behaviours were assessed mainly through face-to-face semi-structured in-depth interviews. It is likely that other factors that inhibit Chinese international students in Canada from obtaining quality medical treatment may not be revealed through interviews only (Lim & Tan, 2001).

Chapter Summary

This chapter outlined the methodology employed to conduct this study. By describing the specific procedures, data collection and analysis methods, and the limitations, a clearer understanding of the research design has been presented.

All twelve participants in the study were Chinese international students who were studying in Canadian universities and colleges in the Ottawa area. They were recruited by advertisements sent through the International Student Office of the University of Ottawa and the researcher's personal network. By discussing the pros and cons of the procedures, data collection, and data analysis, the chapter provided a justification for adopting semi-structured in-depth interviews.

In the following chapter, the results of this study will be reported and analyzed.

Chapter 4: Results and Analysis

Twelve participants were recruited for this study, among whom, nine were female, and three were male. The participants' age ranged from 21 to 27 years. All of them were from the People's Republic of China (Mainland China). Three of them were undergraduate students and the other nine were graduate students. Ten participants were employed, including as research assistant, teaching assistant and part-time jobs. Two participants had no employment. All of the participants in this study had health insurance (see Appendix E Table 1 for participants' full demographic characteristics).

The purposes of this study were: 1) to explore the ways Chinese international students seek medical treatment in Canada; 2) to find out barriers/perceived barriers, if any, for Chinese international students to obtaining quality health care services in Canada; and 3) to understand the influences of Chinese culture on Chinese international students' search for medical treatment. To this end, semi-structured in-depth interviews were conducted, which ranged from 14 to 54 minutes. The data was subjected to the thematic analysis method (Langdrige, 2004). The data were coded into thematic categories and subcategories (Creswell, 1998; Deng, 2008; Seidman, 1998). Accordingly, the data was examined in detail to obtain a general sense of the information and its various themes (Baxter & Babbie, 2004). These themes emerged in the process of examining the data, and were coded until they reached saturation point (see Appendix D for the

thematic analysis data chart). Finally, four main themes were identified, perceptions of health and illness; barriers/perceived barriers to health care; self-care management; and influence of sojourn life on health. The theme perceptions of health and illness includes two sub-themes, food and traditional Chinese medicine. The theme barriers/perceived barriers to health care includes two sub-themes, structural and cultural barriers.

Perceptions of health and illness

Participants' responses to the question as to how they perceived health revealed their high regard for health. Many participants described that health issues play a significant role in their daily lives. For instance, Terry indicated that good health meant everything to him. Terry explained that without good health, he would be unable to maintain a normal student life, which would in turn affect his timely graduation and the search for a job. Grace and Henry shared similar feelings. Henry remarked that good health ensures he has "the strength to take part in all activities." Grace indicated that without good health, she would not be able to enjoy anything, even if earning a lot of money.

When talking about the causes of diseases, many participants' responses revealed the influence of traditional Chinese culture on their health-related attitudes and perceptions. In traditional Chinese culture, diseases are considered to be caused by both internal and external factors (Bond, 1993). Internal factors comprise personal habits, emotional changes, fatigue,

irregular diet, and daily routines. External factors refer to weather or environmental changes, and viruses. Both internal and external factors can lead to imbalances within an individual's body, resulting in disease (Bond, 1993). Remarkably, many participants believed that diseases are caused by both internal and external influences. As Sunny stated as follows:

If your daily routine is not very regular, for example, you often stay up late, then you may have a stomach ache; or if there is a classmate getting a cold or fever, then it may affect many students in the class; and also people's own problems, such as wisdom teeth, which is not comfortable, but it is their own physical problem.

Like Sunny, Grace also believed that many factors could cause disease, "for instance, if you do not take good care of your body, or if there are some changes in external circumstances, or if you are experiencing a lot of work and life pressure, then you will probably get sick," stated Grace. Cindy shared a similar thought. Cindy noted that "on the one hand, diseases may be caused by personal habits; on the other hand, they are related to the environment."

Food

Food is an important concept in Chinese culture. Willa explained that *ying* foods can reduce the fire in the body, while *yang* foods are tonics that nourish the body. "They are complementary," explained Willa. Cindy also stated that there are *cold* and *hot* food in TCM, which can do harm to one's health if one does not pay attention. Cindy explained that "during menstrual period, girls cannot take *cool* food, such as watermelon, and crabs." Cindy's thoughts were shared by Ilene, who indicated that she always drank hot water. Even in summer, she never

bought iced drinks. Similarly, Yvonne also expressed that Canadians usually take cold food, such as sandwiches and iced drinks, while Chinese are used to taking hot and warm food, which is quite different. Larry indicated that when he got a cold, he would usually make some ginger soup to drink. Ginger is considered *hot* food in TCM, which can cure diseases such as cold and diarrhea. Some participants, Grace, Sunny, and Yvonne, expressed that they paid much attention to food and nutrition. Yvonne stated that she took three meals on time every day. These three participants believed that it is very important to take a certain amount of vegetables, meat, and fruits every day. “Keeping a balanced diet can improve our immunity,” explained Sunny.

Traditional Chinese Medicine

It was interesting to note that although most of the participants were quite young, ranging from 21 to 27 years old, many participants were quite familiar with traditional Chinese medicine (TCM) concepts and knowledge, such as *yin-yang* balance. *Yin-yang* balance, a Taoist concept, plays an important part in traditional Chinese medicine. Kelly explained that the *yin-yang* balance means “all the things in the world are in balance, such as a balanced diet, and a balance between work and rest. All of these can be regarded as *yin-yang* balance.” Yvonne pointed out the basis of TCM: “males are *yang*, or the sunny side is *yang*; females are *ying*, and the shaded side is also *ying*.” Henry explained the *yin-yang* balance in a more detailed way:

Yin-yang balance is a state of harmony, that is, each body has all kinds of conflicts inside. When these conflicts maintain a balanced and harmonious state, then you can maintain a

healthy state; however, if some conflicts grow out of proportion causing an imbalance, health problems may occur due to this imbalance.

Henry's description of *yin-yang* balance was shared by another participant, Peggy. Peggy explained that in the TCM, *yin-yang* includes five elements: metal, wood, water, fire, and earth. They mutually benefit and isolate, dictated by nature's reciprocity principle. Peggy added that in TCM, when people get sick because they have too much humidity inside the body, then traditional Chinese doctors will remove the humidity through the Cupping Therapy and acupuncture.

However, when talking about another concept in TCM, *qi* (which means energy in English), most of the participants were not familiar with it. Only two participants had some knowledge of it. Grace noted that *qi* means blood circulation, or blood flow. Grace indicated that according to TCM, *qi* is smooth, a concept which was quite abstract to her. Terry explained *qi* in a more concrete way. *Qi* can be viewed as a state of mind. In Chinese culture, *qi* also represents anger. If one gets angry, that means one has too much *qi* inside his/her body, so that he/she will *Shengqi* (get angry). Terry further explained that if one's *qi* is smooth, then he/she is happy. *Qi* is also an aspect of *yin-yang* balance in TCM. Terry noted that people should not get angry every day since the *qi* that people generate when they are angry does harm to their body and health.

The majority of the participants exhibited a favourable opinion of traditional Chinese medicine (TCM). Participants believed that TCM has many advantages compared with Western

medicine. In Sunny's view, TCM regards the body holistically, emphasizing harmony. Sunny explained as follows:

There are a lot of acupuncture points in our hands and feet, and they are related to many parts of our body. As a result, a traditional Chinese doctor can identify problems within a patient's body simply by pressing particular locations on the patient's hand(s).

Sunny further shared her mother's experience of consulting a traditional Chinese doctor in China. One time, her mother felt a stomach discomfort. Sunny's uncle was a traditional Chinese doctor, and he went to see her mother. Her uncle just looked at her mother's face and tongue, and felt her pulse, and then he asked her whether she had been angry a lot recently, and if she felt tired and so on. Sunny added that her uncle only had a brief look, found some symptoms, and then prescribed some traditional Chinese medicine. After taking those prescriptions, Sunny's mother recovered very quickly.

Similarly, other participants described many advantages of TCM. Henry indicated that compared to Western medicine, TCM is not that effective that immediately, but it usually takes a more mild way, such as stimulating a certain part of one's body to resist diseases through medicines or acupuncture. Another participant, Larry, explained that traditional Chinese medicine emphasizes harmony. "There are no such things as surgery in TCM, since traditional Chinese doctors usually redress patients' *yin-yang* balance through traditional Chinese medicine rather than surgical operations," stated Larry.

Other participants believed that Western medicine had its advantages as well. They indicated that Western medicine was very efficient. Ilene believes that Western medicine could alleviate symptoms very quickly. Ilene also noted that Western medicine could provide a lot of information by means of medical tests and let patients know their health status, which could be more accurate than TCM.

However, the majority of Chinese lay people believe that Western medicine can cure only the superficial symptoms of diseases (Koo, 1984), while traditional Chinese medicine is competent in curing diseases at the root (Cai, 1988; Koo, 1984; Wang, Rosenberg, & Lo, 2008). Participants in this study were no exception. For instance, Sunny suggested that Western medicine provides only “a temporary medical relief.” “Western medicine could only cure where it hurts,” she added. Peggy also indicated that she always believed in what TCM emphasizes: “the human body as a whole.” Peggy explained that “you may have a liver problem, and it can be reflected in the color of your face, but the root cause still lies in the liver rather than on the face. Western medicine sometimes can cure only the surface problem.”

TCM was believed to have smaller side-effects on the human body compared with Western medicine. Terry indicated that once he had a headache, and so he took some Western medicine. However, the medicine made him feel dizzy and nauseous. “It was really terrifying; traditional Chinese medicine will not make you feel so awful,” stressed Terry.

Grace posited that TCM can also provide spiritual support. Grace revealed that she suffered from hair loss a short time ago. After she had tried everything, she still could not find a way to deal with the problem. Hence, Grace told her mother about her problems and asked her mother to see a traditional Chinese doctor in China. After that, Grace's mother got a prescription from a traditional Chinese doctor and mailed those traditional Chinese medicines to Grace. "Taking the traditional Chinese medicine has a function of comforting your concerns. As I have taken the medicine, I think I will get better soon," Grace explained. Terry shared similar feelings. Terry indicated that traditional Chinese medicine "build up one's health physically and spiritually." As Terry explained, "not only does TCM restore your physical health, the point is that it makes you set your own beliefs. When you drink the medicine, though bitter, you will think that you are going to get better."

These accounts highlight the fact that most of the Chinese international students in Canada in this study happen to be greatly influenced by traditional Chinese culture. Many participants indicated that they maintained their health according to their TCM knowledge. For instance, Terry stated that in TCM, being angry can do harm to one's physical and mental health. Therefore, he tried not to get angry a lot, and stayed calm. However, in the current study, although most participants described that TCM had many advantages, participants did not exhibit a particular preference for TCM. On the contrary, many participants stated that they would rather

rely on Western medicine when they were ill because of its high efficiency. In Terry's view, Western medicine is "better in curing tricky diseases," since "traditional Chinese medicine will take at least half a month for recovery." Willa also indicated that TCM usually took a long time to recover, which could be a problem, since people all wanted to recover as soon as possible.

Willa's feelings were shared by Peggy, who stated that most of the doctors in hospitals practiced Western medicine. Therefore, people are used to taking Western medicine. Other participants indicated that they would decide which medicine to take based on which diseases might befall them. Grace explained that if she had a cold or fever, then she would definitely go to see a Western doctor; but if she had some respiratory or chronic diseases, or if she wanted to condition her body, then she would go to see a traditional Chinese doctor. Similarly, Larry said that if he got some injuries, then he would see Western doctors. Both Grace and Larry admitted that generally they would see Western doctors and take Western medicines.

When asked about TCM in Canada, many participants indicated that they did not know the location of traditional Chinese doctors. While many others stated directly that they do not trust TCM in Canada for various reasons. Ilene was concerned that TCM treatment in Canada might be very expensive. Ilene's concerns were shared by Grace, who stated that TCM is not covered by the Canadian health insurance, which was part of the reason why she did not consult a traditional Chinese doctor.

Peggy shared her concerns: “I dare not trust TCM in Canada; I have a sense of alienation.

Those doctors are not in China, they are from China, so I don’t know if their medical background is real.” Similarly, Terry indicated that some of his friends had an experience of seeing a traditional Chinese doctor in Canada, and it was not well received. Therefore, the controversy about the reputation became part of the reasons why participants did not prefer TCM in Canada.

Grace shared her experience of seeing a traditional Chinese doctor in Canada. Grace explained that her boyfriend Ben twisted his ankle a long time ago. Ben knew a very famous traditional Chinese doctor in Toronto, so Ben and Grace drove to Toronto to see the doctor. The doctor put Ben’s ankle back to its original joint, and applied some traditional Chinese medicine on Ben’s ankle. The next day, Ben was able to walk as usual. Grace commented that the reputation of a doctor was very important. Grace further explained that she would go to visit a traditional Chinese doctor only if he/she had good reputation.

Barriers/perceived barriers to health care

For the purpose of this study, participants were asked about their health-seeking experience in Canada. Participants’ experience with access to and utilization of health care services in Canada were examined, and barriers and perceived barriers were evident. These barriers and perceived barriers to Canadian health care services in this study can be divided into two categories: structural and cultural barriers. Structural barriers were examined through seven

aspects, including lack of information, long waiting time, affordability, health insurance, location, improper treatment, and identity as Chinese international students; cultural barriers were examined through five aspects, including language, health beliefs, low level of cultural competence among health care practitioners, self-treatment, and sojourn experience and health.

Structural barriers

Lack of information. Many participants described experiencing some degree of lack of information in their health-seeking process. Ilene stated that after staying in Ottawa for more than one year, she was still not familiar with the health care issues in Canada. Ilene did not know how to visit a doctor in Canada. Her relatives told her that in Canada, everyone had his/her family doctor; but Ilene did not know if she could have a family doctor as an international student.

Lack of information about the Canadian health care system was also true of many other participants. Kelly described that after she had obtained her health card at the beginning of her first semester, she never had the opportunity to use it since she “did not know how to see a doctor in Canada.” Later, her friend told her that one can use the health card to have a physical examination, and then Kelly went to the on-campus health clinic in her university. In addition to the advice and information provided by friends, some participants also sought pertinent information via the Internet.

Under such circumstances, participants turned out to be unfamiliar with the Canadian health care facilities and procedures. Sunny once suffered from a high fever and went to a walk-in clinic to see a doctor. However, she was not aware that her follow-up visit could only be conducted with the same doctor. Late that night her fever began to worsen. However, when she went back to the clinic again, she was told by the nurse on duty that she could only see the same doctor, but the doctor was off work at that time. Sunny was told that she could not see another doctor in the clinic. “I was very unhappy,” Sunny stated, “my temperature was thirty-nine degree at that time, but I could not see any other doctor in the clinic; and the nurse told me that the rise of the temperature was normal, which made me even angrier.” Sunny further noted that sometimes the Canadian health care system is not very user-friendly. “What shall I do when I am very sick but the doctor is not in the clinic?” Sunny was still quite concerned with that matter.

Besides a lack of information, participants occasionally felt that they had been misled by medical staff. Larry shared his friend’s experience of seeing a doctor in Ottawa. Once his friend twisted his wrist, and then he went to see a doctor. After taking an X-ray, the doctor told him that the X-ray was not covered by the health insurance, so Larry’s friend had to pay for it. The cost of the X-ray was about thirty dollars. Although it was not so expensive, the fact that it was not covered by the health insurance made Larry’s friend quite angry, because he thought the doctor should have told him about the cost before taking the X-ray.

International students in Canada are required to purchase the University Health Insurance Plan (UHIP). Some participants stated that they knew relatively little about the health insurance. In one case, Ilene had obtained a health card from her college. However, she did not know the cost of the health insurance itself, not to mention the extent of the coverage. Ilene stated that she hoped her college could offer some help. As she noted:

Universities that have foreign student enrolment should have an information session explaining the Canadian health care system, and the process students should become familiar with should they become ill.

Larry's experience, although different, revealed that his feelings were similar to Ilene's when accessing health care services in Canada. Larry indicated that he could not find a source of health-related information. "Even if we could ask our friends, not everyone had the experience of visiting a doctor in Canada, and they did not go to any other place to see a doctor besides the on-campus health clinic," explained Larry.

Similarly, Henry stated that his University never informed students about health insurance or health care options. Many participants wished that their educational institutions would offer assistance on the matter of the Canadian health care system and procedures. Ilene stated that "it is not easy for an international student to study and live alone in another foreign country." She hoped that someone could explain the health issues to them. "After all, it is about our health, and it is a life-death problem," as Ilene expressed. These concerns echoed those noted by other

participants. Sunny noted that many Chinese international students did not like to check information on the Internet, because the information was not sufficient and helpful; thus, she hoped that the international student office could offer more detailed information directly to students, rather than asking them to “visit the following website for further information.” In this way Sunny explained that, international students would better know how to make use of their health insurance card, and which fees or charges can be reimbursed. On this matter, Larry suggested that the university could list necessary and important information on the Canadian health care system and procedures through the university website, or they could “send that information to students’ university mailboxes.” These possible measures suggested by participants provide a number of ways that can help Canadian health care system improve international students’ health-seeking experiences.

Long waiting time. Most participants complained that the waiting time in Canadian hospitals and clinics was too long, and the overall efficiency was much slower than in China. Peggy stated that in China, patients might have to wait one or two hours before seeing a doctor, but at least they could see the doctor on the day they went to the hospital. Wherever in Canada, they had to make an appointment in advance so that they could possibly see a doctor two or three months later, which was quite a long waiting time. Even though they made an appointment, they still had to wait for quite a long time to actually see a doctor. Additionally, Willa indicated that perhaps

Chinese doctors “are not as cautious and responsible as Canadian doctors, so they are faster.”

Willa further explained that “but you grow up in China, and you find doctors can still cure diseases in that environment, so that you will wonder why it cannot be faster in Canada.” In fact, many participants experienced the same problem of long waiting time when accessing and utilizing health care services in Canada. In one case, Grace had some allergy problems in July, 2010, so she went to make an appointment with a doctor. She was transferred by the on-campus health clinic to another clinic. However, she had to wait several months before finally seeing a doctor. Grace further stated that when she went to see the doctor on that day, she had to wait at least twenty minutes between procedures. Grace also shared her first experience of going to an emergency department in a hospital in Ottawa, a few days after having arrived here for the first time. She had accidentally cut her finger. It was quite severe, so Grace rushed to the emergency department as soon as she could. She arrived at the hospital at about 12 o’clock, but she waited six hours before she could finally consult a doctor. During all that time, Grace’s wound kept bleeding. “The waiting time was particularly long,” Grace reiterated.

Kelly shared similar experiences with long waiting time. Kelly once had knee pain, and she went to visit a doctor. Since many patients were there that morning, the receptionist transferred her to another nearby clinic and Kelly was scheduled to see the doctor in the afternoon on that day. However, when Kelly arrived at the second clinic during the afternoon, she still had to wait

more than half an hour before actually seeing a doctor. “As far as I know, even if you have a serious disease or need a surgery, scheduling an operation might still require up to six months,” Kelly said with exaggeration.

Kelly’s description of the long waiting time was shared by other participants in the study.

Yvonne found that the waiting time in the emergency room was long as well. Yvonne once accompanied her friend Nancy (whose osteomyelitis had recurred) to the emergency room at the biggest hospital in Toronto. Arriving around 9 p.m., they had to wait more than three hours.

Yvonne stated that the efficiency in the emergency department was very slow. “There were not enough doctors to serve even the few patients awaiting treatment,” said Yvonne. After more than three hours, Yvonne and Nancy finally saw a doctor, but the doctor only took a film and then sent them home, without prescribing any medicine to alleviate Nancy’s pains.

As a matter of fact, according to many participants, the long waiting time made it inconvenient to visit a doctor, leading to their reluctance to consult a doctor when ill. When Lucy was ill, she did not want to go to see a doctor because it was really inconvenient due to the long waiting time; she did not want to wait for such long time when she was ill. “You have to make an appointment in advance, which usually takes at least two days before you can see a doctor,” explained Lucy. However, due to the unpredictability of diseases, most participants stated that it was hard to master the timing. Cindy stated that “we need to make an appointment early before

seeing a doctor, but the problem is, we cannot predict whether we will get sick in the next one or two weeks.” Cindy went on to describe how tricky the problem was to make an appointment early before she got ill. Therefore, when Cindy went to see a doctor on the scheduled day, she already recovered.

Many participants expressed a wish that the waiting time in Canadian clinics could somehow be shortened. Specifically, in two cases, participants expressed their willingness to pay a fee to reduce the long waiting time. For instance, Sunny suggested that Canadian government could open some private clinics. Sunny was willing to spend some money to get better health care services rather than waiting two or three hours in the hospital. Sunny’s feelings were echoed by Willa, who is also willing to pay additional money to “see a doctor sooner rather than having to wait.”

These accounts have highlighted the long waiting time as one of the biggest structural barriers to participants when accessing and utilizing health care services in Canada. Additionally, the long waiting time led to participants’ reluctance to utilize health care services in Canada.

Affordability. Canada implements a universally public health care system (Asanin & Wilson, 2008), and international students are required to purchase the University Health Insurance Plan (UHIP), but many participants in this study still had some financial concerns when accessing and utilizing health care services.

Due to the unfamiliarity with the health insurance, several participants described their confusion with the extent of the health insurance coverage. In one case, Ilene described that she once went to an on-campus health clinic to treat a toothache. The doctor took an X-ray of Ilene's teeth, and examined all her teeth. However, Ilene later found that she did not have a dental insurance. The health insurance that she had at Algonquin College did not cover dental treatment. Ilene further explained that the college might have mentioned that during the orientation, but at that time her English was very poor, so she could have missed vital information. As a result, Ilene had to pay the \$280 fee herself.

Under such circumstance, some participants expressed their willingness to go back to China to go through necessary tests and treatment. For instance, Peggy chose to go back to China to pull out her wisdom teeth. "The price of seeing a dentist in Canada is really high," explained Peggy, "having my two wisdom teeth removed might cost me nearly \$900 Canadian dollars. Although my health insurance covers probably 75% of this, I would still need to pay about \$200." Peggy added that in China the same procedure costs only \$100 Canadian dollar; therefore, she decided to have her wisdom teeth removed in China.

Additionally, several participants expressed their concerns of the fees of consulting a doctor. Ilene stated that she was worried that visiting a doctor in Canada might be very expensive, and this cost became part of the reasons why she did not go to see a doctor in the past year in Ottawa.

Health insurance. Many participants described the necessity of having health insurance in Canada. Terry observed that students under UHIP can consult a doctor without having to pay directly for treatment. However, due to his status as an international student, he had to spend a lot of money to purchase health insurance. Several participants expressed their concerns with the high cost of health insurance. As Lucy described, “it is quite expensive to see a doctor in Canada. Of course our health insurance covers a lot, but that’s because we have paid so much for it.” Similarly, Peggy indicated that health insurance became quite expensive, especially for international students, since they “already have to pay more tuition fees than domestic students do, and still have to spend so much money on the health insurance.”

Some other participants noted that they seldom had the necessity to consult a doctor, but they were still required to pay for the health insurance, which to them was unacceptable. “Many Chinese international students take a lot of medicine from China when coming to Canada,” explained Lucy, “so the price of the health insurance is very expensive if we do not use that.”

Even though the price was considered quite high, some participants still found it necessary to have health insurance in Canada; otherwise, they might not be able to afford seeing a doctor in Canada, so they chose to accept it.

Participants suggested that the health insurance could be purchased voluntarily or in a different way. Yvonne explained that she seldom gets sick, thus she rarely needs the coverage

provided by UHIP. Hence, she indicated that student membership under UHIP should be an elective decision, rather than a mandatory requirement. Terry shared the same opinion: “I want the health insurance to be voluntary rather than mandatory; or at least, we should be permitted to buy health insurance for each semester as needed, rather than for an entire year.”

Participants found that the UHIP could only be accepted in certain clinics and hospitals, which they found to be inconvenient. In Willa’s words, international students, as a group, are vulnerable. Therefore, they wish that the UHIP would not only be accepted at the on-campus health clinics, but at other clinics and hospitals as well.

Location. In only one case, Larry indicated that he did not know where the on-campus clinic of his university was located. Other participants stated that they usually went to on-campus health clinics to see a doctor. When asked about the influence of the location, all participants noted that the location had nothing to do with visiting a doctor. Grace noted that she once met her classmate at the clinic, but her classmate did not ask her anything about her disease. “It is normal to get sick; people will not ask you embarrassing questions,” Grace explained. Sunny made similar observations by indicating that the fact that clinics are usually located in shopping mall plazas brought much convenience to her, since she could “take buses to get there.” Terry’s explanation revealed that his feelings were similar to Grace and Sunny. Terry described that he

would even ask a friend to carry him to the hospital when he was very ill. “That is a place that we must go to when we are very ill. Who cares where it is?” said Terry.

These accounts suggest that the location of health clinics had limited to no influence on participants’ health-seeking attitudes and behaviours.

Improper treatment. Several participants believed that they were subjected to improper treatment and misdiagnosis when utilizing health care services in Canada. For instance, Grace accidentally injured her finger a few days after she came to Ottawa for the first time. Although she managed to get to the nearest emergency department in a hospital as soon as possible, she waited for six hours to see a doctor. Moreover, Grace complained that the doctor there did not give her stitches even though she asked for it. The doctor only gave her a bandage. “It was revealed later that the doctor did not treat me properly because the scar left by the cut is particularly obvious, and when the weather changes, the wound will itch,” revealed Grace.

Terry also shared his experience of being misdiagnosed. Early in 2010, Terry kept getting many lumps on his body, so he went to the on-campus health clinic in his university to consult a doctor. Terry elaborated that “after viewing my condition, the doctor could not give an explanation. She just simply gave me a prescription of some anti-allergy medicine, and I took the medicine for quite a long time, but my condition did not improve.” However, later, Terry found that he did not have any allergy; rather he was bitten by bed bugs. After disinfecting his bed, he

was fine. “To be frank, the doctor did not help me with anything,” Terry indicated; yet, Terry explained that this situation might be due to the doctor’s lack of experience of dealing with such problems, which he could understand.

Identity as Chinese international students. With regards to their status as Chinese international students, several participants stated that they did not experience related barriers to health care services in Canada. They did not experience any identity-related discrimination when accessing and utilizing health care services. Other participants believed that their identity as Chinese international students resulted in some cultural barriers when utilizing health care services in Canada, such as language proficiency, which in turn led to doctor-patient communication difficulties. Yvonne responded that as an international student, the biggest inconvenience was the language problem. “You think that you have made your point, but you are not sure whether health care providers understand what you are talking about,” shared Yvonne.

Moreover, participants acknowledged that as international students, they were unfamiliar with the Canadian health care system, which to some extent influenced their effective access to and utilization of health care services. Ilene indicated that as an international student, she felt lost when accessing and utilizing Canadian health care services. “I do not even know where to see a doctor. In China, we all went to hospitals rather than a clinic when we were ill since the quality of clinics was not considered as good as hospitals,” revealed Ilene. However, in Canada, people

tend to go to clinics rather than hospitals. Only those people with major health problems or emergency would go to hospitals, Ilene suggested.

Cultural barriers

English language proficiency. Chinese international students are required to take an IELTS or TOEFL test before being admitted into Canadian universities and colleges. Most of the participants considered their English proficiency to be fine; however, when accessing and utilizing health care services in Canada, participants experienced varying degrees of difficulties in the language aspect. Peggy explained that although they had learned English for so many years, they still found it difficult to use English properly. “There are many terms that you do not know, and you don’t need to use them in your daily lives,” said Peggy.

Peggy further stated that she always had trouble finding appropriate words to describe her symptoms. However, every time she went to see the doctor, she would be asked to describe her symptoms. “It is really a torture,” Peggy shared. She also indicated that one time she went to see a doctor, and the doctor asked what vaccines Peggy had ever taken. “I knew what vaccines I had taken, but I did not know how to say them in English,” said Peggy.

Several other participants, Kelly, Yvonne, and Terry, also admitted that language was the biggest difficulty when accessing and utilizing health care services in Canada, which could reflect participants’ lack of knowledge of medical terminology, medicine, and how to describe

their symptoms in an understandable way. Yvonne stated that her friend and she took an electronic dictionary with them every time they went to visit a doctor. “However, sometime even if we have found the word, we can’t express it in the proper way; thus, we still cannot make ourselves understood,” shared Yvonne.

Moreover, the language difficulty was also considered to have further influenced the doctor-patient communication. Participants worried that the ineffective and inefficient communication between doctors and patients could possibly lead to adverse outcomes. “Since I cannot make myself understood, I am worried that the doctor may conduct misdiagnosis,” explained Ilene.

Two other participants shared similar experience of language difficulties during doctor-patient communication. Sunny once had a terrible case of broken blood vessels in one of her eyes, and it was so uncomfortable that she had to see a doctor; she found language to be a really big problem because she could not clearly communicate her symptoms to the doctor. “I could not find some words. It also took the doctor quite a long time to explain to me what disease I had contracted,” said Sunny. “Since I could not understand what the doctor said, the doctor even drew a picture for me to explain what my eyes looked like now and what bacteria had caused that,” she further described. However, Sunny also shared that although the doctor spent

so much time explaining to her what diseases she had got, she still had no idea what the doctor was talking about, since English medical terminology was too difficult for her to understand.

Another participant, Kelly, once went to the clinic for a regular physical examination, and she was told that she needed a vaccination. “The doctor asked me whether I had been vaccinated before in China. The types of vaccinations in China are very unique, so I did not know the answer. The doctor even let me see the descriptions in Wikipedia, but I could not understand that either,” explained Kelly. As a result, Kelly had to review her medical record, and went back to the clinic a few days later. Although “the attitudes of health care providers were accommodative,” Sunny and Kelly admitted that the language barrier influenced their satisfaction with the communication with the doctors. As another participant, Peggy, explained that “if you cannot communicate effectively with doctors, no matter how nice doctors and nurses are, you still cannot get a satisfying result.”

Even though many participants experienced language and communication difficulties when accessing and utilizing health care services in Canada, most of them still kept a positive attitude, and managed to find a way to deal with the problem. For instance, Grace would prepare in advance before visiting a doctor by referring to the dictionary and wrote down all of her symptoms, thoughts, and questions in English beforehand. “As a result, when I am able to see a doctor, verbal communication is less needed. I only need to give the doctor the paper full of my

descriptions of symptoms and questions, and then he better understands what I want to say,” shared Grace.

Nevertheless, language was still considered by participants as one of the biggest difficulties when accessing and utilizing health care services in Canada. Most of the participants indicated that, if possible, they preferred Chinese-speaking physicians rather than English-speaking ones. Participants believed that communication with Chinese-speaking physicians would be more convenient and understandable. “After all,” said Cindy, “when you go to see a doctor, you will want him to explain clearly without any misunderstanding.” Grace also explained that most of the time, it was very difficult to describe symptoms in English. “Even if you refer to the dictionary, it may not be the same with your own condition,” said Grace. Accordingly, Grace believed that seeing Chinese-speaking doctors could avoid the possibility of misdiagnosis.

However, when asked whether they would like to have an interpreter to assist them, Grace expressed her unwillingness directly. “The body is private; I don’t want friends or interpreters to be present.” Sunny had the same concern: “When you are describing your condition to a doctor, it feels weird to have a stranger to stand there. Sometimes you go to see a doctor, but you will not want others to know that.”

Besides the concerns of privacy, more participants were worried about the cost of an interpreter. They wondered whether the health insurance covered that item. For instance, Lucy

explained that as international students, most of the time, if the health insurance does not cover a test or health service, they would likely not take the test or service.

Chinese cultural health beliefs. Most of the participants recognized to varying degrees, their health-related attitudes and behaviours were influenced by traditional Chinese culture. Participants believed that it was very important to keep a balanced way of life, which could be reflected in their daily routines and eating habits. Yvonne stated that “regular daily routine and three meals a day on time are very important.” Moreover, every morning, after getting up, Yvonne would drink a cup of water and then go to the washroom, which has the function of detoxification.

Most participants found health behaviours of Chinese and Canadian people differed greatly. Ilene noticed that Canadian young people wear very little clothing, even in winter times, with which Ilene could not agree. Ilene stated that she paid much attention to keep herself warm. No matter outside or inside, she wore more clothes to keep herself warm. She always drank hot water. Even in summer, she did not have any iced drinks.

Other participants noticed that there were some differences in health behaviours and beliefs between Chinese and Canadian people. Yvonne found that Canadians take a lot of vitamins every day, and they like to exercise. Chinese seldom take vitamins, and do little exercise, but they pay more attention to other aspects. “We (Chinese) sometimes soak our feet in hot water to

promote blood circulation, and we eat hot rather than cold food to keep our body warm. It is quite different,” shared Yvonne.

Most of the participants acknowledged that as a deeply rooted habit, traditional Chinese culture played a significant role in shaping their health-related attitudes and behaviours. Peggy explained that when Canadians had a headache, doctors would recommend taking some painkillers, such as aspirin. However, Chinese would not simply take such medicine. “We (Chinese) prefer a more moderate and mild way to condition our body, for instance, some traditional Chinese medicine,” explained Peggy.

Participants usually felt dissatisfied or even angry when doctors advised them to take painkillers, since they thought it was a reflection on doctors’ irresponsibility. Ilene explained that in China, people always say every medication has side effects. No matter traditional Chinese medicine or Western medicine, they both do some harm to human body. Consequently, influenced by Chinese culture, participants paid much more attention to the condition of their bodies, and emphasized concern for the side effects.

Lack of cultural sensitivity among health care practitioners. Many participants thought that when providing health care services to patients, Canadian health care practitioners lacked cultural sensitivity. In one case, Lucy went to see a doctor in the hope of getting a complete physical examination, and she told the doctor that she had rheumatism. “The doctor only said

that there was something wrong with my bone, but he did not give me any prescription, not even calcium tablets,” stated Lucy.

Lucy was very dissatisfied that the doctor did not explain her illness well and did not give her any medicine. Lucy further complained that doctors in Canada usually advised patients to take painkillers, which to her was very unacceptable. Lucy further stated that she once had a belly ache so she went to visit a doctor, and the doctor advised her to take some painkillers, which upset her. “It is not curing. I think it is very ridiculous, because painkillers do so much harm to human body,” said Lucy.

Hence, Lucy did not buy any painkillers; instead, she chose to take some traditional Chinese medicine that she brought from China, which she believed to have very minor side effects on the human body. Yvonne was also resistant to taking painkillers, since she did not “want to develop a dependency.” Grace noted that doctors should communicate more with patients. She indicated that patients also have their personal view of health and health care services. “After all, it is my own body, so I care a lot about it. You (doctors) are not patients; of course you never understand how much we value our body,” expressed Grace. She hoped that Canadian doctors could be more culturally sensitive.

Self-care management. Most of the participants noted that choosing to see a doctor or not depended on the degree of their sickness. With minor sickness, participants tended to resort to

self-treatment rather than going to see a doctor since most of them had brought some medicines from China; as a result, participants were used to taking medicine by their own choosing. For instance, when Larry got sick with cold, he would just take some cold medicine. Larry thought that even if he went to see a doctor, they would probably just give him the medicine he already had.

Kelly had the same tendency, who indicated that she would only go to consult a doctor when she was very uncomfortable and her self-treatment did not work out.

Some participants complained that they did not get any prescription from doctors when they went to visit the doctor, which led to their distrust and dissatisfaction with doctors. Grace stated that even if she went to the hospital, doctors would not prescribe any medicine to her or give any treatment unless she described her conditions in a very serious way.

Consequently, under such circumstances, participants usually chose to stay at home and treat themselves when they were ill, instead of going to see a doctor. Furthermore, many participants turned to their friends or relatives when they got sick rather than seeking health care from health care professionals. Participants usually asked their friends or relatives about some symptoms and information about health insurance and hospitals. Nevertheless, most of the participants noted that they would like to receive some assistance from their universities and colleges, such as some necessary information related to Canadian health care system. As Larry said, he was used to the

health care system in China; however, in Canada, he had relatively little knowledge of how things work in clinics and hospitals. “In China, the on-campus health clinic is not as good as hospitals, so we are confused as to the abilities of the on-campus health clinics in Canada. If the disease is very serious, shall we go to other hospitals to see a doctor or simply rely on the clinic?” wondered Larry.

Larry hoped that the university could inform them of the extent to which on-campus health clinics handle patients’ diseases. Willa wished for the same assistance. Willa noted that at first she did not know anything about the Canadian health care system; as a result, she could only go to the on-campus health clinic when she got sick. “I believe our university should create an information session, so that we can have a better understanding of how the system works, and how we can better utilize system,” indicated Willa.

Larry and Willa suggested that the university could provide a brochure to introduce the health care system in Canada, including how to make an appointment and related procedures so that international students could have a better understanding of the Canadian health care system.

Influence of sojourn life on health. Among the twelve participants, three had been in Canada for more than two years, seven had been in Canada for more than one year, and the other two were recent arrivals. Each group had one participant who was determined to go back to China at the completion of their study. Five participants clearly indicated that they would stay

and plan to settle down in Canada. The other four participants were still in the decision-making stage.

When asked about their health status before and after coming to Canada, three participants thought that there was no difference. Four participants believed that their health status worsened. Two participants indicated that they always felt tired after coming to Canada. For instance, Cindy stated that she usually woke up at six or seven o'clock in China, and her body clock was very regular. However, after coming to Canada, her schedule changed because of her workload. This change resulted in her staying up late at night and difficulty in waking up in the morning. Yvonne shared that while in China, her family took care of her, but in Canada she had to take care of herself. Since she did not have sufficient sleep, and the diet was different than that in China, Yvonne believed her health status was not as good as it used to be in China. Cindy arrived in Canada three months ago, and Yvonne had been staying here for one year. However, those participants who had been staying here for more than two years, their responses were quite different. Most of them considered their health status became much better after coming to Canada. Henry stated that when he was in China, he often got fever, but in Canada he seldom got fever. Grace also believed that her health status was much better after coming to Canada. "The environment in Canada is very good," stated Grace. Similarly, Sunny expressed that her daily

routine was not very regular when she was in China, but after coming to Canada, since she was on her own, she learned to take care of herself and had a regular daily routine.

Several participants indicated that they were worried of getting sick in Canada, and not knowing what to do. Seeing a doctor might be difficult, and the waiting time was quite long. Sunny said, “getting sick is very inconvenient since I have to wait a long time to see a doctor.” Moreover, several participants stated that they went back to China or thought of going back to consult a doctor in China because of the financial and communication problems, or their lack of knowledge of the Canadian health care system and procedures. For instance, Ilene went back to China to pull out her wisdom teeth because “it is really expensive to do that in Canada.” Similarly, Peggy indicated that it was very inconvenient to arrange a test in Canada. Besides, problems such as communication and cost influenced her decision to go back to China to see a doctor.

However, most of the other participants would rather stay in Canada for treatment. Grace speculated that “for what kind of diseases do we need to go back to China to visit a doctor? The older people will probably go back, because they are familiar with their doctor, and they cannot speak English very well.” While for young people, stated Grace, the language problem would not be that difficult compared with the elderly; thus, Grace thought of it as a waste of money to go back to China to see a doctor.

Chapter Summary

This chapter explored the results of the semi-structured interviews conducted with twelve participants in this study. The results revealed four main themes, which included perceptions of health and illness, barriers/perceived barriers, self-care management, and influence of sojourn life on health. The theme perceptions of health and illness includes two sub-themes, food and traditional Chinese medicine. The theme barriers/perceived barriers to health care includes two sub-themes, structural and cultural barriers.

In the chapter which follows, a discussion will take place on these results and their analysis employing Witte and Morrison's (1995) intercultural health communication model. At the same time, the two research questions posed in chapter two will be discussed.

Chapter 5: Discussion

Although the findings of this study have uncovered a number of themes emerging from participants' responses and their perceptions of multiple barriers/perceived barriers when accessing and utilizing health care services in Canada, these themes must also be examined through a theoretical lens for further understanding. Accordingly, the study findings are discussed in relation to the research question using Witte and Morrison's (1995) intercultural health communication model in order to shed further light on participants' utilization of health care services in Canada.

The first research question asked about the role of Chinese culture in Chinese international students' health-related attitudes and behaviours in Canada. In response to this question, participants answered in ways which suggest that traditional Chinese culture has an influence on participants' perceptions of health and illness, and guide them when and how to seek care.

Scholars have argued that culture generates and forms rules for individuals to function in society (Samovar, Porter, & McDaniel, 2006), which influence how people interpret symptoms and attributions, and guide them how and when to seek health services (Anderson et al., 2003). This idea has been reflected in this study as many participants believed that diseases are caused by both internal and external factors, which is an important concept in Chinese culture. Most participants were quite familiar with central traditional Chinese medicine (TCM) concepts and

knowledge, such as *yin-yang* balance. Many participants claimed to have been influenced by TCM concepts in terms of how they interpreted symptoms of diseases, conditioned their body, and took self-treatment methods.

Some participants believed that Western medicine could alleviate symptoms efficiently, and could provide scientific information regarding the state of one's health. Many other participants believed that TCM has more advantages over Western medicine, such as smaller side-effects, and powerful conditioning benefits. Similar to Chinese immigrants' beliefs reported in existing literature (Cai, 1988; Koo, 1984; Wang, Rosenberg, & Lo, 2008), participants in this study also claimed that Western medicine provides only "a temporary medical relief," and is able to cure disease only at the surface level, but that TCM can cure the root cause(s) of a disease. Matocha (1998) has found that young Chinese people generally seek Western medicine initially when they get sick; if Western medicine does not cure their diseases, they will then turn to TCM. In the current study, most participants revealed that typically they first seek Western medicine, turning to TCM in the event of failure. Participants explained that most of the doctors in Chinese hospitals practiced Western medicine, thus these participants were already habituated to Western medicine, rather than TCM. Participants added that despite TCM's many perceived advantages, patient recovery may require an extended period of time - one of the reasons why TCM was not their first choice when seeking treatment.

Additionally, participants explained that the reasons for not choosing TCM in Canada included financial cost considerations, which corresponded to Derose, Escarce, and Lurie's (2007) and Mori's (2000) presumptions that financial status has an influence on people's access to health care. Another reason provided by participants was their lack of information on the location of traditional Chinese doctors in Canada. Similarly, Russell, Thomson, and Rosenthal (2007) posited that the knowledge of the locations of health care services is related to international students' utilization of health care services. The third reason mentioned by participants was their mistrust of traditional Chinese doctors practicing in Canada, which has not been taken into consideration in existing literature. Participants indicated that they did not know the backgrounds of these traditional Chinese doctors. Therefore, they relied on recommendations from their friends who had the experience of visiting a traditional Chinese doctor in Canada. Participants stated that some of their friends did not think well of traditional Chinese doctors in Canada. Some participants stated that they would consult a traditional Chinese doctor only if that doctor had a good reputation.

Many participants admitted that they were influenced by traditional Chinese culture in terms of conditioning their body and taking self-treatment methods. Food plays a significant part in Chinese daily lives. Participants in this study, Chinese international students, placed importance on food and nutrition by means of having three meals a day on time, taking a certain amount of

vegetables, meat, and fruits every day, and paying special attention to *yin* and *yang* food during special times. The majority of participants revealed that they generally resort to self-diagnosis and self-treatment with minor health problems, such as colds and fevers. Most participants relied on the medicines they brought from China. In addition, participants stated that if they went to a clinic or a hospital, doctors would probably just give them the medicine they already had, or rather, would give no prescription at all. Participants indicated that they would consider consulting a doctor only when incapable of directly treating their illness or if their self-treatment was unsuccessful. These results are similar to findings in previous studies. For instance, in Chau and Yu's (2010) study, Chinese people were found to have a tendency to take various methods to manage their health, such as food remedies, herbal tea, and acupuncture. Similar to the findings of the current study, scholars also found that Chinese immigrants have a tendency to resort to self-diagnosis and self-treatment rather than seek help from health care practitioners when they are ill (Chau & Yu, 2010; Matocha, 1998; Wang, Rosenberg, & Lo, 2008).

Additionally, some participants believed that every medication incurs side-effects; therefore, they held cautious attitudes towards certain medicines, such as painkillers. In circumstances where participants had been advised by Western doctors to take painkillers – which in Chinese culture are considered to have detrimental side-effects on human body – participants complied only reluctantly or not at all. Conversely, many other participants complained that upon

consulting a Western doctor, no medicine had in fact been prescribed. As such, participants preferred to administer self-treatment rather than to visit a doctor. These findings correspond with existing research. In Witte and Morrison's (1995) findings, they noted that Chinese "may be reluctant to seek physician care," and "expect to receive medication at visit and may lack confidence in physician who does not dispense medication" (p. 232).

The second research question asked about Chinese international students' barriers/perceived barriers to health care services in Canada. While participants' responses revealed some barriers/perceived barriers to health care services, such as lack of information, long waiting time, and language problems, that support findings in existing literature (Blignault et al., 2008; Chesla, Chun, & Kwan, 2009; Russell, Thomson, & Rosenthal, 2007), other responses from participants provide different insights into understanding Chinese international students' perceptions and utilization of health care services in Canada. To better understand study participants' health-seeking barriers/perceived barriers, they can be examined within the context of Witte and Morrison's (1995) intercultural health communication model.

According to Witte and Morrison (1995), people's health-related attitudes and behaviours are influenced by three general variables: perceived threat, perceived efficacy, and barriers/perceived barriers. Perceived threat refers to the degree to which one feels threatened by a health problem. Perceived efficacy refers to the degree to which one feels able to avoid a health

threat by taking an effective response. Barriers/perceived barriers refer to the physiological, physical, or financial cost of performing a recommended response. Accordingly, participants' responses in this study can be discussed in relation to these three variables.

Perceived Threat

Several participants indicated that they experienced emergent health problems, such as knife cut and osteomyelitis. Most of the other participants usually visited a doctor for general health inquiries. As a whole, most participants in this study did not report confronting any severe health threat. The lack of participants' perceived threat might be partly due to the limitation of the size of the sample in the study. In addition, most participants in the study had the opportunity to bring traditional Chinese medicines (TCM) from China or consult doctors when they were back in China; therefore, they had more than one option with regards to curing their illness. All of these alternative self-treatment methods might have an influence on participants' perceptions of severe health threat, which provided space for future research.

Perceived Efficacy

Perceived efficacy includes self-efficacy and response efficacy. Self-efficacy refers to “the degree to which one feels able to perform a recommended response to avert a health threat” (Witte & Morrison, 1995, p. 238). Response efficacy refers to “the degree to which one believes a recommended response effectively prevents a health threat” (p. 238). In other words, perceived

efficacy can be understood as the degree to which one feels able to avoid a health threat by taking an effective response. Participants' perceived efficacy was found to be quite high in this study. Most of the participants revealed high regard for health. Accordingly, most participants employed various methods to maintain good health. Participants indicated that by keeping regular hours and a balanced diet, they could improve their immunity, and thus maintain good health.

Barriers/perceived Barriers

Upon reflection of the responses provided by the twelve Chinese international students in this study, it is obvious that participants perceived themselves confronting multiple barriers when accessing and utilizing health care services in Canada. These difficulties can be categorized into two main aspects, structural and cultural barriers. Structural barriers included: lack of information, long waiting time, affordability, location, improper treatment, and identity as Chinese international students. Cultural barriers included: English language proficiency, Chinese cultural health beliefs, lack of cultural sensitivity among health care practitioners, self-care management, and influence of sojourn life on health.

Scholars (Russell, Thompson, & Rosenthal, 2007) have found that the lack of information on the existence of health care services, locations, fees, and health care system are part of the reasons why Chinese international students fail to seek medical help when they are in need of it.

Most of the participants in this study described experiencing lack of information in their health-seeking process as well. Participants were unfamiliar with the Canadian health care system and procedures, which brought them much inconvenience and trouble when accessing and utilizing health care services in Canada. Several participants experienced taking medical tests and treatment that were not covered by their health insurance without being aware of it. Some participants attributed their unproductive utilization of Canadian health care services to their lack of knowledge of the health insurance. Participants were not clear about the extent of care their health insurance covered, and worried that it might be expensive to consult a doctor in Canada. Some participants expressed that they did not have an effective source to find health-related information since the universities and colleges participants attended did not provide necessary information and sufficient assistance to them. Therefore, participants had to rely on themselves to search the Internet for health-related information and to ask for help from their friends or relatives.

The long waiting time was considered as one of the major structural barriers for Chinese international students in this study when attempting to seek medical treatment in Canada. Most participants found it hard to accept the long waiting time when visiting a doctor, especially when they had some illness or injuries that need to be dealt with as soon as possible. Some participants indicated it was not practical to make an appointment in advance to consult a doctor. Since

participants had to wait quite a long time, sometimes they had already recovered when they actually saw a doctor. Similarly, in Frank's (2000) study, international students expressed their surprises at the "length of time it took to get an appointment and waiting time to see the medical provider after arriving at the clinic" (p. 37). Therefore, the long waiting time to some extent inhibited many participants from seeking medical treatment when they got ill. Under such circumstance, several participants suggested that Canadian government could open some private clinics, and they would rather pay to get better and quicker health care services.

Previous studies have found that the physical locations of health care services are associated with international students' utilization of health care services (Mori, 2000). Scholars have noted that patients and their families will avoid seeking counselling help if health care services are located where patients can possibly meet their acquaintances. It is because in some cultures, mental health problems are considered to be a shame for both patients and their families (Mori, 2000; Purnell & Paulanka, 1998). However, the physical locations of health care services were not found to be a barrier in this study. Most of the participants usually went to on-campus health clinics to consult a doctor. All of the participants stated that the location of health clinics did not have any influence on their health-seeking decisions. In fact, several participants believed that clinics in the shopping mall were more convenient since they could get there very easily. It may be due to the fact that all of the participants in this study only had some general health problems,

none of them were in need of professional counselling help. Therefore, they might not find the locations of health services to have anything to do with their health-seeking attitudes and behaviours. What needs to be noted is that Chinese international students in this study did not reveal their major health concerns. This omission may be attributed to the fact that Chinese people may feel uncomfortable talking about sex-related issues, especially “sexuality, sexually transmitted infection (STI) and AIDS” (Zhang, Li, & Shah, 2007, p. 352), since “talking about sex is taboo” in traditional Chinese culture (Woo, Brotto, & Gorzalka, 2009, p. 599).

Legal status is also found to have some influence on Chinese people’s access to health care services in foreign countries (Derose, Escarce, & Lurie, 2007). Derose, Escarce, and Lurie (2007) found that Chinese immigrants tend to have low rates of health insurance coverage compared with their U.S.-born counterparts. Therefore, the researchers assumed that the lack of health insurance might lead Chinese immigrants to seek a less regular source of health care. However, International students in Canada are required to purchase the University Health Insurance Plan (UHIP). As such, all of the participants in this study had their university or college health insurance. Nevertheless, most participants still had some financial concerns when seeking medical help. Although most participants considered it necessary to have the health insurance, some participants noted that the price of the health insurance was a little high since they had brought a lot of medicine from China and seldom had the necessity to visit a doctor in Canada.

Some participants suggested that the UHIP could be optional; purchased every semester. In addition, several participants indicated that their college health insurance did not include dental insurance; even when they had dental insurance, participants still had to pay a certain amount of money for teeth check and removal, which many participants found was far more expensive compared with that in China. Consequently, many participants chose to go back to China to go through medical tests and treatment.

Language is considered to be one of the most challenging issues for the Chinese to seek medical treatment (Blignault et al., 2008; Constantine et al., 2005; Derose, Escarce, & Lurie, 2007; Lin & Yi, 1997; Mori, 2000; Wang, Rosenberg, & Lo, 2008). Most participants in this study also stated that language became a major barrier when accessing and utilizing health care services in Canada. Difficulties in understanding medical terminologies, symptoms descriptions and communication patterns had an influence on participants' effective communication with Canadian doctors, which in turn led to participants' unwillingness to visit a doctor when they were ill. Participants admitted that, if possible, they preferred to consult Chinese-speaking doctors instead of English-speaking doctors since communication with the former could be more convenient and understandable. Scholars have suggested that the linguistic gaps between limited English proficiency patients and health care providers can be eliminated by turning to interpreters (Barone, 2010; Derose, Escarce, & Lurie, 2007; Dohan & Levintova, 2007;

Willgerodt, Kataoka-Yahiro, Kim, & Ceria, 2005); however, several participants in this study expressed their concerns of privacy and cost; thus, they were unwilling to seek help from interpreters.

Chinese international students in this study were mostly influenced by traditional Chinese culture in their health-related decisions, which correspond to previous studies (Anderson et al., 2003; Dong, Loignon, Levine, & Bedos, 2007; Kreuter & McClure, 2004; Purnell & Paulanka, 1998). Participants found many differences between Western and Chinese culture. For instance, in Chinese culture, painkillers are considered to be harmful to human body. Therefore, most participants felt dissatisfied or even angry when they were advised to take painkillers to alleviate pains. Several participants also complained that doctors seldom prescribed any medicine or provided any treatment, even if they asked for it, which led to their distrust and dissatisfaction with doctors. As such, physician's lack of cultural sensitivity also became a barrier for participants seeking medical treatment.

Existing literature found that most of the Chinese immigrants used Chinese medicine products and Chinese herbal patches for minor injuries or illness (Chau & Yu, 2010; Koo, 1984; Tsai, 2009; Quah & Bishop, 1996; Wang, Rosenberg, & Lo, 2008). Scholars have also noted that Chinese people manage their health by resorting to various methods, such as taking Chinese medicine products, and eating *yin-yang* balanced meals, rather than seeking help from health

care practitioners (Chau & Yu, 2010; Matocha, 1998; Wang, Rosenberg, & Lo, 2008). In the same way, many participants in this study were found to resort to self-diagnosis and self-treatment when they were ill. Some participants described that they would only visit a doctor when their conditions were very serious, or their self-treatment methods were not successful. Nevertheless, most of the participants expressed their willingness to receive some assistance from their universities and colleges, such as receiving some necessary information related to Canadian health care system and procedures.

Scholars also suggested that the duration of sojourn is very significant in understanding international students' health status (Zheng & Berry, 1991). For those participants in this study who had been staying in Canada for less than one year, they tended to think that their health status had worsened after coming to Canada due to study and life pressure. While many other participants who had stayed for more than two years believed that their health status was much better after coming to Canada. Several participants chose to go back or thought of going back to China to go through medical tests and treatment as a result of financial and communication concerns. However, some participants who had the willingness to settle down permanently exhibited a preference for dealing with their health problems in Canada.

It can be seen from the above discussion that participants in this study confronted relatively high barriers/perceived barriers to access and utilize health care services in Canada.

Participants tended to underutilize health care services in Canada, a finding which is similar to other Chinese populations in many developed countries.

Many participants provided their suggestions with regards to ways to improve the quality of Canadian health care services for international students. Most participants expressed that some barriers/perceived barriers could be alleviated with the help from their educational institutions. More efforts can be made by educational institutions to help international students understand Canadian health care system and procedures by means of sending out brochures, and holding information sessions and lectures.

Chapter Summary

This chapter discussed participants' responses using Witte and Morrison's (1995) intercultural health communication model as the theoretical framework. Specifically, Witte and Morrison's concerns with perceived threat, perceived efficacy, and barriers/perceived barriers were applied to discuss the themes which were drawn from participants' responses (perceptions of health and illness, barriers/perceived barriers to health care, self-care management, and influence of sojourn life on health). The discussion indicated that many Chinese international students in this study experienced high barriers/perceived barriers when attempting to access and utilize health care services in Canada. Witte and Morrison's intercultural health communication

model helped shed further light to understand participants' unproductive utilization of Canadian health care services.

The concluding chapter will first provide a summary of the findings. Second, limitations of this study will be presented. Then, directions for future research will be discussed. Finally, the chapter will wrap up with a personal reflection on this study offered by the researcher.

Chapter 6: Conclusion

This study has examined the health-seeking experience of Chinese international students in Canada. To this end, semi-structured in-depth interviews were conducted with twelve participants. The study aimed to: explore the ways Chinese international students seek medical treatment in Canada, find out barriers/perceived barriers for Chinese international students to obtain quality health care services in Canada, and understand the influences of Chinese culture on Chinese international students' search for medical treatment.

The findings show that most of the participants were greatly influenced by traditional Chinese culture. For example, their perceptions of health and illness were influenced by traditional Chinese medicine (TCM). Chinese international students in this study believed that diseases were mainly caused by both internal and external factors; thus, they usually tried to maintain a regular daily routine and paid much attention to the balance of their diet and nutrition in order to keep a healthy way of life and prevent diseases. Although most of the participants indicated that the TCM had many advantages compared with Western medicine, most of them expressed that they would take Western medicine because of its high efficiency.

The Chinese international students in this study were reluctant to consult a doctor when they got ill. Specifically, participants' responses revealed a number of themes and sub-themes which influenced their decisions not to seek medical help. Although Canada implements a universally

public health care system (Asanin & Wilson, 2008) and international students are required to purchase the University Health Insurance Plan (UHIP), participants confronted structural and cultural difficulties when accessing and utilizing health care services. Because of these barriers/perceived barriers, including lack of information, long waiting time, affordability, health insurance, English language proficiency, health beliefs, lack of cultural sensitivity among health care practitioners, and influence of traditional Chinese culture, the Chinese international students in Canada in this study delayed or avoided seeking health treatment. As a result, most of them had the tendency to perform self-diagnosis and self-treatment. The theoretical framework for this study, Witte and Morrison's (1995) intercultural health communication model, has shed light on participants' reluctance to consult a doctor when getting sick. Participants' responses revealed that their reluctance to seek medical help was due to the relatively high perceived efficacy (e.g., participants' regular daily routines and various self-treatment methods), and high barriers/perceived barriers to health care services in Canada (e.g., lack of information, long waiting time, and language). However, their responses did not reveal any perceived threat to any severe health problem.

Limitations and Directions for Future Research

Although this study has gained some academic insights into Chinese international students' health-seeking behaviours in Canada, still, there are several limitations that need to be taken into

consideration while interpreting the findings. First of all, the size of the study sample is relatively small. All of the twelve participants were from specific universities and colleges in the Ottawa area only. Participants' age ranged from 21 to 27, and female participants accounted for the majority (nine were female, and three were male). Therefore, the participants in this study do not represent all of the Chinese international students throughout Canada. Future research can look into the distribution of male and female students to examine the role of gender in Chinese international students' health-seeking behaviours in Canada. Second, all of the participants in this study were from Mainland China (People's Republic of China). Scholars have argued that Chinese international students from Mainland China may retain more traditional Chinese culture than those in Hong Kong and Taiwan (Zheng & Berry, 1991). If time allowed, ideally, the researcher would have liked to recruit Chinese international students from Hong Kong, Macao, and Taiwan. Thus, expanding the scope, the study could obtain a deeper understanding of Chinese international students' health-seeking behaviours in Canada. Third, this study only focuses on Chinese international students' general health-seeking behaviours in Canada; thus, participants' major health concerns were not taken into consideration. The lack of information about participants' health profile, risky behaviours, and other related topics limited the scope of this study, which leaves space for future research.

In addition, Witte and Morrison (1995) have noted that two cultural variables, family values and fatalism, influence patients' health-related decisions; however, these two cultural influences were not revealed in this study. Therefore, future study can investigate these topics, and further explore the health-seeking behaviours of Chinese international students in Canada.

Real World Implications

Notwithstanding the above limitations, the findings of this study provide important insights into examining the ways in which Chinese international students in Canada seek medical treatment, investigating barriers/perceived barriers which confront these students during their health-seeking process, and understanding the influences of Chinese culture on Chinese international students' search for medical treatment in Canada. Most of the existing literature mainly relate to Chinese immigrants (Wang, Rosenberg, & Lo, 2008), few insights have been gained into the health-seeking experiences of Chinese international students in a multicultural setting. Hence, relatively little is known about the accessibility and utilization of health care services among Chinese international students, not to mention the barriers/perceived barriers that Chinese international students may confront when accessing and utilizing health care services in Canada. This study, however, helps to look into a small number of Chinese international students' health-seeking experiences in Canada. The findings of this study, more specifically, the

barriers/perceived barriers which confront Chinese international students during their health-seeking process in Canada have important implications.

The findings provide an empirical basis for future research in assessing Chinese international students' barriers/perceived barriers to health care services in a multicultural setting. For Chinese international students in this study, language and long waiting time were considered as the biggest barriers to access and utilize health care services in Canada. Moreover, culture was found to play an important part when participants made health-related decisions. In addition, the lack of cultural sensitivity among health care practitioners calls for a necessity to investigate issues related to culturally competent health care services as well (Wang, Rosenberg, & Lo, 2008).

The findings can help future investigations to find solutions to quality health care services for this group of international students. Since the number of Chinese international students coming to Canada continues to increase, more and more international students will be in need of health care services (Asanin & Wilson, 2008). Therefore, there is a necessity to develop culturally appropriate health care practices in order to provide quality health care services for patients with diverse cultural backgrounds (Asanin & Wilson, 2008). For instance, health care practitioners need to have a basic knowledge of Chinese culture and its health belief system

(Dong, Loignon, Levine, & Bedos, 2007; Kwan & Holmes, 1999; Ma et al., 2010), such as how Chinese people perceive health and illness (Dong, Loignon, Levine, & Bedos, 2007).

Reflections

During the past year of thesis writing, I have obtained important understanding of Chinese international students' health-seeking experiences in a foreign country.

As an international student myself I have personal experience of visiting a doctor in Ottawa. At the very beginning, without any knowledge of the Canadian health care system and procedures, I was sort of lost. I could not describe my symptoms correctly and clearly, which always led to doctors' confusions and my frustrations. After several visits to the doctor's office, I began to gain some knowledge of the procedures of consulting a doctor, and I managed to at least make myself understood by doctors. From then on, I kept wondering, how do other Chinese international students see a doctor in Canada? Do they have the same difficulty as I do? Who do they turn to when they need health information and help? These thoughts initially formed the basis of my thesis. In existing literature, few studies have examined how Chinese international students in particular seek medical treatment in Canada, and even fewer such studies have linked aspects of Chinese culture to Chinese international students' attitudes and behaviours in their search for health care services.

During the data collection of my thesis, using my personal network and recruitment advertisements, I approached twelve individuals in total. I found that those Chinese international students experienced various kinds of difficulties just like I did. I also discovered that, due to all those difficulties, Chinese international students in this study tended to delay and even avoid seeing a doctor in Canada; they would rather take some medicine brought from China. However, most of them looked forward to receiving some professional assistance to help solve their health-related problems.

My personal experience of consulting a doctor and the gap in existing literature with few insights into the lack of access to health care services for Chinese international students in Canada led to my interest in examining the ways in which this group seek medical treatment, barriers/perceived barriers during their health-seeking process, and the influence of Chinese culture on their health-related attitudes and behaviours. Due to the rapidly rising number of Chinese international students in Canada, and their contribution to Canada's economic and cultural development, developing an understanding of access to health care services among Chinese international students in Canada is an important research area. The findings revealed that Chinese international students in this study confronted multiple structural and cultural barriers when accessing and utilizing health care services in Canada. The findings of this study may provide important insights into assisting Canadian universities and institutions in addressing

some of the problems confronted by Chinese international students when assessing their health-seeking behaviours in Canada.

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Appendix A

Recruitment Text

Previous studies have suggested that the Chinese people experience many difficulties in accessing and utilizing health care services in developed countries. We would like to know how this applies to Chinese international students in Canada. So, if:

- You are a Chinese international student;
- You are now studying in a Canadian university or college;
- You have seen a physician in Canada before;
- You have anything to say about health care services in Canada;

If you fulfill the above requirements, you are the person we are looking for!

Goals of this study:

This study aims to explore how Chinese international students in Canada access and utilize health care services in Canada, the barriers/perceived barriers, if any, they have experienced, and the influences of Chinese culture on their health-seeking attitudes and behaviours.

Participation:

Your contribution consists of participation in a voluntary face-to-face interview that will last about one or two hours. During the interview, you will verbally answer questions concerning your personal opinion about your health-seeking experience in Canada. This interview will take place at a time that is convenient to you and the researcher will meet you on campus.

Who can participate?

People who are 18 years of age and older, who are currently living in the Ottawa region, and who can express themselves in Mandarin or English.

Help us increase knowledge in this domain.

Thank you for your support and collaboration!

Xueyi Shen, Communication Student

Appendix B

Interview Guide for interviews on Understanding the Role of Culture in Health-seeking Behaviours of Chinese International Students in Canada

General Demographic Information: Please note that all information is confidential. Answers to these questions will be used only to compare responses across study participants.

1. What is your age?
2. What is your sex?
3. Where were you born?
4. What is your level of education?
5. Are you employed (according to your current situation)?
6. Who support(s) your study and life in Canada?

Perceptions about Health & Illness and Influences from Chinese Culture

1. What does health mean to you?
2. What does illness mean to you?
3. What do you think cause diseases?
4. What do you think of *yin-yang* balance? How does it influence your health attitudes and behaviours?
5. What do you think of *qi*? How does it influence your health attitudes and behaviours?
6. What do you think of traditional Chinese medicine?
7. What do you think of Western medicine?
8. How do you maintain your health and prevent any illness?

Experiences with Health Care Providers and Services

1. Have you ever visited a physician in the past years/months in Canada?
 - (a) If yes, could you explain the best/impressive health-seeking experience in Canada?
 - (b) Would you mind if I ask you to also share your worst health-seeking experience?
 - (c) If so, how did you deal with that situation?
 - (d) Suppose the same happens in China, what would you think and what would you do?

-
- (a) If not, what were some reasons for you to choose not to see a doctor?
 - (b) How important were those reasons to you/your family?
 - (c) What would happen if you did go to see a doctor?
-

2.
 - (a) What do you usually do when you are ill in Canada?
 - (b) If and how is it different from what you would do in China?
 - (c) If different, what do you think have caused the differences?
 - (d) Did you prefer traditional Chinese medicine or Western medicine when you were in China? Why and why not?
 - (e) Did you prefer traditional Chinese medicine or Western medicine when you were in Canada? Why and why not?
 - (f) Have you ever tried to seek traditional Chinese medicine treatment in Canada? If yes, how is that situation?
3. Do you know how to approach to a health clinic/doctor in Canada?

4. (a) How is the health care services and system in Canada different from that of in China?
(b) Are those differences acceptable to you? Why and why not?
5. Besides going to the hospital, what other self-treatment do you take when you are ill in Canada?
6. Do you have a tendency to operate self-diagnosis and self-treatment rather than seek help from health care practitioners? If so, what causes that?
7. Have you ever taken Chinese medicine products in Canada? If so, for how long?
8. Generally, what do you think of Canada's health care services and system?
9. What advice would you give health care providers in order to offer quality health care services to Chinese international students?

Perceived Barriers

1. Do you have health insurance? If yes, which one?
2. (a) How much do you know about UHIP (University Health Insurance Plan)?
(b) How do you feel about UHIP?
(c) How much money do you think it will cost if you go to see a doctor?
3. Have you ever felt reluctant to see a doctor? Why and why not?
4. (a) What is the location of hospitals/clinics that you usually go to?
(b) How do you know the location?
(c) Do you have any difficulty to find the location and transportation to hospitals/clinics?
(d) Does the location of the hospital/clinic have any influence on your utilization of its health care services?
5. How much do you know about Canada's health care system? Do you face any difficulties using it?
6. (a) What do you think of your English language proficiency?
(b) When you see a doctor, do you find any language difficulties between you and health care providers? Could you give some examples?
(c) Do the language differences have an impact on your satisfaction with the health care services you received?
(d) If possible, do you prefer Chinese-speaking physicians rather than English speaking physicians?
(e) Would you like an interpreter to be present when you are receiving health care services? Why and why not?
7. (a) What do you think of your interactions with health care practitioners?
(b) Are there any problems? If so, what are those?
(c) What do you expect health care practitioners and services to be?
8. (a) Do you find any health-related behaviour in Canada to be different from that in China? Could you specify them?
(b) Have you ever resisted some health care services or medicine in Canada? Why and why not?
(c) Do you think Chinese culture has influenced your health-related attitudes and behaviours? Why and why not?
9. Have you ever found that being an international student poses any inconvenience or difficulty for you when accessing and utilizing health care services in Canada? Could you tell me about that?

10. What do you think is the biggest difficulty in accessing and utilizing health services in Canada?

Assistance Needed

1. When you are ill, did you seek assistance from anyone? If yes, from whom did you receive assistance?
2. How did that help?
3. When do you think you would seek assistance from others?
4. What assistance do you think you need when receiving health care services in Canada? How would you like to receive the assistance?
5. What assistance do you want to receive from other sources (for example, your friends, you family, etc)? How would you like to receive the assistance?

International Student Status & Sojourner Experience

1. How long have you been in Canada?
2. What is your plan after completing your study?
3. In your opinion, what are the differences between Chinese culture and Canadian culture? How do you cope with those differences?
4. What do you think of your health status before and after coming to Canada?
5. What do you think of your health-seeking attitudes and behaviours before and after coming to Canada?
6. Do you think those changes, if any, in your health status and health-seeking attitudes and behaviours, are associated with your studying abroad experience? If yes, in what ways?
7. Have you ever gone back to China to take care of health problems? If yes, could you talk about that?

Appendix C

Informed Consent Form

Title of the Study: Understanding the Role of Culture in Health-seeking Behaviours of Chinese International Students in Canada

Name of researcher: *Xueyi Shen*, Department of Communication, Faculty of Arts, University of Ottawa.

Name of supervisor: *Dr. Rukhsana Ahmed*, Department of Communication, Faculty of Arts, University of Ottawa.

Invitation to Participate: I am invited to participate in the abovementioned research study conducted by *Xueyi Shen*.

Purpose of the Study: The purpose of this study is to understand how Chinese international students in a multicultural society like Canada access and utilize health care services. The study is also interested in exploring barriers/perceived barriers, if any, that Chinese international students confront during their health-seeking process. As such, the objectives of this study are: 1) to explore the ways Chinese international students seek medical treatment in Canada; 2) to find out barriers/perceived barriers for Chinese international students to obtaining quality health care services in Canada; 3) influences of Chinese cultures on Chinese international students' health-seeking attitudes and behaviours.

Participation: My participation will consist essentially of one-to-one interviews (which will last for about two hour), during which I will be asked to answer questions about my perceptions of health and illness, barriers/perceived barriers in my health-seeking process, and cultural factors that influence my health-seeking attitudes and behaviours. This interview has been scheduled at the study room in University of Ottawa. I understand that direct quotes from my interview will be used in the researcher's thesis; as a result, I agree to be contacted for a second meeting to verify the accuracy of transcripts.

Risks: I understand that this study may cause some psychological or emotional discomfort attributed to possible frustration, disappointment or resentment towards the Canadian Health Care System. As a result, the researcher has provided the contact information of on-campus health clinic on the consent form to minimize such a risk or at least to help me cope with such feelings.

Benefits: My participation in this study will help myself to gain more knowledge of Chinese international students' health-seeking behaviours in Canada, and barriers/perceived barriers that prevent Chinese international students from getting quality health care services. Moreover, I can have the opportunity to understand Chinese cultural influences on my health-seeking attitudes and behaviours.

Confidentiality and anonymity: I have received assurance from the researcher that the information I will share will remain strictly confidential. I understand that the contents will be used only for research purposes and that my confidentiality will be protected.

Anonymity will be protected in the following manner: my name will be anonymous throughout the research paper.

Conservation of data: The data collected (both hard copy and electronic data, including transcripts, notes, and tape recording of interviews) will be kept in a locked drawer in the researcher's house throughout the research. Only the researcher and the researcher's supervisor will have access to the data. After completing the thesis, all the data will be stored in the locked drawer in the researcher's supervisor's office for five years (2010 – 2015). After then, all data will be shredded.

Compensation: No compensation will be given for this interview.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be deleted and not be used in the research.

Contact Information:

On-campus health services: 100 Marie Curie Street, Ottawa, Ontario. K1N 6N5. Tel. 613-564-3950

Acceptance: I, _____, agree to participate in the above research study conducted by *Xueyi Shen* of the Department of Communication, Faculty of Arts, University of Ottawa, which research is under the supervision of *Rukhsana Ahmed*.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, Ottawa, ON K1N 6N5

Tel.: (613) 562-5841

Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

Participant's signature:

Date:

Researcher's signature:

Date:

Appendix D

THEMATIC ANALYSIS – DATA CHART

Code	Themes	Findings/Evidence	Conclusions/Thoughts
Physical and mental health, illness causation	Perceptions of health and illness	<p>Sunny stated that “health includes physical and mental health.”</p> <p>Grace indicated that “many reasons can cause illness. For example, if one does not take care of one’s body, or there are some changes in external circumstances and work and life pressure as well, these can all incur illness.”</p>	The findings highlight the fact that most participants are greatly influenced by traditional Chinese culture.
<i>Ying</i> (cold) and <i>yang</i> (hot) food	Food	<p>Willa explained that “<i>ying</i> foods can reduce the fire in the body, while <i>yang</i> foods are tonics that nourish the body.”</p> <p>Cindy stated that “there are <i>cold</i> and <i>hot</i> food in TCM, which can do harm to one’s health if one does not pay attention.”</p>	
<i>Yin-yang</i> balance	Traditional Chinese Medicine	Yvonne pointed out that “males are <i>yang</i> , or the sunny side is <i>yang</i> ; females are <i>ying</i> ,	

		<p>and the shaded side is also <i>ying</i>.”</p> <p>Henry stated that “<i>yin-yang</i> balance is a state of harmony, that is, each body has all kinds of conflicts inside. When these conflicts maintain a balanced and harmonious state, then you can maintain a healthy state; however, if some conflicts grow out of proportion causing an imbalance, health problems may occur due to this imbalance.”</p>	
Don't know how to see a doctor	Lack of information	<p>Ilene stated that “I don't know how to see a doctor in Canada. I don't know much about the Canadian health care system.”</p> <p>Kelly described that “I had obtained my health card at the beginning of the first semester, but I never had the opportunity to use it since I did not know how to see a doctor in Canada.”</p>	Participants experienced evident structural barriers when accessing and utilizing health care services in Canada.
Low efficiency; slowness	Long waiting time	Peggy stated that “we need to make an appointment to see a doctor, and the waiting time	

		<p>can be two or three months.”</p> <p>Yvonne indicated that “there were not enough doctors to serve even the few patients awaiting treatment in the emergency room.”</p> <p>Cindy stated that “we need to make an appointment early before seeing a doctor, but the problem is, we cannot predict whether we will get sick in the next one or two weeks.”</p>	
Bill, insurance, financial cost	Affordability	<p>Peggy indicated that “the price of seeing a dentist in Canada is really high.”</p> <p>Ilene stated that “I am worried that consulting a doctor can be very expensive.”</p> <p>Lucy described that “it is quite expensive to see a doctor in Canada. Of course our insurance covers a lot, but that’s because we have paid so much for it.”</p>	
Difficulty in using English properly	English language proficiency	<p>Peggy explained that “there are many terms that I do not know, and I don’t need to use them in my daily lives. I also</p>	<p>Participants experienced evident cultural barriers when accessing and utilizing health care</p>

		<p>have trouble finding appropriate words to describe my symptoms.”</p> <p>Yvonne stated that “my friend and I will take an electronic dictionary with us every time we went to visit a doctor.”</p>	services in Canada.
<p>Actions taken to maintain one’s health</p>	<p>Chinese cultural health beliefs</p>	<p>Ilene stated that “no matter outside or inside, I wear more clothes to keep myself warm. I drink hot water in winter. Even in summer, I never drink iced water.”</p> <p>Peggy explained that “we (Chinese) prefer a more moderate and mild way to condition our body, for instance, some traditional Chinese medicine.”</p>	
<p>No prescriptions from doctors; uncomfortable with prescriptions or treatment</p>	<p>Chinese cultural health beliefs</p>	<p>Lucy complained that doctors in Canada usually advised patients to take painkillers. Lucy stated that “it is not curing. I think it is very ridiculous, because painkillers do so much harm to human body.”</p> <p>Grace stated that “doctors will</p>	

		only talk with me for a while, and he will not prescribe any medicine unless I describe my conditions in a very serious way.”	
Take one’s own medicine	Self-care management	<p>Larry thought that “even if I go to see a doctor, he will probably just prescribe some medicine that I already have.”</p> <p>Kelly indicated that “I will go to see the doctor if my self-treatment does not alleviate my pain.”</p>	Participants were used to performing self-diagnosis and self-treatment when they were sick.
Health status changes after coming to Canada	Influence of sojourn life on health	<p>Cindy stated that “after coming to Canada, my biological clock changed because of my workload. This change resulted in my staying up late at night, and difficulty in waking up in mornings.”</p> <p>Sunny expressed that “when I was in China, my daily routine was not very normal. After coming to Canada, since I am on my own, I began to learn to take care of myself and have a regular daily routine.”</p>	Participants’ perceived health status was related to the duration of their sojourn.

Appendix E: Table

Table 1

Socio-demographic Characteristics of Participants (N = 12)

	Variable	N	%
Age	Range: 21-27	Mean: 23.2	
Sex	Male	3	25
	Female	9	75
Place of Birth	Mainland China	12	100
Level of Education	Undergraduate	3	25
	Graduate	9	75
Employment	Yes	10	83
	No	2	17

Health Insurance	Yes	12	100
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