Negotiating Health and Migration Aspirations

Lay Health Beliefs among Chinese Rural-to-Urban Migrant Workers in Shanghai and Beijing

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[1]

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Abstract

Adopting both demographic and ethnographic approaches, this thesis examines the processes through which health inequalities are reinforced and reproduced among rural migrants in contemporary urban China. It places a particular focus on what appears to be a common struggle shared by rural migrant workers, that of meeting their migration aspirations and expectations while afflicted by health, illness and disease-related constraints. This thesis will first examine the demographic health characteristics of Chinese migrant workers' before utilising ethnographic research approaches to examine their subjective constructions of health knowledge and lay health practices. By contrasting how migrant workers, specifically migrant parents, manage their family health problems in different individual and social settings, my thesis explores the micro-mechanisms of the reproduction of health inequalities as reflected in migrant workers' understandings and interpretations of health-related behaviours, lay health beliefs and lay aetiologic accounts. Ultimately, this thesis illustrates the processes through which social inequalities have become embedded in health, which, in turn, shape people's subjective understandings of achievement and health. Similar to other migrant workers over the world, the health challenges faced by Chinese rural-to-urban migrant workers are influenced by many other broad social inequalities and limitations they encounter in new spaces. As this thesis demonstrates, it is not simply enough to address the health challenges of migrant workers in a vacuum, focusing on illness or disease alone. A greater focus must be placed on understanding the aspirations of migrant workers and their changing perspectives throughout their migration journeys.

Table of Contents

Acknowledgements .... **iii**

Abstract .... **v**

Table of Contents .... **vi**

List of Tables .... **xii**

List of Figures .... **xiii**

Preface .... **xiv**

Chapter 1 Research Questions, Strategies, and Main Findings **2**

1.1 Research questions 2

1.2 Fieldwork strategies 3

1.3 Research findings 5

1.4 Summary of chapters 6

Chapter 2 Behind the Curtain of "Made in China": An Exploration of Chinese Rural-to-urban Migrant Workers and their Health Challenges in Contemporary China **10**

Chapter introduction 10

2.1 The changing image of "Chinese workers" 11

2.1.1 Rural-urban social framework and the replacement of "Chinese workers" in China 11

2.1.2 Regional inequalities and internal migration in China 13

2.2 Health characteristics of rural-to-urban migrant workers in China 17

2.2.1 Health trends, health selection theory, and the Salmon bias effect in China 17

2.2.2 Health characteristics of Chinese rural-to-urban migrant workers 19

2.3 Health inequalities experienced by Chinese rural-to-urban migrant workers 22

2.3.1 Rural-to-urban migration and associated Healthcare Insurance Disparities in China 23

2.3.2 Healthcare services and health utilisation patterns among Chinese migrant workers 27

2.4 Health challenges in relation to Chinese migrant workers' living and working

circumstances 30
2.4.1 Occupational injuries and work safety threats among Chinese migrant workers 31
2.4.2 Children's education and family separation among Chinese migrant workers 31
2.4.3 Migrants' population health indicators in Shanghai and Beijing................ 32

Chapter 3 Researching the Social Determinants of Health in Migration: Narratives of Lay Health Beliefs and Health Subjectivities 38

Chapter introduction 38

3.1 Conceptual framework 38
3.1.1 The social determinants of health 38
3.1.2 Migration and health.. 40
3.1.3 Theoretical framework.. 42

3.2 Understanding lay health beliefs in health experiences 44
3.2.1 An exploration of the lay health belief model and health-related behaviours 44
3.2.2 The definition of lay health knowledge 46
3.2.3 Social class, socio-economic status and lay health beliefs 47
3.2.4 Living circumstances and the social construction of lay health beliefs 50
3.2.5 Health subjectivities and lay health beliefs 52
3.2.6 Lay health beliefs and traditional Chinese medicine culture..................... 54

3.3 Health subjectivities, aspirations, and lay health beliefs of migrants............... 55
3.3.1 Health subjectivities as migrants 55
3.3.2 Migration aspirations and meanings of health 56

Chapter 4 Research Methods and the Fieldwork in two Migrant Urban Villages in Shanghai and Beijing.. 60

Chapter introduction 60

4.1 Research design: research questions and approaches 61
4.1.1 Sampling 61
4.1.1.1 The selection of research sites: Shanghai and Beijing 61
4.1.1.2 The selection of research participants.. 65
4.1.2 Research approaches: an ethnography of lay health beliefs and health practices.. 68
4.1.3 Interview outline 69

4.2 Accessing socially excluded people: barriers and reflections on health.......... 74

4.2.1 Barriers to gaining access to Chinese rural-to-urban migrant workers 74
4.2.1.1 Locating channels: volunteering at an NGO that provides services for migrant workers' children in Shanghai 74
4.2.1.2 Failed access in XF village: "I am sorry, but we must be careful" 75
4.2.1.3 Refusal from the local grass-roots level government bodies in Shanghai: "who would be interested in these migrant workers?" 77
4.2.1.4 Barriers in Beijing: replacement in a migrant village 77
4.2.2 Positionality and identity in the field: developing a mutual trust with migrant workers 79
4.2.2.1 Gatekeepers and building trust in Shanghai: Interviewing migrant workers 80
4.2.2.2 Gatekeepers and building trust in Beijing: immersing myself in the field 81
4.3 Consent and privacy: research ethics and interview settings 83
Statement of Ethical Review Approval 83
4.3.1 Verbal consent: informality as a way to avoid uncertain risks 84
4.3.2 Interview setting matters: places and occasions 85
4.4 On ethnography: immersing, empathising and distancing 87
4.4.1 Immersing in the village life 87
4.4.2 Distancing from the field 89
Chapter 5 Mistrust and Informality: Understanding the Health-seeking Patterns among Chinese Rural-to-urban Migrant Workers in Shanghai and Beijing 92
Chapter introduction 92
5.1 Health-seeking channels and trust Issues: rural-to-urban migrant workers' health-seeking preferences in Shanghai 93
5.1.1 The forms of mistrust: migrant workers' perceptions of doctors and medicine in Shanghai 93
5.1.2 The forms of trust: uncertainty, risks and the selection of hospitals 103
5.2 Informality in the Migrant Village: Health-seeking Patterns among Migrant Workers in Beijing 109
5.2.1 Health-seeking patterns among migrant workers in Slope Village 109
5.2.2 Individual health practices: explanations for failing to seek healthcare services among the migrant workers in Slope village 112
5.2.3 Clinics in the village: the mystery paper bag and the role of informal healthcare providers 115
5.3 Social reproduction of informality: migrant workers' perceived barriers and perceived benefits on heath-seeking channels in Shanghai and Beijing 119

5.3.1 Longstanding exclusionary health policies in Shanghai and Beijing and perceived barriers ... 120
5.3.1.1 Understanding migrant workers' mistrust in Shanghai: 'rich people only' ... 120
5.3.1.2 Healthcare insurance barriers in Beijing: the 1800 Yuan threshold ... 122
5.3.2 Preference for Informal Health Practices in Shanghai and Beijing: perceived benefits ... 124
5.3.2.1 Reliable and convenient: preference for informal health practices in Shanghai ... 124
5.3.2.2 Familiar and accessible: preference for informal healthcare providers in Beijing ... 125
Chapter summary ... 125
Chapter 6 Lay Health Beliefs of "Kang": Negotiation between Health, Migration and Gender ... 127
Chapter introduction ... 127
6.1 Explanations of "kang": lay knowledge of health resistance and resilience among the migrant workers in Shanghai and Beijing ... 128
6.1.1 Understanding the folk medical term "kang" in the Chinese context ... 128
6.1.2 Self-recovery: lay understandings of immunity among migrant workers in Shanghai and Beijing ... 129
6.1.2.1 Shanghai: strengthening weakened "immunity" ... 129
6.1.2.2 Beijing: preserving immunity from disease and illness ... 132
6.1.3 Ignoring mild symptoms ... 133
6.2 Resistance and tolerance: gendered lay health perceptions among the male migrant workers ... 135
6.2.1 Ignoring symptoms and carrying on work ... 135
6.2.2 Lay definition of pain as a DIDI driver ... 137
6.3 Bearing the pain: lay aetiology of "dampness" among female migrant workers ... 140
6.3.1 Perceived "dampness" in female migrant workers' everyday lives: cold, wet and bad emotions ... 141
6.3.2 Bearing the unbearable: a story of childbirth, raising children and future expectations ... 143
Chapter summary ... 148
Chapter 7 Lay Health Beliefs related to Aspirations: Examining Migrant Workers' Perceptions of Health and Migration Aspirations ... 149

Chapter introduction 149

7.1 Driven by poverty: migrant workers' stories of tuberculosis, hypertension and leukemia 150

7.1.1 "Being too frugal": a migrant worker's explanation of tuberculosis and aspirations.. 150

7.1.2 "Being too feisty": lay understandings of hypertension and leukaemia... 153

7.2 Health and aspirations for family: how children's education and the separated households influence migrant workers' health 156

7.2.1 Left-behind for education: the common struggles faced by Chinese rural-to-urban migrant workers and their children 157

7.2.2 The unsolvable health dilemma and aspirations for children's education 159

7.3 Migrant workers' health and false hopes: a way of living 162

7.3.1 Lay perceptions of improving living conditions as migrant workers 163

7.3.2 The end of false hope: a story of sharing a cigarette in a detention centre 166

Chapter summary 169

Chapter 8 Conclusion and Discussion: Understanding the Lay Health Knowledge Systems Shared by Chinese Rural-to-urban Migrant Workers in Shanghai and Beijing.. 171

Chapter introduction 171

8.1 Addressing the health challenges shared by Chinese rural-to-urban migrant workers in urban China 171

8.2 Dealing with health challenges: health-seeking patterns among Chinese rural-to-urban migrant workers 174

8.3 Conceptual framework of the lay health knowledge systems shared by Chinese rural-to-urban migrant workers 176

Conclusion and Discussion... 182

Bibliography 184

List of Abbreviations... 204

Appendix A Research Recruitment Information Forms i

A.1 Information sheet.. i

A.1.1 Information sheet in English i
A.1.2 Original information sheet in Chinese iv

A.2 Research consent forms vii
A.2.1 Research consent form in English vii
A.2.2 Original research consent form in Chinese ix
A.2.3 Original verbal consent in Chinese x
A.2.4 Verbal consent (translated from the original Chinese version) xi

Appendix B Semi-structured Interview Questions in Chinese xii

Appendix C Fieldwork Materials xiii

C.1 Case coding xiii
C.1.1 Research participants in Shanghai xiii
C.1.2 Research participants in Beijing xiv

C.2 Fieldwork Photographs xvi
C.2.1 The health service provided by the NGO in Shanghai xvi
C.2.2 The broken and leaking ceiling in Ms Su’s bedroom in Beijing xvii

List of Tables

Table 1 The coverage and availability of basic medical insurance schemes in China 25
Table 2 Medical service providers in urban China 28
Table 3 The Health Belief Model 45
Table 4 The Salience of Lifestyle Index model questions 49
Table 5 Lay explanations of good health 51
Table 6 Comparative demographic characters of Shanghai and Beijing 64
Table 7 Research Participants in Shanghai 66
Table 8 Research Participants in Beijing 66
Table 9 Illness events and solutions among the migrant workers in Harvest village, Shanghai 95
Table 10 Lay definitions of pain from a DIDI driver 139

List of Figures

Figure 1 Fieldwork site in Shanghai 4
Figure 2 Fieldwork site in Beijing.. 4
Figure 3 China's expanding regional development gap indicated by GDP per capita (Chinese Yuan) in 1978 and 2007 (Li and Wei, 2010) 14
Figure 4 Inter-provincial migration flows to the coast of China, 1995-2000 (Huang and Luo, 2009) 15
Figure 5 Increasing number of Chinese rural-to-urban migrant workers (1982 - 2019) 17
Figure 6 Morbidity of hypertension and diabetes among Chinese migrant workers (2017)... 19
Figure 7 Morbidity rates of minor illness among Chinese migrant workers (2017) ... 21
Figure 8 Proportion of seeking treatment for health problems among Chinese migrant workers (2017) 22
Figure 9 Chinese Rural-to-urban migrant workers' healthcare insurance enrolment by locations (2017)... 27
Figure 10 Health-seeking patterns among Chinese rural-to-urban migrant workers (2017)... 29
Figure 11 Infant Mortality Rate (per 1,000 live births), Shanghai and China 34
Figure 12 Maternal Mortality Ratio (per 100,000 live births), Shanghai and China .. 34
Figure 13 Infant Mortality Rate (per 1,000 live births) in Beijing 36
Figure 14 Maternal Mortality Ratio (per 100,000 live births) in Beijing 36
Figure 15 The Dahlgren-Whitehead Rainbow 39
Figure 16 Theoretical framework.. 43
Figure 17 Health-seeking patterns among migrant workers in Slope village, Beijing 111
Figure 18 The unlabelled pills and paper bags from the migrant clinic................... 117
Figure 19 Conceptual framework of the lay health knowledge systems shared by Chinese rural-to-urban migrant workers 177

Preface

When I was 11 years old, my parents went to Shanghai and left me at our hometown village in Henan province. Growing up as a “left-behind” child, people always asked me if I have problems with my parents, and I always tell them that I understand my parents. They went to Shanghai for work opportunities, and they supported our family, especially my education, with their hard labour. I remember my mother’s first job was a sewing machine operator in a Japanese garment factory in Shanghai. She worked more than 13 hours per day and did not have any days off over the whole year. In the second year, she developed a lumbar disc herniation and could not even stand up due to the lack of rest and working conditions. She had to quit the job from the garment factory and searched around for cheap treatment channels for her back pain.

I have always asked myself, why do we have to live like this, and why do millions of other rural-to-urban migrant workers have to live like this? This question has dominated my sociological research career. However, throughout my education career, I found that this question is challenging to answer. It is hard to see any valuable discussions about migrant workers which would see them as human, who have human needs and human feelings. The privileged people have more power to discuss migrant workers as either labour products or city management problems, and sometimes as a potential threat who would “have a finger in the pie” from urban social welfare systems. I realised that the voice of migrant workers themselves was absent from public discussions.

My research attempted to explore migrant workers’ own interpretations about their migration and health events. It is qualitative research which is built on the lay health knowledge and beliefs shared by Chinese rural-to-urban migrant workers. It is about their voice, their opinions, their ways of life, and their future aspirations. Through these interpretations, my research illustrated that migrant workers have to balance their health risks and their family responsibilities every day to carry on their lives. It is not about teaching them to change themselves; it is about changing the social injustices and inequalities that shape their health-related decisions.

I recognise also that the COVID-19 pandemic has had a fundamental impact on migrant workers and their ability to sustain their own livelihoods and that of their families in urban destination cities. The fieldwork I carried out for the purpose of this thesis was conducted in 2018 and concluded in early 2019, well before the virus first arose in the city of Wuhan. For these reasons, my thesis does not specifically address COVID-19 and its impact on migrant workers, although I recognise that the precarity that is interwoven in the lives of most of the migrant workers who participated in my fieldwork undoubtedly increases their susceptibility to infectious diseases like COVID-

19, for reasons including, but not limited to, restricted access to healthcare insurance, contract employment, confined living spaces, and financial constraints. While COVID-19 is not addressed in this thesis, the conclusions drawn do have, in my view, implications for formulating effective preventative measures targeted at migrant workers against the virus and other infectious diseases.

In this thesis, I examined and elaborated upon lay health beliefs of “kang” amongst Chinese rural-to-urban migrant workers in Shanghai and Beijing. I found that “kang” is a common negotiating process shared among many migrant workers in order to balance health risks and perceived obligations to their families. I also discussed these observations with my friends, teachers and other social science researchers in Beijing while doing fieldwork there, and I eventually realised these dilemmas and ideas of “kang” are not only prevalent among migrant workers, they are in fact a portrait of most Chinese people who are driven by false expectations, but are struggling with current harsh conditions.

Part I

Introduction

Chapter 1
Research Questions, Strategies, and Main Findings

1.1 Research questions

Migration is well-recognised as one of the most important social factors affecting people's health, entailing often significant changes in position and social-standing within political, economic and social environments (Elliott and Gillie, 1998, Shuval, 2001, Boyle and Norman, 2009, Zimmerman et al., 2011, Abubakar et al., 2018). Although international migration receives the majority of academic and policy attention, the majority of migration globally occurs internally within countries. According to Abubaker et al. (2018, p.2633), in 2009, the number of migrants who moved across major zonal demarcations within their countries was nearly four times the number of international migrants. In Asia, Africa, and Latin America, research illustrates that around 40% of their urban growth results from internal migration from rural to urban areas (Farrell, 2017). However, recognising the inherent difficulties of collecting data on these populations, there is a real absence of comparative national data on the patterns and prevalence of internal labour migration, which in turn creates a particular challenge for addressing population-specific internal migrant health issues.

In China, internal migration has become one of the biggest health challenges, not only due to the considerably large number of "rural-to-urban" migrants – recorded as reaching 290.8 million in 2019 – but more importantly, as a result of China's strict household regulation system, their compromised citizen rights to services, including medical insurance, public health services, education, housing and employment resources (Lancet, 2014, National Bureau of Statistics, 2020). This thesis seeks to examine the mechanisms between the rural-to-urban internal migration and migrant workers' health inequalities, which focuses on the struggles and human sufferings shared by these rural-to-urban migrants in different individual and social settings in urban China. This research aim will be achieved by answering the following four research questions:

a) What are the significant challenges in terms of addressing migrant workers' health issues?
b) How Chinese rural-to-urban migrant workers deal with health problems in urban settings?
c) What kinds of lay health beliefs have been developed among migrant workers?
d) How social structural factors and migration-related issues have influenced migrant workers' health in China?

1.2 Fieldwork strategies

The research data is collected by conducting ethnographic fieldwork among the migrant workers' communities in Shanghai and Beijing. The fieldwork for this thesis is conducted in two "urban villages": Harvest village, which locates in the rural-urban fringe area of east Shanghai, and Slope village, which is located at the west boundary hills of Beijing[2]. As shown in **Figure 1** and **Figure 2**, the approximate locations of the two research sites marked on Shanghai and Beijing's municipal maps.

In **Figure 1** and **Figure 2**, red areas refer to the city centres, blue areas refer to the surrounding urban districts, green areas refer to outskirt suburbs, and yellow areas refer to the rural areas in Shanghai and Beijing. As marked in **Figure 1**, Harvest village is on the east side of the Pudong district. It was in the process of being demolished but used to be one of the more popular places for rural-to-urban migrant workers to reside within Shanghai. As marked in **Figure 2**, Slope village is on the edge of the outskirt district. It is one of the underdeveloped isolated outskirt villages in Beijing's boundary areas. The majority of residents used to be local farmers; in recent years an increasing number of migrant workers have moved into this village as inner-city areas of Beijing have undergone rapid gentrification.

Across mega-cities in China, a large proportion of rural-to-urban migrant workers choose to live and work in these "urban villages". As described by Chinese urban study scholar Li (2004, p.119), the term "urban villages" in the Chinese urban context refers to these spaces located within planned urban development areas, or rural-urban fringe areas, that are surrounded or semi-surrounded by developed urban spaces, with none – or only a few – agricultural land pockets remaining in that village (Li, 2004). These villages are often characterised by inadequate infrastructure and dilapidated buildings (often unlicensed and dangerous to live in), but also relatively cheaper rent compared to developed areas in mega-cities (Wu et al., 2013a).

[2] For the purpose of confidentiality, the names of organisations, villages, and research participants in this thesis are all pseudonyms and not identifiable.

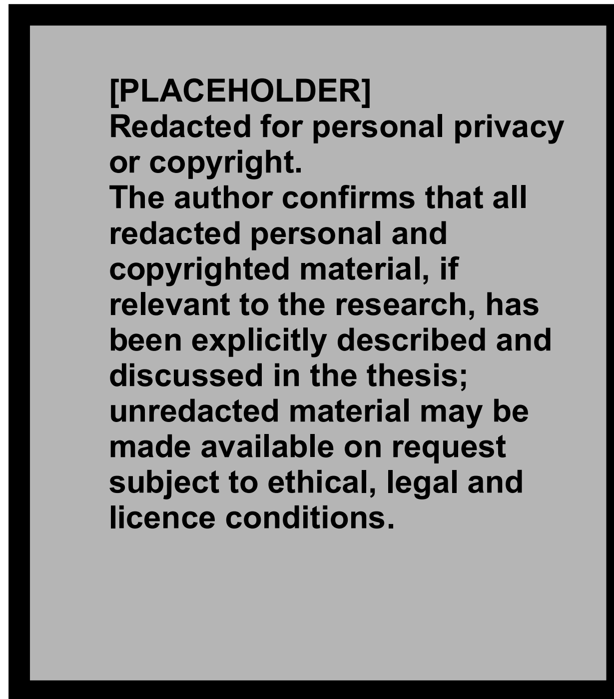

Figure 1 Fieldwork site in Shanghai[3]

*Source of map: Wikipedia (Wikipedia, 2020)

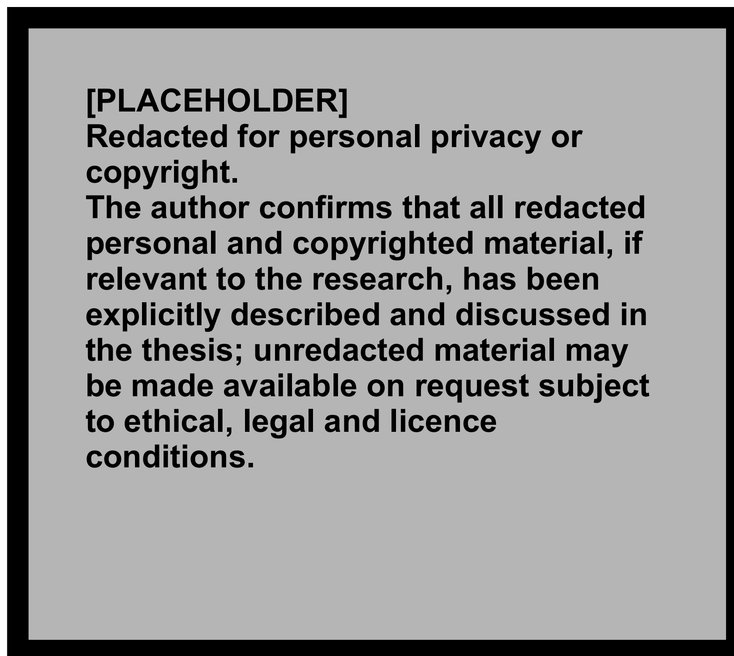

Figure 2 Fieldwork site in Beijing[4]

*Source of map: Beijing Investment Guide (2018 - 2019) (BMBC, 2020)

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[3] The black spot does not indicate the accurate geographic location but only the approximate area where I conducted my fieldwork.
[4] Ibid.

For this research, I recruited participants via two non-government organisations which provide community services specifically for rural-to-urban migrant workers: New-workers Club at Harvest village (Shanghai), and Future Community at Slope village (Beijing). Both organisations provide childcare programs for migrant workers whose children living in the city and enrolled in primary school. While carrying out my fieldwork for this thesis, my role was not only a researcher but also a voluntary tutor with both NGOs tasked with providing homework tutorial programs for migrant workers' children. In agreement with both NGOs, I selected research participants from their clients who were relatively young rural-to-urban migrant parents who have brought their children or older parents with them to their destination urban cities. The narratives of health experiences included in this thesis centre on how the migrant worker research participants address and take care of family health issues, including the health and illness of young children or older parents in urban settings. In total, 40 families of migrant workers and 8 NGO staff participated in my research fieldwork, which was 12 months in duration. Among them, ten migrant workers from Shanghai and 15 migrant workers from Beijing participated in in-depth interviews conducted over a period of time.

1.3 Research findings

By examining lay health beliefs and practices in migrant workers' health narratives, my research reveals several key observations. First, longstanding exclusionary policies in urban China have created a hostile, unfamiliar environment for rural migrant workers, often leading to widespread mistrust and misunderstandings of formal urban healthcare systems and how they operate. As a result, informal but more familiar healthcare practices and providers are preferred by these disadvantaged migrant groups. However, I have found that the prevalence in the uptake of various forms of informal folk medicine practices among migrant workers is not simply a matter of avoiding urban hospitals or expedience. Instead, these practices appear to be considered by migrants as a reliable way of resisting illness in response to well-recognised social inequalities in urban settings.

Second, my research identified what appears to be a common lay health belief synthesised as "Kang" among migrant workers. The word "Kang" is a Chinese folk medical term and cannot be translated into English. My research illustrated that it is a word commonly used by migrant workers to describe more passive-like attempts to resist illness and to justify avoidance of professional treatment. A person's interpretation of "kang" is shaped by an individual's personal experience concerning their bodies and workload tolerance, used to justify taking health risks to continue

working towards one's migration expectations.

This observation dovetails into my third and final research finding. Chinese rural-to-urban migrant workers' definition of health and health-related behaviours appear to be associated with their changing perspectives on fulfilling family responsibilities and aspirations including children's education, housing, and overall improvement of their family financially and socially. The qualitative narrative-based research I have collected indicates that heath is often seen among migrant workers as something that can be compromised and sacrificed to achieve their aspirations and expectations around migration. For some migrant workers, the situation they found themselves in, and the social limitations placed on them, led them to realise the impossibility of ever achieving the level of wealth and change in family status that had driven them to migrate in the first place. They often became complacent and accepted their situation would not improve, including their health. Others, however, appear to have remained determined to fulfil their migration aspirations enduring whatever cost to their health. However, as my research illustrates, both often met the same destination. It is important to explore how these social inequalities and challenges impact on the health and wellbeing of Chinese rural-to-urban migrant workers, not only to understand the relationship between migration and health for this group of migrants – as significant as they are to China and the world – but also to understand the price of human suffering paid behind the "curtain" of expanding global capitalism.

1.4 Summary of chapters

This first chapter is this introduction which provides an overview of my thesis.

The second chapter introduces the historical and social background of Chinese rural-to-urban migrant workers and their health inequalities and health challenges in contemporary urban China. Based on the data derived from the National Census, it provides a preliminary analysis of the health characteristics of rural-to-urban migrant workers, related to their population structure, social environments and living circumstances. It indicates the unclear questions in terms of addressing Chinese rural-to-urban migrant workers' health challenges in qualitative methods.

The third chapter reviews theoretical perspectives on examining the social determinants of health in different social settings. It provides the conceptual framework to analyse the mechanisms between social inequalities and health outcomes, which emphasises lay people's health experiences and subjective meanings of heath in everyday life. It also introduces the importance of examining migrants' lay health beliefs and their migration aspirations.

The fourth chapter introduces the research methods and approaches of this thesis, including sampling methods, fieldwork access, and utilising ethnographic methods to collect data in migrant workers' urban villages.

The fifth chapter provides an analysis of the health-seeking behaviours of migrant workers in Shanghai and Beijing based on the material gathered in my fieldwork. In particular, this chapter identifies among my research participants a general mistrust of formal urban healthcare providers, a preference for informal healthcare channels over formal urban health care systems, and various lay health explanations (for example, self-medicating with Chinese herbs). This chapter seeks to illustrate how the precarious living and working circumstances of migrants, as established in previous chapters, have in turn shaped disadvantaged migrant workers' health-seeking habits and lay health beliefs in urban China.

The sixth chapter focuses on the common lay health beliefs among the Chinese rural-to-urban migrant workers in Shanghai and Beijing, which are summarised as a Chinese word "kang". "Kang" as one of the popular folk medical terms in China, is not believed or preferred by its scientific evidence but the "uncertain" emphasis on "natural immunity" and body resistance which can be used to justify migrant workers' negative reactions to health problems. Male migrant workers and female migrant workers have different interpretations of "kang".

The seventh chapter continues discussing the influences of aspirations in migrants' lay health beliefs. The migration aspirations for a family can be divided into three main stages. By analysing the health-related stories from these three migration stages, I found that migrant workers' health perceptions are also changing over time. At the beginning of the migration, migrant workers are often driven by poverty and are eager to change their family economic situations, and they often blame their health problems on their frugal lifestyles and feisty hardworking personalities. In the second stage, when migrant workers face their children's education challenges, they connect their health problems with their unsolvable dilemma between their migration reality and their children's educational aspirations. These challenges often lead to migrant workers' mental depression and are believed as the reason for other health problems. In the late stage of migration, migrant workers often need to face unpleasant reality checks. For some migrant workers, the situation they found themselves in, and the social limitations placed on them, led them to realise the impossibility of ever achieving the level of wealth and change in family status that had driven them to migrate in the first place. They often became complacent and accepted their situation would not improve, including their health. Others, however, appear to have remained determined to fulfil their migration aspirations enduring whatever cost to their health. However, as my

research illustrates, both often met the same destination.

The last chapter concluded my thesis. I summarised the significant research findings which suggest that reducing social inequalities should be the way of addressing migrant workers' health challenges. It requires systematic reflections on the social inequalities and the human sufferings that Chinese rural-to-urban migrant workers have been going through in contemporary China.

Part II

Research Background

Chapter 2
Behind the Curtain of “Made in China”: An Exploration of Chinese Rural-to-urban Migrant Workers and their Health Challenges in Contemporary China

Chapter introduction

This chapter introduces the social backgrounds of Chinese rural-to-urban migrant workers and focuses on some of their more common health challenges. It seeks to examine how social inequalities have developed since the establishment of the People’s Republic in China to present, based on the Mao-era rural-urban division, and how the perpetuation of reproduction of social and geographical inequalities have created specific health challenges for Chinese rural-to-urban migrant workers in contemporary China.

The first section describes the systematic social changes that have occurred throughout the modern history of contemporary China, looking “behind the curtain” to chart the emergence of Chinese rural-to-urban migrant workers, who they are, and how they became the country’s dominant labour force. This section also examines how regional inequalities and rural-urban inequalities are integrated into Chinese rural-to-urban migrant workers’ living circumstances in urban China.

The second section describes the health characteristics of Chinese rural-to-urban migrant workers. By comparing the general population health characteristics in China with the migrant population, this section identifies neglected areas of research that requires further attention in relation to migrants’ health in China.

The third section identifies and examines inequalities across healthcare insurance and utilisation among Chinese rural-to-urban migrant workers. It explains the disparities between different healthcare insurance schemes, and how Chinese migrant workers are excluded from the “universal healthcare insurance coverage” in China. This exclusion has also created more barriers in migrant workers’ healthcare utilisation in urban cities.

The fourth section introduces different social perspectives that can be used to inspect migrant workers’ health inequalities in their living circumstances, including family arrangements and social integration. This chapter concludes by recognising that these important social factors on health have not been explored well in the literature and requires more specific qualitative research.

2.1 The changing image of “Chinese workers”

To focus on the health of Chinese rural-to-urban migrant workers is not only to examine and shine a light on human suffering behind “closed doors”, but also provides a means to reflect on global capitalism, that which connects most individuals around the world. China has been widely recognised as the “world factory” in the 21st century (Fishman, 2005, Zhang, 2006). As the world’s largest exporter and the second-largest importer, China has never been so closely related to people around the world as today – China-based factories have dominated in many industries, especially those labour-intensive products in global markets (Dai et al., 2016, Brakman et al., 2018). As Shenkar (2006, p.266) described, Chinese factories make up “70 per cent of the world’s toys, 60 per cent of its bicycles, half its shoes, and one-third of its luggage”, and “it is often impossible to find a non-Chinese product on store shelves” (Shenkar, 2006). However, although people over the world have never been this close to “Made in China”, those who behind the curtain of “Made in China” are rarely known by the world – mostly being Chinese rural-to-urban migrant workers.

In 2009, “The Chinese Worker” was voted as one of the runners-up for “Person of the Year 2009” of TIME Magazine because of their contribution to the Chinese economy as well as the world economy. The TIME magazine dedication to Chinese workers specifically stressed that “the tens of millions of workers … have left their homes, and often their families, to find work in the factories of China’s booming coastal cities” (Ramzy, 2009). In contrast to the general picture of “workers” in many other countries, Chinese workers are, at least globally, regarded as synonymous with Chinese rural-to-urban migrant workers.

2.1.1 Rural-urban social framework and the replacement of “Chinese workers” in China

This changing definition and imagery of Chinese workers can be attributed to the historical transformation of modern China in the 1980s, where a Soviet-style regime with a closed planned economy transitioned into an open global capitalist economic player (Sheehan, 2002). These social changes in effect provide a framework to understand Chinese rural-to-urban migrant workers’ social environments, including the basic social framework prefaced on the rural-urban household registration (“hukou”) system.

Chinese workers who worked for state-owned or collective enterprises in Mao’s era (1949-1976) were once referred to as “the owners of the country”. They were mainly comprised of urban residents, who were separated from the rural residents (comprising the majority, being 74.1 per cent of Chinese population in 1970) by the

household registration system (Kelliher, 1992, Chan, 1993, Bian and Logan, 1996). The household registration system, also known as the hukou system, is an institutional regulating system established in 1951 by the Chinese Government to control population movement. All Chinese families were registered with either an urban or rural hukou, which effectively restricted each individual to their place of registration and stripping them of the right to choose or move their place of residence during Mao’s era. A household's hukou was also continued to be inherited by the next generation in the family (Banister, 1991, Chan and Zhang, 1999). It created two radically distinct social groups in China based on their citizen rights – for instance, Chinese workers entitled with urban hukou registration were granted generous fringe benefits, including subsidised housing, free health services, free education, and were guaranteed with subsidised products (Afridi et al., 2015). In contrast, those with rural hukou – the so-called “Chinese peasants” – were forced into collective communes and deprived of private property (Sicular et al., 2007). Rural residents were also required to pay heavy agricultural taxes for their farming land, which was represented in Mao era Government discourse as “efforts” to prioritise “socialist national industrialisation” (Kueh, 2006, Kennedy, 2007).

This division implemented by the hukou system has created a clear social division between “privileged Chinese workers” and so-called “inferior poor peasants” in Chinese society in terms of citizen rights and living standards (Potter, 1983, Unger, 2002). This rural-urban division in the Mao era was firm and clear, so much so that it also determined opportunities for survival. During the Great Famine (1959 - 1961), approximately 30 million people starved to death in China, all of the people who resided in rural areas who ‘were forced to abandon all private food production’ to ensure the ‘preferential supply of food to cities and the ruling elite’ (Smil, 1999, Meng et al., 2015c, Zhou, 2012). For a long time in Mao’s era, the urban residents, mainly “socialist workers”, were perceived as superior, well-educated and were entitled to a full range of state-welfare in Socialist China between 1949 to 1978 (Whyte, 2010). In contrast, Chinese “peasants” were perceived as low-educated disposable labourers without any social entitlements or state welfare coverage (Bernstein, 1984).

However, the “privileged” social status of the “Socialist Chinese workers” did not last long. Led by Deng Xiaoping since 1978, China embarked on its reform and “opening-up” policy-led market-oriented transformation. Two years after Mao’s death, Deng Xiaoping changed the total direction of China’s economy while maintaining the rule of the Chinese Communist Party (‘CCP’) (Chow, 1987, Qian, 2000, Vogel, 2011). In this market-oriented economy era, most nation-wide state-owned and collective enterprises lost their government subsidies and went bankrupt, and their urban workers were laid off and soon fell into poverty (Solinger, 2002). The image of

“Socialist Chinese workers” was soon replaced with laid-off, ageing workers who struggled to claim their “stolen” retirement welfare, which was previously organised and promised by the “socialist enterprises” but disappeared with the nation-wide bankruptcy (Cai, 2006). However, an alternative image emerged in the labour markets – the new “Chinese workers”, who were younger and worked for lower wages compared with the former “socialist workers”. These Chinese workers were, and continue to be, Chinese rural-to-urban migrant workers. Since the 1980s, market-oriented reform was promoted throughout rural China, and Soviet-style collective agriculture communes gradually dissipated. Chinese rural residents (or “peasants”) were no longer constrained to their collective compulsory farming labour and were allowed to work for their family livelihoods by farming their own contracted lands or working for other private channels (Parish and Whyte, 1980, Selden, 2002). The rural-urban restrictions were gradually loosened during the 1980s in China, and the rural peasants started to seek employment opportunities in cities (Chan and Zhang, 1999). At the same time, China’s ongoing reform and effects of the opening-up policy dramatically reshaped China’s economic geography, leading to large-scale internal migration from one region to another.

2.1.2 Regional inequalities and internal migration in China

China’s “opening-up” policy strengthened investment along its coastal provinces, and the process of industrial agglomeration and urbanisation was accelerated in eastern megacities like Beijing, Shanghai and Guangzhou (Xu and Zhu, 2009, Chuang-Lin, 2009, Zhang et al., 2009, Cartier, 2011). At the same time, given this rapid and uneven development process, regional socio-economic disparities also expanded at an increasing rate, effectively dividing China’s economic geography into three main parts: the developed eastern region; the developing middle region; and the underdeveloped western region (Zha, 1996, Fleisher et al., 2010). **Figure 3** illustrates the increased regional inequality across China by Gross Domestic Product (‘GDP’) per capita (Chinese Yuan) in 1978 (a) and 2007 (b). After the “opening-up” and reform policy was introduced in 1978, cities located along the east coast of China have rapidly developed; meanwhile, the economic gap between the east coast regions and the rest of China has hugely expanded in 2007 (Li and Wei, 2010).

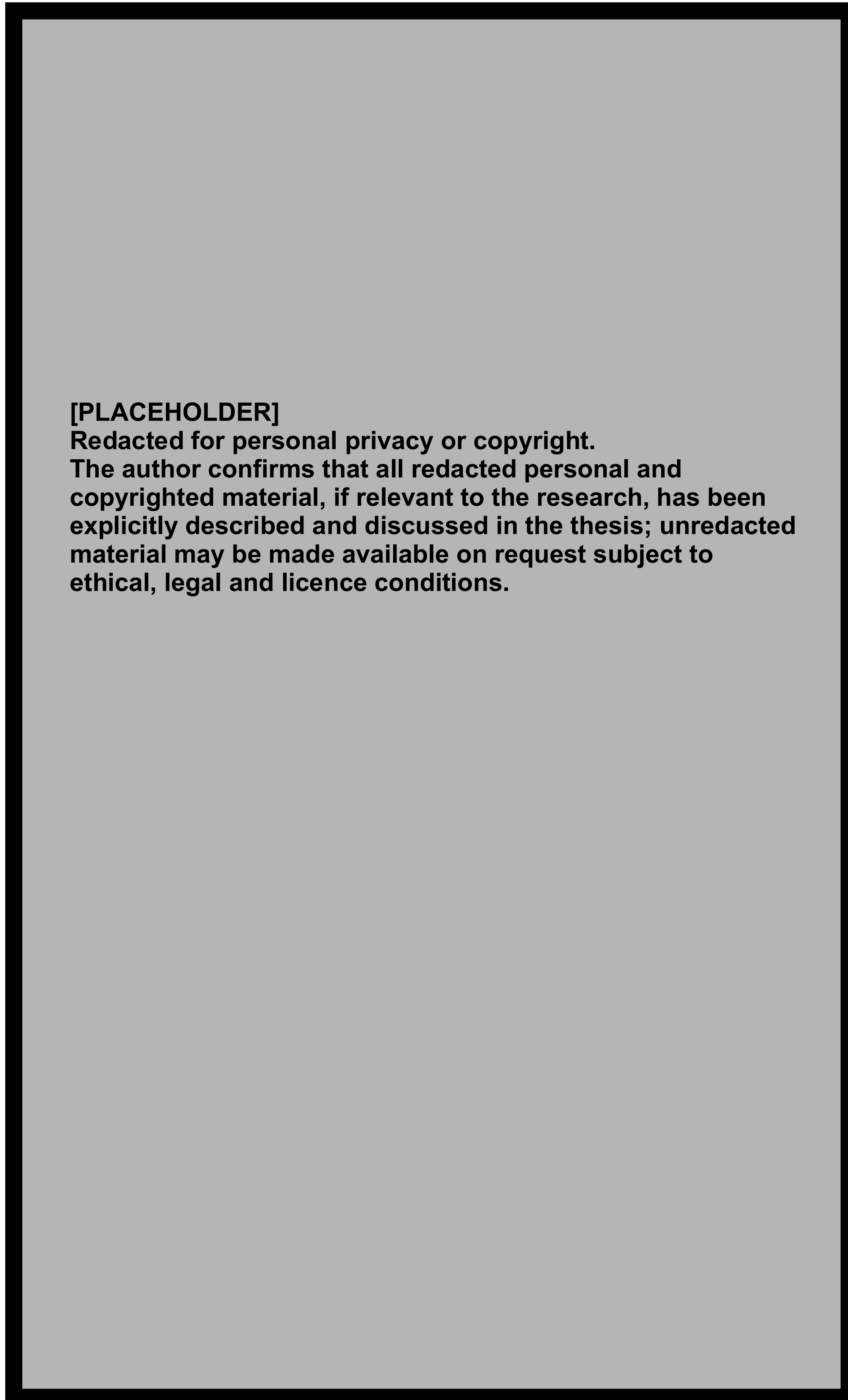

Figure 3 China's expanding regional development gap indicated by GDP per capita (Chinese Yuan) in 1978 and 2007 (Li and Wei, 2010)

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Figure 4 Inter-provincial migration flows to the coast of China, 1995-2000 (Huang and Luo, 2009)

While cities underwent major transformations and became key economic players mostly in eastern and southern coastal regions, the rural residents from middle and western China, as well as the underdeveloped areas in eastern China, started flocking to the coastal cities. As shown in **Figure 4**, during 1995 to 2000, the general migration trend is from the inland areas to the east coast cities. Shanghai and Beijing are among the popular destinations receiving migrants from rural China (Huang, 2010). However, the policy framework – including the hukou system, population mobility restrictions, and governance strategies – was not adjusted concurrently with the country's dramatic economic transformation. Rural residents were still officially restricted to their hukou registration places and were not encouraged to move to other cities/places during the 1980s (Cheng and Selden, 1994). In 1982, the Chinese Government issued the "Custody and Repatriation System" to control rural-urban mobility. This regulation authorised urban police to approach migrant workers, check their residence permits, and arrest and repatriate any migrant workers under their jurisdiction back to their hometowns (Yi, 2003). This regulation, however, underwent reform in 2003 due to public outrage over the "Sun Zhigang" event, where a college student was beaten to death by Guangzhou police because he was mistakenly arrested as an unemployed migrant worker on the street (Hand, 2006).

Although the 2003 reforms ensured that Chinese rural migrants would not be arbitrarily arrested and repatriated while they were out in public in urban cities, their main citizen rights including housing, education and health insurance were still bonded with their hukou registration and only available in their places of household registration. In this way, migrant workers cannot access these citizen rights in urban cities, which continues to this very day due to various policy restrictions (Chan and Zhang, 1996, Wu and Treiman, 2007).

However, these restrictions did not stop the rapidly increasing rate of migration of Chinese rural-to-urban migrant workers to cities. According to the National Bureau of Statistics, the definition of Chinese rural-to-urban migrant workers refers to these rural residents who migrated to a different city outside of their hometown to work for a period greater than 6 months, but still have their original rural hukou registered at their respective "hometowns" (NBS, 2018). The number of Chinese migrant workers rapidly increased from 6.6 million in 1982 to 290.8 million in 2019, which accounts for approximately 20% of China's population (National Bureau of Statistics, 2020, UNICEF, 2020). This increase is illustrated in **Figure 5**. This large number and percentage of Chinese rural-to-urban migrant workers has dominated the labour markets in China – representing the image of "Chinese workers".

However, as the majority of the Chinese labour force, rural-to-urban migrant workers

must confront a wide range of challenges and social inequalities in urban settings, including rural-urban migration and hukou division, incomplete citizen rights, and marginalised living circumstances in urban settings (Wong et al., 2007, Shi, 2008).

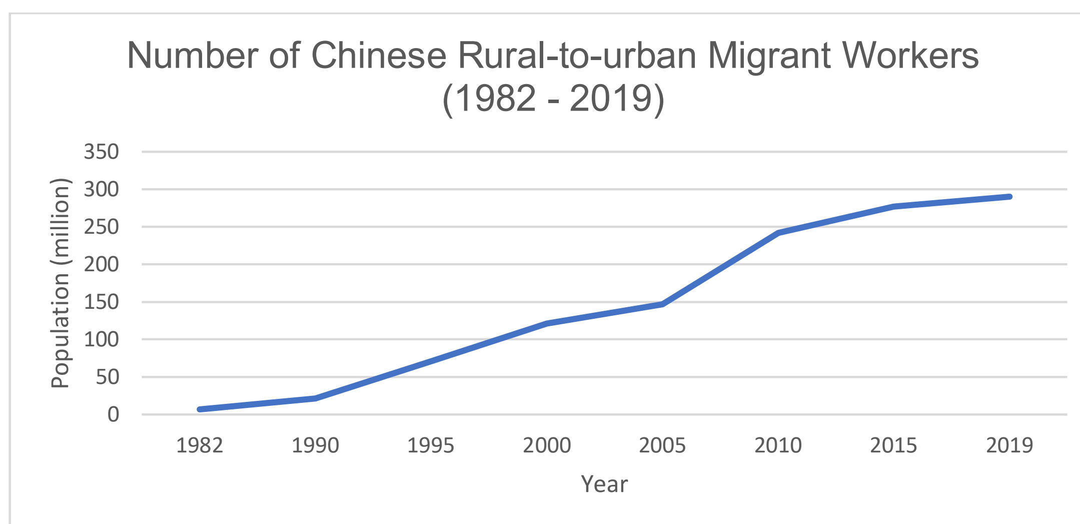

Figure 5 Increasing number of Chinese rural-to-urban migrant workers (1982 - 2019)

2.2 Health characteristics of rural-to-urban migrant workers in China

Population health trends and related health challenges in China have dramatically changed after the "opening up" and reform policy of the 1980s. These trends and challenges are closely associated with changes in environmental, population structure, medical technique, and health policy reforms (Yang et al., 2013, Liu, 2016, Zheng et al., 2019, Zhou et al., 2019). In 2008, "Internal Migration and Health in China" was published on the Lancet, which found that Chinese rural-to-urban migrants are at higher risk of infectious diseases, maternal health problems, and occupational diseases and injuries (Hu et al., 2008). However, the general characteristics of Chinese rural-to-urban migrant workers' health are different from national population health trends, and these differences present inherent challenges to understanding health disadvantages experienced by migrant workers.

2.2.1 Health trends, health selection theory, and the Salmon bias effect in China

In recent decades, health trends in China have focused on chronic non-communicable diseases. According to the *Chinese Disease Surveillance Points System Data* from 2004 to 2016, chronic non-communicable diseases are the main causes of deaths in

China, accounting for 86.81% of deaths in men and 89.13% of deaths in women in 2016. Among them, malignant neoplasm, cerebrovascular disease, heart disease and Chronic obstructive pulmonary disease ('COPD') are the top four causes of deaths, which are all chronic non-communicable diseases and been on the increase throughout the last two decades (Zhu et al., 2019a). Data from the *Global Burden of Diseases, Injuries, and Risk Factors Study* in 2017 also shows that stroke, ischaemic heart disease, lung cancer, chronic obstructive pulmonary disease, and liver cancer are the five leading causes of years of life lost ('YLLs') in China (Zhou et al., 2019).

Chronic non-communicable diseases appear to be the main health challenges as per China's current health policy agenda (Tang et al., 2013). However, due to different population structures, Chinese rural-to-urban migrant workers face different health challenges, which are often neglected in national health statistics. The first difference is that the migrant population tends to be of a younger age. According to the *China Migrant Workers Dynamic Monitoring Survey Report* 2018, the average age of Chinese rural-to-urban migrants is 35.2 years old, and 69.9% of migrant workers are younger than 40 years old (NBS, 2019). Additionally, rural-to-urban migrants also tend to be healthier than their peers left behind in the countryside, and more likely to return to their household registration "home-town" when aging or becoming sick, as illustrated by various migrant surveys in China. In the population health literature, this phenomena is known as the "health selection" and "Salmon bias" effect (Abraido-Lanza et al., 1999, Fennelly, 2007, Chen, 2011, Qi and Niu, 2013, Lu and Qin, 2014, Zhang et al., 2015).

The limited data available that represents the health conditions of rural-to-urban migrant workers is often interpreted as showing migrants are more healthy than non-migrants/urban residents – however, these interpretations do not factor in the "health selection" and "salmon bias" effect as described above (Chen, 2011). For example, in 2015 statistics indicated that about 23.2% of the Chinese adult population had hypertension, although only 46.5% of them were aware of their condition (Wang et al., 2018, CCDC, 2019). The morbidity of diabetes in China has also been on the increase in the past three decades, from less than 1% in 1980 to 10.9% in 2013 (Hu and Jia, 2018). Hypertension and diabetes are two of the most common chronic diseases in the Chinese population, but the available data on migrant workers paints a different picture. As shown in **Figure 6**, a much smaller proportion of Chinese rural-to-urban migrant workers have hypertension and diabetes (morbidity rates) compared with the national average level. According to the most recent survey data produced by the Migrant Population Service Centre of the National Health Commission P.R. China titled *"China Migrants Health and Family Planning Dynamic Monitoring Survey 2017"* ('CMDS'), among the selected 80,397 samples of rural-to-urban migrant workers

throughout China, only 3.5% of Chinese rural-to-urban migrant workers are reported as having hypertension; 0.51% are reported as having diabetes; and 0.32% are reported as having both hypertension and diabetes (CMDS, 2018).

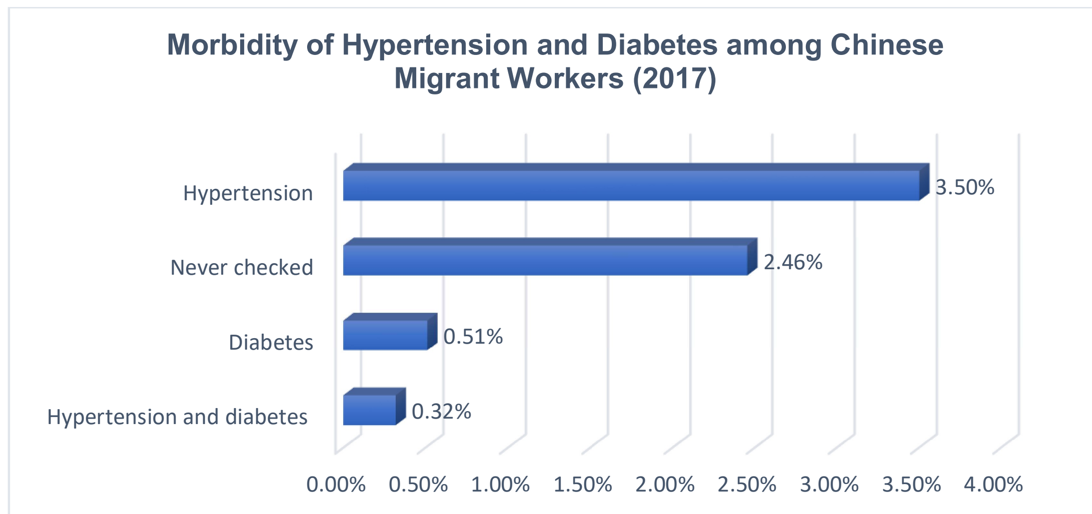

Figure 6 Morbidity of hypertension and diabetes among Chinese migrant workers (2017)

2.2.2 Health characteristics of Chinese rural-to-urban migrant workers

Rather than non-communicable chronic diseases, research shows that rural-to-urban migrants in China have increased health risks, including occupational injuries, infectious diseases, reproductive health and mental health issues, and these increased health risks are mostly related to migrant workers' difficult living circumstances and inadequate healthcare (Nuwayhid, 2004, Feng et al., 2005, Li et al., 2007b, Li et al., 2007a, Wong et al., 2008, Fitzgerald et al., 2013, Mou et al., 2013b, Wong et al., 2016). These health inequalities are often difficult to measure due to the effects of "health selection" and "salmon bias" in the migrant population, as discussed previously.

In a study carried out by Chinese scholars Zhou and Lu (2016, p.81), they applied the concept of "health depletion"[5] to measure health inequalities among a same-age population across different social positions. "Health depletion" refers to the aggravation of a person's health with age and is measured by a person's self-rated health on different occasions over a period of time to determine whether any specific groups become unhealthy earlier, or at a more rapid rate, than others. By analysing the data from the *China General Social Survey (CGSS) 2010,* Zhou and Lu (2016, p.89) found that the health depletion of Chinese migrant workers in manufacturing and construction work is at a more rapid rate, compared with urban workers and migrant

[5] This concept is translated from Chinese "健康损耗".

workers in administrative positions. Their analysis indicated that manual labour, incomplete social security, and migration distance are the main health-damaging factors associated with Chinese rural-to-urban migrant workers' worsening health in urban cities (Zhou and Lu, 2016). Their research suggests that health inequalities are reflected by the health problems faced by migrant workers in everyday life, which, in turn, is closely connected with migrant workers' living circumstances. These health inequalities and related health struggles are often reflected in the common ailments experienced by people in everyday life (Backett-Milburn et al., 2003, Hodgetts et al., 2007).

Continuing with this approach, in the following sections I provide an analysis of the available survey data with the aim of presenting a reflection in-part of the common, "everyday" health struggles and challenges faced by Chinese rural-to-urban migrant workers. The *China Migrants Health and Family Planning Dynamic Monitoring Survey* 2017 lists the self-reported morbidity of six common aliments among Chinese rural-to-urban migrant workers in the year before the survey (2016 - 2017), which includes:

- Diarrhoea: having more than 3 episodes of diarrhoea in one day;
- Fever: body temperature is higher than 38-degree ℃;
- Skin rash: abnormal colour, swelling or blisters appear on the surface of the skin;
- Jaundice: elevated serum bilirubin to make the skin, mucous membrane and sclera yellow;
- Conjunctival redness: Redness and swelling of the conjunctiva of the eye; and
- Cold or flu.

As shown in **Figure 7**, according to the survey (CMDS, 2018), cold and flu are the most common health problems experienced by Chinese rural-to-urban migrant workers, with a much higher morbidity rate (57.46%) compared to other health problems. Diarrhoea is the second common disease with a lower morbidity rate (13.85%) compared with cold and flu, often associated with unsafe water, unsafe sanitation and nutrition deficiency in living circumstances (Keusch et al., 2016, Dadonaite and Ritchie, 2018). Similar to diarrhoea morbidity, there are 12.2% of migrant workers reported experiencing fever symptoms. The morbidity of skin rash, conjunctivitis, and jaundice symptoms appears to be relatively uncommon among Chinese migrant workers (CMDS, 2018).

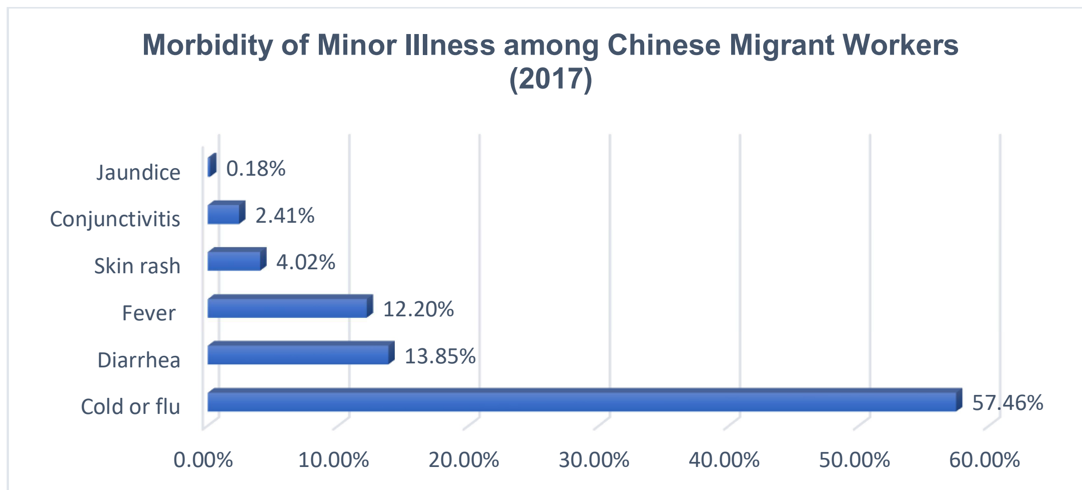

Figure 7 Morbidity rates of minor illness among Chinese migrant workers (2017)

The high morbidity rates of cold and flu among Chinese migrant workers is not particularly significant since they are the most common ailments among adults and children (Eccles, 2005). However, the CMDS (2017) survey results illustrate that the ways that Chinese migrant workers *deal with* and *manage* their cold and flu symptoms is of significance. According to the same survey from CMDS (2017) summarised on **Figure 8**, approximately 37% of migrant workers with cold and flu symptoms would seek medical treatment for their symptoms, and 63% tend not to seek treatment. As shown in **Figure 8**, the proportion of Chinese migrant workers seeking medical treatment does not align with the morbidity rates of the six types of health problems listed previously. Jaundice has the highest rate of seeking treatment despite its low morbidity rate among Chinese rural-to-urban migrant workers. Over half of migrant workers would seek treatment for skin rash and fever symptoms, less than half (42.3%) of migrant workers would seek treatment for conjunctivitis, and only about 30% of migrant workers would seek treatment for their diarrheal diseases (CMDS, 2018).

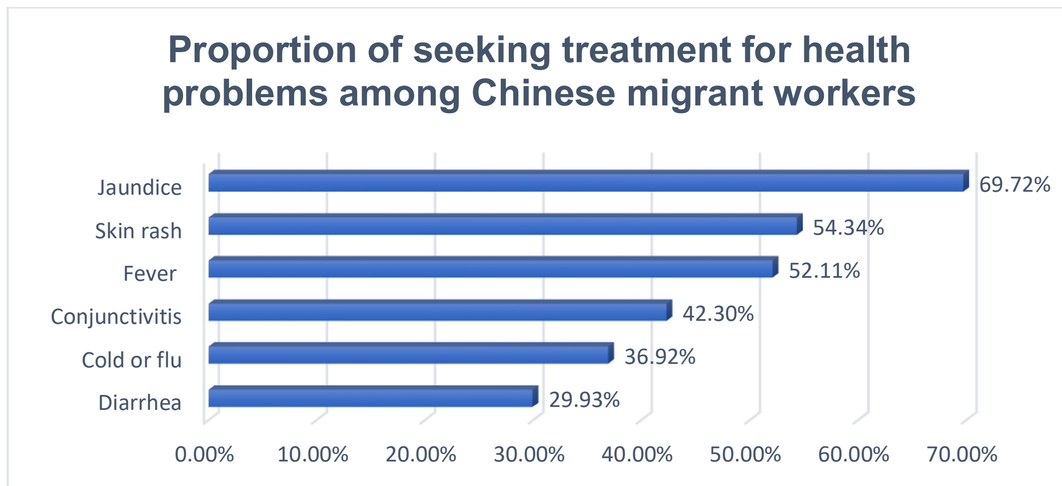

Figure 8 Proportion of seeking treatment for health problems among Chinese migrant workers (2017)

While there is ample Western literature that explores how social groups employ different methods to treat and deal with common ailments, such as cold and flu and diarrheal problems, no literature to date has enquired into the methods and practices employed by Chinese migrant workers. In this way, no factors have yet been put forward to explain these inconsistencies between the morbidity rates of cold and flu and diarrheal problems and the lower rates attributed to seeking medical treatment for these ailments. This raises a number of key questions as follows:

a) Without medical treatment, how do migrant workers deal with these common “everyday” health problems?
b) Have health inequalities (as discussed in previous section) influenced migrant workers’ health seeking-behaviours? If so, what particular health inequalities?
c) How do migrant workers perceive and explain their health-seeking patterns?
d) Are health-seeking behaviours related to internal migration issues and health policy factors?

I will explore these questions in the following section.

2.3 Health inequalities experienced by Chinese rural-to-urban migrant workers

Healthcare insurance is one of the most important health policies in the Chinese context. It was purportedly introduced to lower out-of-pocket medical expenditure and ensure affordable medical services for all citizens (Qingyue and Shenglan, 2013, Ramesh et al., 2013). In this section I will examine the position of migrant workers in relation to universal healthcare coverage. In doing so, I will explain how Chinese migrant workers have been excluded from the promise of “universal healthcare

coverage" in China, and how that exclusion affects their healthcare utilisation in urban settings and presents distinct challenges.

2.3.1 Rural-to-urban migration and associated Healthcare Insurance Disparities in China

Rural-to-urban migrant workers continue to increase in numbers, and are frequently described in specific ways as "peasant-workers" or the "floating population"[6] in policy discourses concerning their civil rights (Li et al., 2006, Chen et al., 2011). Due to the hukou system, many Chinese rural-to-urban workers are systematically excluded from urban social welfare systems, especially basic public medical insurance schemes in urban China. This exclusion is rooted in the division of rural-urban medical care systems. Most rural migrants remain bonded with rural medical care systems, which are of a far lower standard when compared with urban healthcare systems.

In the 1960s, China set up the basic Rural Cooperative Medical Scheme in rural areas, the Labour Insurance Schemes, and the Government Employee Insurance scheme in urban areas (Blumenthal and Hsiao, 2005). The current healthcare challenges faced by migrant workers are historically associated with rural healthcare systems in China. The Rural Cooperative Medical Scheme employed local "barefoot doctors" to provide very basic medical services with minimum Western medicine but more traditional Chinese alternative medicine, and the main purpose was to control infectious diseases in rural areas with the lowest cost. These "barefoot doctors" were selected from rural residents in local farming communes, with very basic medical training 'in first aid and in the treatment of minor and common illnesses' (Sidel, 1972). The promotion of "barefoot doctors" in the 1960s-1970s created a large number of semi-professional rural health workers in China. They are not all qualified since there is no national or regional professional standard for selection, training, and certification (Hsu, 1974). Alternative traditional Chinese medicine (eg, use of traditional herbs, among others) was encouraged without experiment or professional supervision. The fact that these "barefoot doctors" continued to carry out their farming duties in addition to a busy part-time medical "practice" without economic reward resulted in common dissatisfaction among both patients and "doctors" (Perkins and Yusuf, 1984). The "barefoot doctors" system was abolished in the 1980s along with the Soviet-style commune farm system, and the Rural Cooperative Medical Scheme soon collapsed in rural China (Lin, 1991). However, rural migrants still prefer some unqualified rural doctors although they have been classified as illegal or underground medical practices in urban cities (Lyu, 2016).

The coverage of medical insurance for rural inhabitants in China dramatically fell from

[6] Translated from Chinese "农民工" and "流动人口", both terms are referring to rural-to-urban migrant workers.

84.6% in 1975 to 5% in 1985 (Zhu et al., 1989, Zhang and Unschuld, 2008). Around the same time, the Chinese Government significantly reduced its health investment and encouraged privatisation and marketisation in health service systems (Blumenthal and Hsiao, 2005). The insufficient rural healthcare resources have led to high health expenditure and significant poverty, which has largely been considered an individual responsibility for rural Chinese (Liu et al., 2003). For example, a series of public health crises from the 1990s to the early 2000s can be considered as a reflection of the deterioration of China's irregular rural healthcare service system, including the AIDS crisis in Henan province during the 1990s, where AIDS was transmitted to 'up to a million people … in this single province through a vast, largely unregulated blood-selling operation' (Rosenthal, 2002, Watts, 25 Oct 2003, Yardley, 2007); and the outbreak of the Severe Acute Respiratory Syndrome ('SARS') crisis in 2003, which was aggravated due to an absence of formal medical regulations and resources in rural China (Gittings and Meikle, 2003).[7]

After almost three decades of marketisation, privatisation and decentralisation in the healthcare system, the Chinese Government began to centralise its health care system, strengthen its supervision, and increase its investment in the health system (Chen, 2009). In 2005, China embarked upon the New Rural Cooperative Medical Insurance System ('NRCMI') in rural areas (Wagstaff et al., 2009). This new medical insurance system provides Chinese rural residents with basic medical insurance within a certain range of diseases and medicines (Jiansheng, 2005). In this scheme, rural patients pay a certain amount for medical insurance annually, and then they can enjoy a certain proportion of reimbursements after their treatment (Wagstaff et al., 2009). However, since people with a rural hukou can only enjoy this rural medical insurance in their household registration places, it is often difficult for rural migrants to use this medical insurance scheme in everyday life (You and Kobayashi, 2009).

The healthcare system in urban China has a different trajectory, and rural migrants are also influenced by its changing reforms. Before the 1980s, China had two medical insurance schemes in urban areas: the Labour Insurance Scheme and the Government Insurance Scheme (also called "free medical care"). These two schemes provided free medical services for workers in state-owned enterprises and government officials in urban areas (Liu, 2002). During the 1990s, the Labour Insurance Scheme collapsed due to reform of enterprise ownership. In 1998, the Chinese Government embarked upon the alternative urban medical insurance scheme – the Urban Employees Basic Medical Insurance ('UEBMI'). This insurance scheme is financed by

[7] There is of course the COVID-19 pandemic that continues today. However, at this time no thorough investigations have been undertaken into its transmission in China in order to provide any useful commentary.

both the government, employees and employers, and promised to provide universal medical insurance coverage for all workers in urban areas regardless of their hukou status (Liu and Zhao, 2006, Su et al., 2019). In 2007, the Chinese government embarked upon another complementary medical insurance scheme for non-employees in urban areas, the Urban Resident Basic Medical Insurance ('URBMI'), which provides medical insurance for all urban residents who are not covered by the UEBMI system (Lin et al., 2009). In 2016, the Chinese government started to promote a medical insurance scheme for all residents who are not employed regardless of their hukou status, the Urban and Rural Residents Medical Insurance Scheme (URRMI). The aim of which is to reduce the social welfare gap between rural and urban China (Council, 2020). **Table 1** shows the current co-existing medical insurance schemes for different hukou statuses, they together designed to purportedly meet the government's agenda of achieving "universal medical insurance coverage" in China (Ferreira, 2017, He and Wu, 2017, Li et al., 2017).

Table 1 The coverage and availability of basic medical insurance schemes in China

* NRCMI: New Rural Cooperative Medical Insurance Scheme

* URRMI: Urban and Rural Residents Medical Insurance Scheme

* UEBMI: Urban Employees Basic Medical Insurance Scheme

* URBMI: Urban Resident Basic Medical Insurance Scheme

Hukou status	Covered by	Available
Rural residents	NRCMI or URRMI	NRCMI or URRMI
Urban residents	URBMI or URRMI; UEMBI	URBMI or URRMI; UEMBI
Rural-to-urban migrant workers	NRCMI or URRMI; UEMBI	NRCMI or URRMI (hometown); UEMBI (employed)

Although China declared that the "universal health insurance coverage" was achieved in 2011 (Yu, 2015), there are two considerable restrictions which have limit the ability to claim medical insurance benefits in practice. First, the utilisation of basic medical insurance schemes is normally limited to locations of enrolment, which is either hukou

registration or employment locations. Rural-to-urban migrant workers can enrol in basic medical insurance schemes as either rural residents (NRCMI) or urban employees (UEBMI), but they are not able to enrol or claim their medical insurance benefits in their work cities if they are enrolled in the basic medical insurance schemes in their hukou registration places (Chen et al., 2017, Brugiavini et al., 2018, Deng et al., 2020). Second, different medical insurance schemes are independent of each other, and this fragmentation has prevented people from claiming their insurance benefits across different schemes (Meng et al., 2015a). As shown in **Table 1**, although people with different hukou status are covered by different basic medical insurance schemes, the available medical insurance schemes for rural-to-urban migrant workers are restricted by their migration and employment status.

As indicated in the last section in **Table 1**, rural-to-urban migrant workers are entitled to enrol in NRCMI or URRMI at their rural hometown places, which only can be claimed in hometown places. They are also entitled to enrol in the UEBMI, which can be claimed in work cities. However, the UEBMI requires contributions from employers and requires a formal contract to enrol, which has excluded migrant workers working in informal sectors, including most construction workers (Gao et al., 2012, Wang and Yu, 2016, Yu and Shi, 2019). These disparities in entitlement and access results in many migrant workers being unable to claim medical insurance benefits in their work cities (Guan, 2017, Lu et al., 2017b). For instance, the survey data from the *China Migrants Health and Family Planning Dynamic Monitoring Survey 2017* provides about 74,258 Chinese rural-to-urban migrant workers' medical insurance enrolment information, and it shows that there are only 22.67% Chinese rural-to-urban migrant workers enrolled in the Urban Employee Basic Medical Insurance Scheme (UEBMI). By contrast, over 70% of migrant workers are enrolled in the NRCMI or URRMI, which are usually not available in their work cities (CMDS, 2018).

For many Chinese rural-to-urban migrant workers, the most important and convenient basic healthcare insurance is the Urban Employee Basic Medical Insurance Scheme (UEBMI) in their work cities. More importantly, healthcare insurance schemes in different provinces have very different standards and benefit levels, and the utilisation of healthcare insurance is often restricted in the enrolment cities (Sun et al., 2017, Liu et al., 2017). As shown in **Figure 9**, the survey data which describes the places of Chinese migrant workers' healthcare enrolment, there are only 20.36% enrolled in medical insurance schemes in their work cities, and the majority of migrant workers only have their healthcare insurance enrolled in their "home-town" locations (CMDS, 2018).

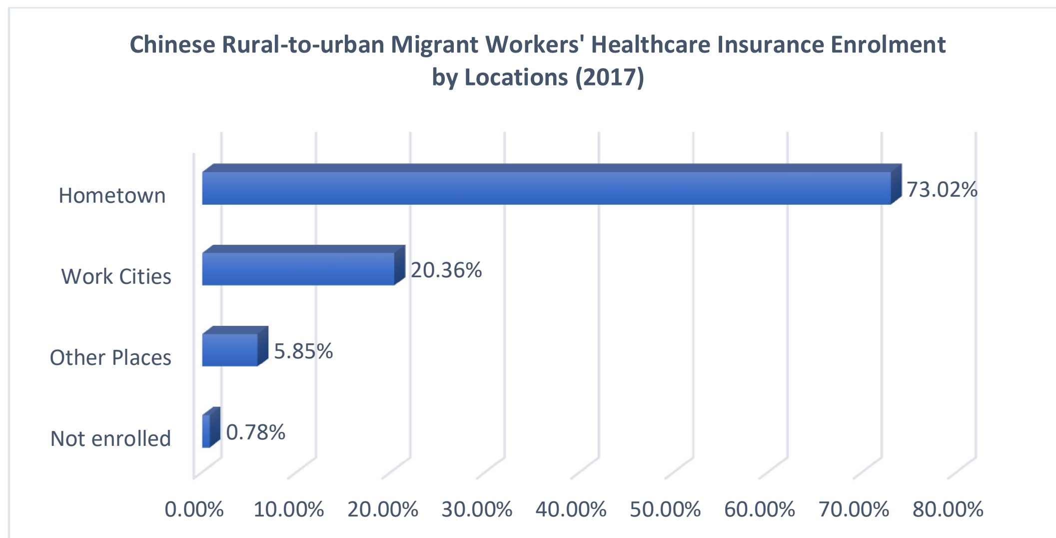

Figure 9 Chinese Rural-to-urban migrant workers' healthcare insurance enrolment by locations (2017)

Without available basic healthcare insurance, out-of-pocket medical expenses are a significant financial burden for Chinese migrant workers due to the increasing price of medical services and medicine in China (Fu et al., 2018, Chen et al., 2018). For example, various case studies illustrate that different medical insurance schemes can directly influence a person's hospitalisation service utilisation and cost, and the effectiveness of treatment is adversely affected by high out-of-pocket medical expenses among migrant workers in China (Samuels, 2017, Chen et al., 2015, Fitzpatrick et al., 2015, Feng et al., 2013). These case studies also illustrate that inequalities in healthcare insurance policies is not the only social factor that has shaped Chinese migrant workers' health-seeking behaviours – the changing environment of urban healthcare providers is another important factor that is seen to influence the health-related behaviours of migrant workers in urban settings.

2.3.2 Healthcare services and health utilisation patterns among Chinese migrant workers

The majority of healthcare providers are state-owned and subject to government-control, which include three levels of tertiary hospitals and three levels of grass roots primary medical service centres (Liu et al., 2006, Meng et al., 2015b). However, although both public and private medical services providers are market-oriented, Chinese people have shown a clear preference for public hospitals (Wong et al., 2016, Tang et al., 2016, Wang et al., 2017). As shown in **Table 2**, although public medical service providers follow the bureaucratic order covering different levels, public tertiary hospitals have dominated the medical service market in China (He et al., 2016, Xu et al., 2019). In contrast to the popular triage systems in most Western countries, Chinese patients can visit different levels of hospitals without first accessing primary

healthcare providers, such as a general practitioner (Kong and Yang, 2015). These tertiary public hospitals are therefore quickly expanding in cities because of their advantages in terms of medical insurance, medical equipment and quality of medical services (Li and Fu, 2017). In this way, tertiary public hospitals are often overcrowded as the Chinese people prefer them over primary healthcare facilities, including public clinics and community healthcare centres (Wang et al., 2017, Lu et al., 2017a, Chen and Qian, 2019).

Table 2 Medical service providers in urban China

<table>
<tr><th>Category</th><th>Public Providers</th><th>Private Providers</th></tr>
<tr><td rowspan="3">Tertiary hospitals</td><td>State-level hospitals</td><td rowspan="3">Private hospitals</td></tr>
<tr><td>Provincial hospitals</td></tr>
<tr><td>City hospitals</td></tr>
<tr><td rowspan="3">Primary healthcare networks</td><td>District hospitals</td><td rowspan="3">Private clinics;
Private Pharmacies;
Informal clinics</td></tr>
<tr><td>Community health service centres</td></tr>
<tr><td>Community clinics</td></tr>
</table>

Additionally, public health providers always have internal pharmacies which are only available for its inpatients and outpatients. The profits made from medicine have become a main source of profit for many public hospitals (Sun et al., 2008, TAO et al., 2011, Fu et al., 2017, Gong et al., 2018). In recent years, more private hospitals, clinics and pharmacies have emerged and expanded in urban China (Tang et al., 2016). Compared with the overcrowded public hospitals, private hospitals do not have a good reputation in China (Sun et al., 2019). There is also an increasing number of private clinics and pharmacies in urban China, which provide both prescription and over-the-counter drugs. However, due to the absence of reimbursement available from the government and the shortage of qualified pharmacists, these private pharmacies are often unable to provide high-quality medical diagnosing and dispensing services. Some private pharmacies have developed a bad reputation for promoting expensive drugs for profit only and selling illegal antibiotics without prescription (Fang et al., 2013, Ge et al., 2014, Chang et al., 2017).

Like other developing countries, there are also some informal unlicensed clinics in urban China (Sudhinaraset et al., 2013). As discussed previously, many underground informal clinics are run by former rural doctors without urban medical practice licences, and they have become an essential medical service provider for the low-income rural-to-urban migrant workers in urban settings (Lyu, 2016). As summarised in **Table 2,** these healthcare providers together comprise the health and treatment-seeking options available for Chinese migrant workers in urban cities.

The most recent CMDS (2017) survey data provides a preliminary exploration of the health-seeking patterns of Chinese migrant workers. The survey data contains 39,738 Chinese rural-to-urban migrant workers' responses to the survey question: "For the last time you were ill or sustained injuries, where did you visit?" (CMDS, 2018). As shown in **Figure 10**, the most popular health-seeking channel for Chinese migrant workers was pharmacies in their work cities – about 31% of those surveyed chose this option as their last visit location in 2017. Community healthcare centres, which comprise the main body of public primary healthcare networks in urban China, is the second most popular option, chosen by 20.73% of migrant workers. About 17% of Chinese migrant workers did not seek any healthcare services the last time they were ill or injured. Only about 15.23% of Chinese migrant workers went to general or specialised hospitals, which is the same percentage of workers who chose private clinics.

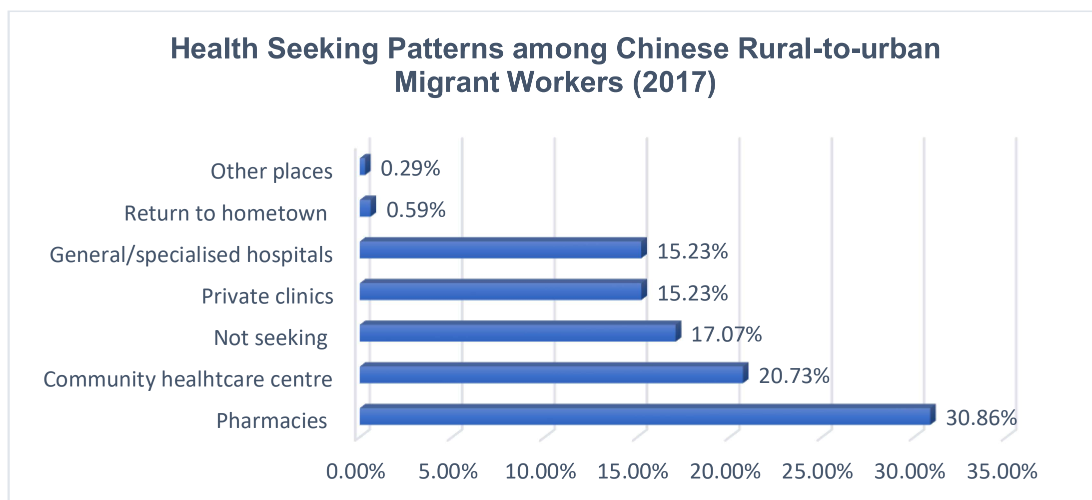

Figure 10 Health-seeking patterns among Chinese rural-to-urban migrant workers (2017)

However, most Chinese rural-to-urban migrant workers have chosen to deal with their health problems in their work cities, and only about 0.6% of them went back to their hometown for medical services. These results are significant given the general background of healthcare insurance and healthcare providers discussed previously. First, while the majority of Chinese migrant workers are not enrolled in healthcare insurance in their work cities, most of them have chosen to deal with their health problems at the healthcare providers in their work cities rather than travelling back to their hometown. This means that the majority of Chinese rural-to-urban migrant workers are dealing with their health problems without effective basic healthcare insurance. Second, in contrast with Chinese people's general preference for public tertiary hospitals, the majority of Chinese migrant workers appear to rely on pharmacies and self-treatment or no treatment for their health problems without

seeking professional medical counselling. Further, primary healthcare providers are preferred over general or specialised hospitals among Chinese migrant workers, which means that the majority of Chinese migrant workers are potentially excluded from high-quality medical services in China.

In light of the above, a number of key questions arise:

a) Why do so many Chinese migrant workers tend to deal with their health problems themselves?
b) What are the experiences of Chinese migrant workers when encountering a range of different healthcare providers in urban settings?
c) What are the main barriers between Chinese migrant workers and accessing different types of healthcare providers?

From my review of the relevant literature, these questions have not been explored in detail as yet. They will therefore comprise the key questions, among others, to be addressed in this thesis.

2.4 Health challenges in relation to Chinese migrant workers' living and working circumstances

In recognition of the impact that social inequalities inevitably have on health, this thesis aims to reveal how social inequalities influence and impact Chinese migrant workers' health in the context of rural-to-urban migration across China. In addition to the inequalities and challenges related to healthcare insurance and healthcare-seeking patterns, Chinese migrant workers are often confronted with a number of other challenges in urban settings, including poor living and work conditions and family household separation, among others (Fan, 2009, Wang and Fan, 2012). This section focuses in particular on three factors that are recognised as having a significant impact on the physical and mental health conditions of Chinese migrant workers in urban China: occupational injuries; their children's education (if they have children), and related household family separation. In this section I will also introduce comparative population health statistics for both Shanghai and Beijing, focusing on the migrant population's health figures. Importantly, these comparisons show that the correlation between migration and health can be complicated in health statistics, and qualitative research is needed to gain a comprehensive understanding of the situations of migrants in urban settings and the mechanisms between their social environments and health outcomes. This section will first introduce the social policy environment in relation to rural-to-urban migration in Shanghai and Beijing, before discussing the comparative health outcomes of the two cities.

2.4.1 Occupational injuries and work safety threats among Chinese migrant workers

Although the policy restrictions around rural-to-urban migration have loosened in recent years, migrant workers are still widely discriminated against as “outsiders” in urban settings (Park and Wang, 2010, Dooling, 2017, Du et al., 2017). Wang and Fan (2012) conducted a rural migrants’ Social Integration Survey in Wuhan in 2008 and found that, although migrant workers’ socioeconomic and cultural integration into urban societies improved over time, the hukou system restrictions continued to be the main barrier that excluded migrants from a range of social welfare entitlements in urban cities (Wang and Fan, 2012). Many migrant workers easily suffer from harsh work conditions, including low and unstable payment, long hours of work, and unsafe environments (Chan, 2002). For example, in 2010, 14 young migrant workers committed suicide at a Foxconn factory in Shenzhen to protest against Foxconn’s inhumane working conditions, where most workers were forced to work long hours and were locked up in the factory and its dormitories without any personal lives (Chan and Pun, 2010, Branigan, Chan, 2013, Pun et al., 2016, Merchant, 2017).

Occupational injuries, and a lack of compensation to treat such injuries, poses one of the biggest health threats among Chinese migrant workers. Research shows that migrant workers account for about 90% of the total number of victims of occupational injuries and disease in China (Fitzgerald et al., 2013, Ding et al., 2013, Sun and Liu, 2016). Most high-risk occupations are fulfilled with migrant employees, including construction, manufacturing, and small mining operations (Fitzgerald et al., 2013). One key example is the prevalence of pneumoconiosis among Chinese migrant workers – in China, there are around six million pneumoconiosis patients, and most of them are migrant workers who worked in unsafe conditions (Yan, 2018, Zhao et al., 2019). Additionally, it is very difficult for migrant workers to claim occupational disease compensation due to the lack of work safety knowledge and inadequate social protection. Many of them ended up losing both their health and their entitled compensation (Sun and Liu, 2016, Reid, 2016, Ning et al., 2017). This has made Chinese migrant workers extremely vulnerable when faced with occupational injuries.

2.4.2 Children’s education and family separation among Chinese migrant workers

Another common struggle faced by many Chinese rural-to-urban migrant workers is their divided households – split between their hometowns and migration destinations (Fan and Li, 2020). There are many migrant workers’ families who are separated due to schooling policy restrictions on migrant children in cities (Wang and Sciences, 2019). In 2014, the Lancet editorial “Migrants’ Health in China” pointed out the following new

trends with respect to rural-to-urban migration in China: the average age of the migrant population is rising; more migrant children have moved along with their parents; more migrant women get pregnant and give birth in their destination cities rather than their hometowns; and more migrants are settling in Beijing and Shanghai rather than the Pearl River Delta cities, like Guangzhou. It stated that dynamic migration has posed more challenges not only for migrants' health, but also on the health care and social welfare system in China, including urban public health services, medical insurance, education, housing and employment, and "a serious knowledge and research gap exists to understand migration and health in China rigorously and comprehensively" (Lancet, 2014). In recent years, although the opportunity of obtaining urban hukou is increasing in some cities, migrants are opting to circulate between the city and their rural hometown. It is summarised by Chen and Fan (2016, p.11) as "China's Hukou Puzzle", in one hand, the farming and housing land rights and benefits associated with rural hukou are valued by more rural-to-urban migrant workers. In another hand, they only have work opportunities in cities (Chen and Fan, 2016).

A number of further questions then arise:

a) How have migrant workers adapted to these new migration patterns?
b) What new challenges, if any, have arisen from current healthcare systems in response to the large scale rural-to-urban migration and circulation?
c) Have these challenges, if any, affected migrant workers' access to healthcare or health-seeking behaviours?
d) How do migrant workers cope with their own or their family members' health problems in these situations?
e) How do migrant workers perceive these social changes, and where do they situate their health in the context of these life changes?

It is quite clear that the increasing mobility and changing livelihood strategies adopted by Chinese rural-to-urban migrant workers have created additional challenges from a health perspective. There is a need for more evidence-based research to support ongoing health policy reform in China (Qi, 2019, Zheng et al., 2020).

2.4.3 Migrants' population health indicators in Shanghai and Beijing

The relationship between migration-related social inequalities and migrants' health outcomes can be difficult to identify, particularly considering the different population structures between residents and migrants, as well as the health migration effects discussed previously. However, there are two important population health figures globally used as population health indexes: infant mortality rate (IMR) and maternal mortality ratio (MMR). Infant mortality rate (per 1000 live births) refers to the probability of a child born in a specific year or period dying before reaching the age of one, if

subject to age-specific mortality rates of that period (WHO, 2020a). The maternal mortality ratio (per 100,000 live births) refers to the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (WHO, 2020b). Both IMR and MMR are essential for describing different populations' health since they are comparing the results at similar age groups among the most vulnerable populations (Reidpath and Allotey, 2003). The comparative migration-related health outcomes in Shanghai and Beijing can be identified from their infant mortality rate and maternal mortality ratio recorded in the official health statistics.

Shanghai has its migrants and local residents' health indexes recorded separately from 2009 to 2015. As shown in **Figure 11** and **Figure 12**, both migrants and local residents' infant mortality rates and maternal mortality ratios are much lower than the national average level in China. In Shanghai, local residents have a much lower infant mortality rate when compared with the migrants in the same city, and the maternal mortality rate of local residents are also generally better than that of migrants in the same city (SMHC, 2020). These comparative results can be interpreted as a reflection of the health inequalities between migrants and local residents in Shanghai considering the social inequalities that rural-to-urban migrants have to confront in Shanghai.

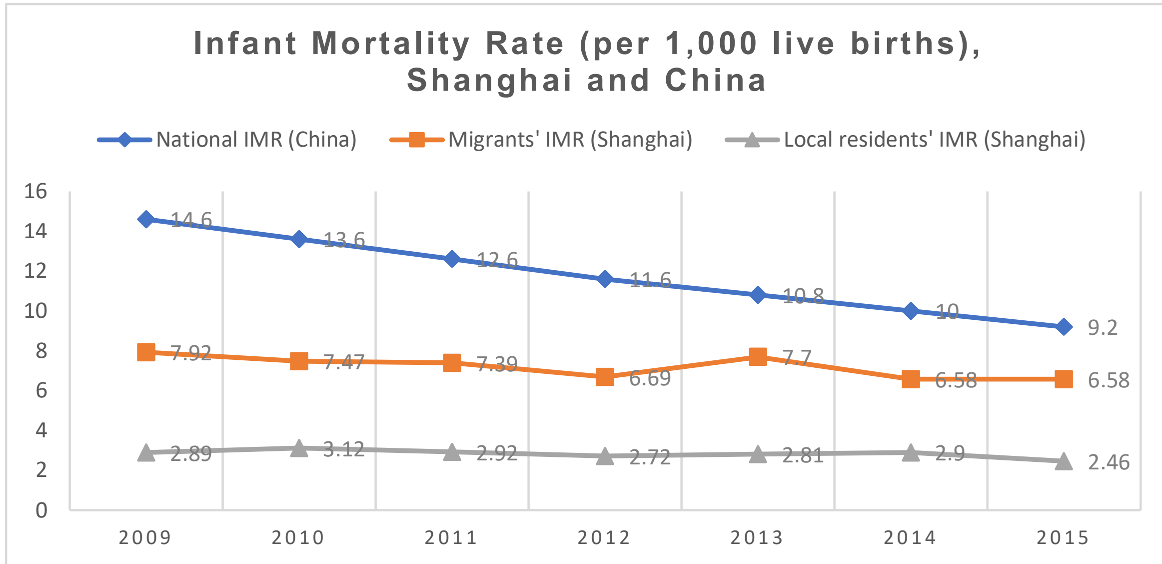

Figure 11 Infant Mortality Rate (per 1,000 live births), Shanghai and China

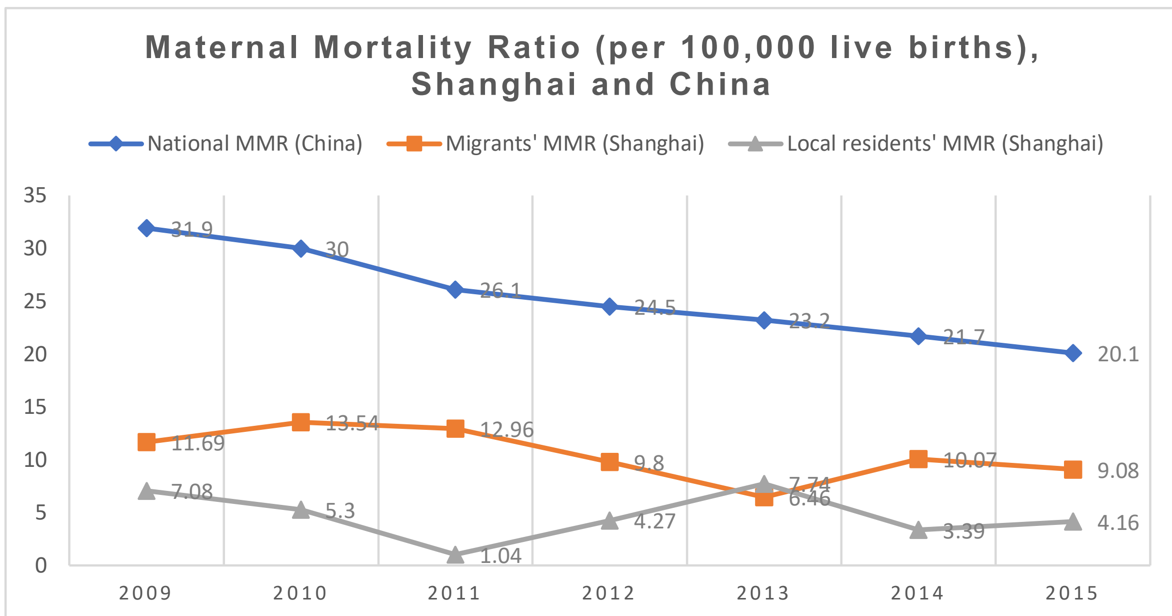

Figure 12 Maternal Mortality Ratio (per 100,000 live births), Shanghai and China

The health statistics in Beijing provide a different comparative result between migrants and local residents. Different from Shanghai, Beijing does not record migrants' health indicators separately in its health statistics. However, they have separated the local residents who have Beijing hukou registration[8] with the long-term residents[9]. Since the migrants are included as long-term residents, we are still able to compare these two groups to see if migrants record any differences in the infant mortality rate and maternal mortality ratio in Beijing. As shown in **Figure 13** and **Figure 14**, the whole population in Beijing has an extremely low infant mortality rate and maternal mortality ratio, which is equivalent to the best figures of the most developed countries recorded by the World Bank (WorldBank, 2020). Different from Shanghai, the local residents in Beijing have a higher infant mortality rate compared with the total population (including migrants) in Beijing, which means that migrants have perform better in this indicator. Similar to the infant mortality rate, the local residents in Beijing also have a generally higher maternal mortality ratio compared with the total population (migrants included) in Beijing (except in 2012 and 2018). However, local residents in Beijing have recorded a slightly lower rate in both the infant mortality rate and maternal mortality ratio compared with the total population (migrants included) in Beijing in 2018, but it is unclear if this trend will continue (BJCHFP, 2019).

[8] Translated from Chinese “户籍人口”, which refers to the residents who local household registrations.
[9] Translated from Chinese “常住人口”, which refers to all of the long-term residents in the city regardless their household registration status.

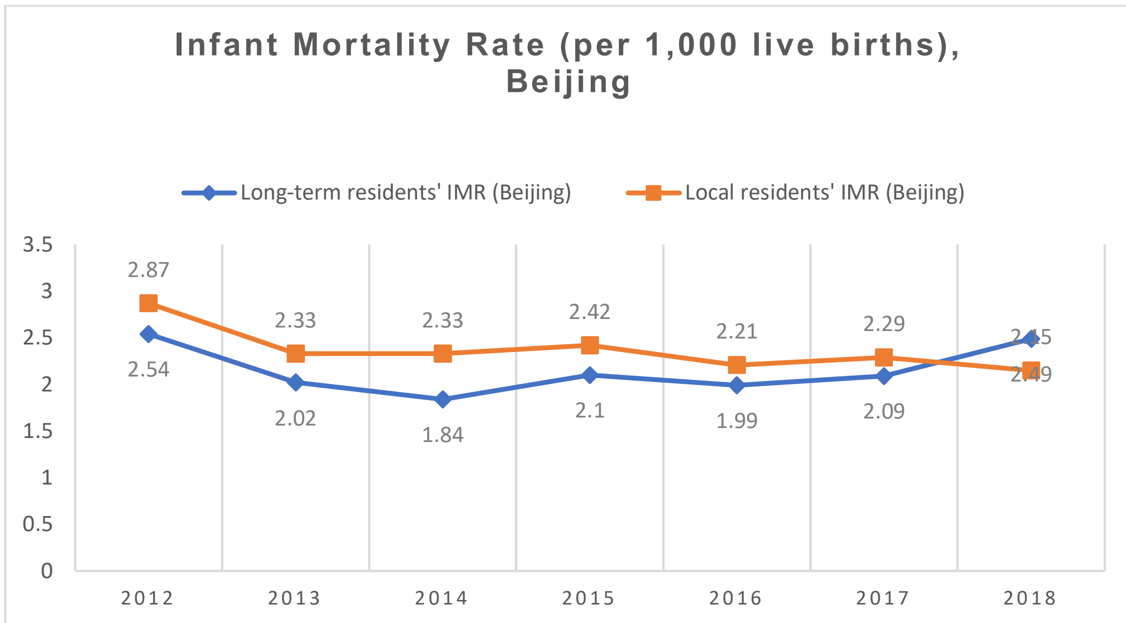

Figure 13 Infant Mortality Rate (per 1,000 live births) in Beijing

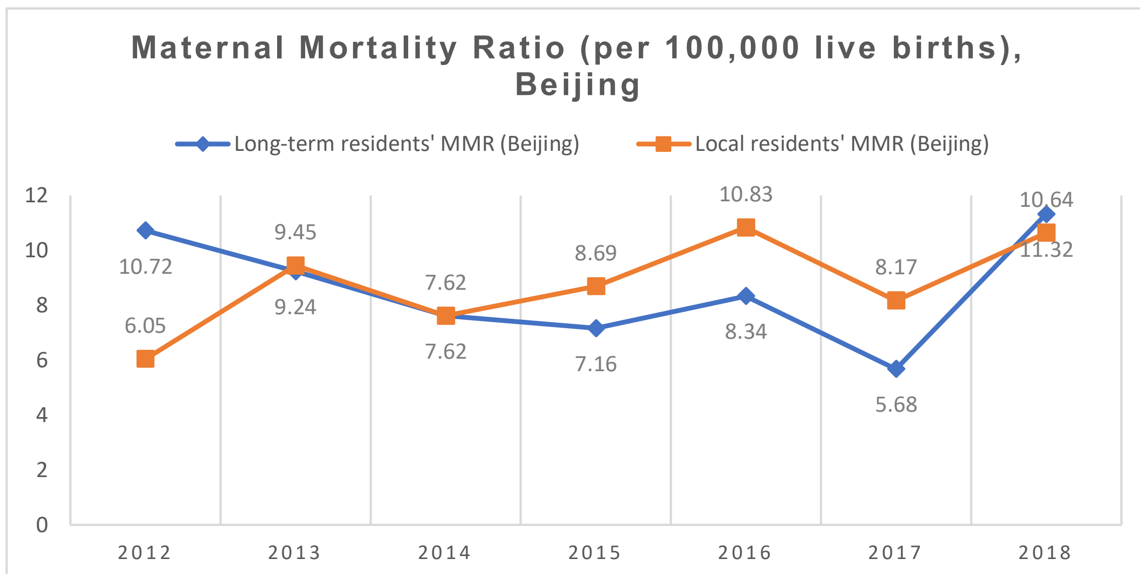

Figure 14 Maternal Mortality Ratio (per 100,000 live births) in Beijing

Given the similar comparisons made in Shanghai, it is difficult to interpret the gaps in infant mortality rates and maternal mortality ratios between local residents and the total (migrants included) population in Beijing. This result is particularly at odds with Shanghai's relatively more inclusive policy environment and better living conditions for migrants compared with Beijing's "tougher" living conditions and hostile policy environment (Chen and Feng, 2013, Denyer and Lin, 2017). It reveals the limitations of quantitative research on identifying the social determinants of health in different

settings. The comparative data presents a number of questions that remain unanswered in the literature as to the relationship between social determinants and health outcomes:

a) What are the links between social inequalities and health outcomes?
b) In what ways, if any, have social inequalities worked to reproduce health inequalities for the migrant worker population?
c) Why are the health outcomes of migrant workers inconsistent in these two cities?

Notwithstanding possible flaws in the datasets or complex social-environmental differences between both cities, qualitative approaches are needed to examine how social inequalities and health outcomes are reproduced among rural-to-urban migrants in both cities. The epistemological foundation first needed to attempt to answer these questions is to recognise what kind of information I will collect from my research participants. In particular I will focus on identifying at this initial stage what health problems are perceived as problematic among migrant workers, and which issues affect and potentially shape their health outcomes.

Chapter 3
Researching the Social Determinants of Health in Migration: Narratives of Lay Health Beliefs and Health Subjectivities

Chapter introduction

This chapter will review the existing research on migration and its related health inequalities. It will provide the theoretical framework to identify the social determinants of health and the social reproduction of health inequalities through the examination of the lay health beliefs and everyday health experiences of people in different contexts. The first section of this chapter will introduce the conceptual framework used to identify the social determinants of health as influenced by different levels of social structural factors. The second section will then review and summarise the literature on lay health beliefs and health inequalities in different contexts, which in turn provides the theoretical approaches that this thesis relies on to analyse the fieldwork data presented in the analytical chapters. The third section will review the literature surrounding migrants' health subjectivities. It will focus on the migration-related subjective meanings attached to health and will outline the importance of migration aspirations in terms of shaping migrants' ways of understanding and dealing with health.

3.1 Conceptual framework

The conceptual framework for this thesis provides the theoretical pathways and identifies the mechanisms between rural-to-urban internal migration and migrant workers' health inequalities in urban China. In the previous social background chapter, this thesis introduced the social inequalities in urban cities and the health characteristics and risks of Chinese migrant workers. However, as the previous chapter illustrates, there is a gap in the literature offering theoretical pathways that examine the impact of social inequalities on the health of Chinese migrant workers, including their health outcomes and their practices with respect to managing their health problems. This section will map the conceptual framework to be applied for the purpose of analysing the health inequalities of Chinese migrant workers.

3.1.1 The social determinants of health

There is an abundance of literature that explores the social determinants of health and their inequalities worldwide (Marmot and Wilkinson, 2005, Marmot, 2005, Scambler, 2008, Braveman et al., 2011). Socioeconomic status or social class is the most powerful predictor for people's health status and life expectancy (Cockerham, 2014),

and statistics of population health in different countries often demonstrate this. As demonstrated by research in the US, the life expectancy of the richest 1% is 14.6 years more than the poorest 1% of individuals (Chetty et al., 2016). Although there is an association between social inequalities and health, it is difficult to determine precisely the social causation of health disparities, not only due to the absence of effective health promotion interventions, but also the ambivalent argument which sees people's health as either social products or the outcomes of people's lifestyle and behaviours (Minkler and Behavior, 1999, Wikler, 2002, Baum et al., 2014).

To understand how social inequalities impact on people's health, researchers have developed different approaches to identify the social determinants of health in different contexts. One of the classic patterns drawn by Dahlgren and Whitehead (1991, p.11), as shown in **Figure 15,** shows the factors that threaten, promote and protect health. The Dahlgren-Whitehead Rainbow illustrates that the main determinants of health consists of different layers; major structural environments are the overall determinants of health, followed by the material and social conditions which people live and work in, including housing, education, healthcare services, among others; then support networks made up of family friends, neighbours and the local community; and the final determinants are actions taken by individuals, such as diet, smoking or drinking habits (Dahlgren and Whitehead, 1991).

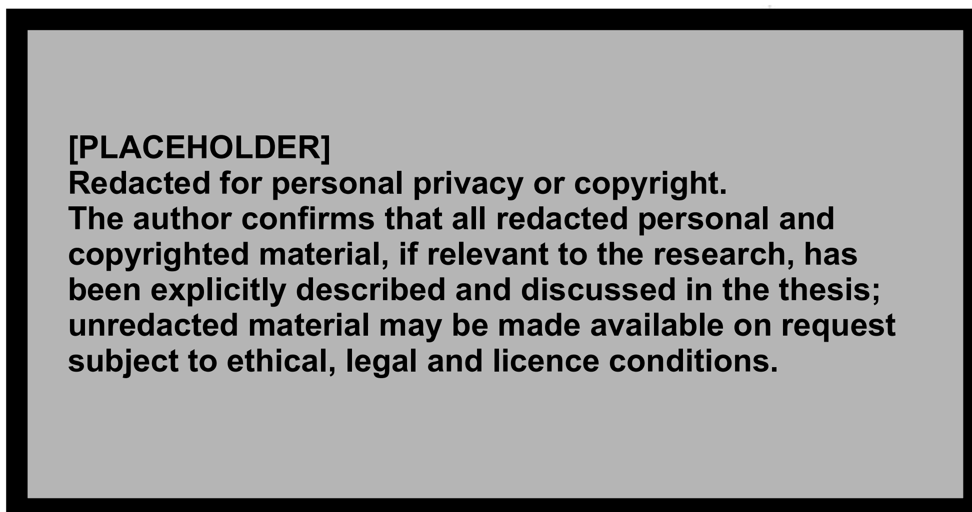

Figure 15 The Dahlgren-Whitehead Rainbow

The meaning of the Dahlgren-Whitehead Rainbow, as explained by Dahlgren and Whitehead (1991, p.12), can be translated into four levels of policy intervention to improve health, especially in the aspect of health equity (Dahlgren and Whitehead, 1991). Braveman et al. (2011, p.383) suggests that social influences on health can be seen as upstream and downstream social determinants, with upstream social determinants – including economic resources, education and racial discrimination –

can fundamentally shape downstream factors, such as individual health-related choices and behaviours (Braveman et al., 2011).

Given the transition of health research in Western countries from that of illness to health, many health social scientists have come to recognise that attempts to provide evidence-based scientific knowledge may result in isolating the health struggles and diseases from individuals' health-related experiences and living circumstances (Popay and Williams, 1996, Hopton and Hunt, 1996, Springett et al., 2007). As indicated by Sharf and Vanderford (2003, p.11), "people undergoing health problems and their families develop their understandings about physical symptoms, revealing health beliefs, augmented with personal and cultural significance, that transcend the material signs relied upon by clinicians" (Sharf and Vanderford, 2003). While individual lifestyle elements such as smoking, the consumption of alcohol, exercise, and diet become more valued in public health promotion and intervention, it requires clearer research to examine, as specified by Short and Mollborn (2015, p.79), " the role of normative structures that shape the social values attached to activities, identities, and choices" (Calnan and Williams, 1991, Popay and Williams, 1994, Bunton et al., 2003, Tomlinson, 2003, Blaxter, 2003, Short and Mollborn, 2015).

This theoretical approach suggests that researchers inspect the link between social inequalities and health outcomes from the "bottom to the top". As suggested by Popay and Williams (1996, p.761), the way to expand the understanding of the nature and significance of lay health beliefs is to recognise and explore lay health knowledge within the social sciences (Popay and Williams, 1996). Invoked by Habermas' insight into the changing relationships of knowledge and power between lay populations or citizens and the professional in modern society, Williams and Popay (2001, p.31) suggested that "the concept of lay knowledge embodies a concern with the subjective views of lay people", which refers to "the way in which those views are shaped in response to particular events and experiences which undermine security and are shaped by the conditions or circumstances in which people live" (Williams and Popay, 2001). In this thesis, the living conditions and circumstances refer to the processes of rural-to-urban migration and the life experiences of rural-to-urban migrants in urban China.

3.1.2 Migration and health

Migration is well-recognised as one of the key social determinants of health, regardless of internal migration or transnational migration (Boyle and Norman, 2009). The UCL-Lancet Commission on Migration and Health pointed out that although migration is generally advantageous for some migrants, the majority of labour migrants are less well-situated taking into consideration unsafe transit, pressures and work

conditions (Abubakar et al., 2018). However, migration is a process across different regions and time, meaning the relationship between migration and health is not always straightforward, in turn creating difficulties in terms of identifying the social determinants that affect people's health (Boyle and Norman, 2009).

As stated by Krieger (2011, p. 7), the focus of epidemiology is to examine why different societies or different social groups have better or poorer health than others (Krieger, 2011). Nauman (2016) suggests that there are three different key mechanisms to inspect migrants' population health disparities (Nauman et al., 2016). First, migrants' health status may differ from that of their non-migrant counterparts at their place of origin before migration. For example, Carballo and Nerukar (2001) found that most non-EU migrants in European countries come from socioeconomically deprived backgrounds, and their health profiles or so-called "diseases of poverty" are mostly shaped by their previous surroundings (Carballo and Nerukar, 2001). Second, migrants' health status is affected by their living circumstances in receiving locations, especially for rural-to-urban migrants, whose physical and mental health status may be affected by exposure to new risks and benefits in urban destinations. Third, the health status of particular migrants may also determine whether they remain in their receiving cities or return to their original hometowns since migrants with relatively poorer health are those more likely to return. For example, in the US, migrants of Latino origin have lower morbidity and mortality rates when compared with non-Latino Whites despite the former's higher poverty rates, less education, and poorer health insurance status (Ribble et al., 2001).

These mechanisms indicate different approaches through which to analyse the health disparities experienced by migrants. In the previous social background chapter, I discussed the effects of Salmon bias and health selection, which is also demonstrated among Latino migrants in the United States to explain the "Latino paradox" (West, 1991, Abraido-Lanza et al., 1999, Turra and Elo, 2008). Ultimately these studies highlight that health statistic results do not always directly represent the real health situations and issues experienced by migrants.

Most health inequalities experienced by migrants are social rights-based in origin, directly related to discriminatory and inadequate migration policies (Zimmerman et al., 2011). The process of migration often involves risks like uprooting, separation from family and traditional values, confronting new social and cultural situations, and deprivement of employment opportunities and legal security (Boyle and Norman, 2009). For example, research has found that immigrants in Denmark, Britain and Netherlands have higher susceptibility to infectious diseases – the proportion of new TB infectious cases rose from 18% in 1986 to 60% in 1996 among foreign-born

persons in Denmark; 40% of TB infections occurred among Indian migrants in England and Wales; and the incidence of TB rose 45% between 1987 and 1995 in the Netherlands with over 50% of cases occurring among immigrants (Carballo and Nerukar, 2001). Rather than placing reliance on incomplete explanations as illustrated by statistical correlations between migration dynamics and migrants' health outcomes, focusing on the health and human suffering experiences of migrants may allow us to garner a more complete understanding of the micro-mechanisms between social inequalities and health outcomes.

3.1.3 Theoretical framework

In China, rural-to-urban migration is not only a domestic process of urbanisation but an ongoing process whereby social inequalities evolve into health challenges (Hu et al., 2008, Hesketh et al., 2008a). Chinese rural-to-urban migrant workers are more likely to suffer from low salaries, poor housing, incomplete social protection, social discrimination, unsafe working conditions, and policy restrictions in urban environments (Wong et al., 2007, Hesketh et al., 2008b). The theoretical framework used in this thesis to explore the health inequalities experienced by Chinese rural-to-urban migrants identifies, and draws upon, the key social determinants of health in migrant workers' health experiences in urban settings. The subjective health views and lay health practices are valued in terms of examining how social inequalities shape Chinese migrant workers' health-related lifestyles, behaviours, arrangements and how these eventually impact on their health outcomes. This thesis is therefore designed as a qualitative research study applying ethnographic approaches to obtain Chinese rural-to-urban migrant workers' health narrative. These narratives focus on their lay health beliefs in relation to the ways they deal with respective health problems in urban settings. The analytical data used in this thesis has been obtained by conducting fieldwork in selected research sites in Shanghai and Beijing.

As shown in **Figure 16**, although I previously introduced some of the social inequalities facing migrants in urban settings in the previous social background chapter, it is not clear how these social inequalities impact on migrant workers' everyday life in terms of dealing with health problems. Although some of the health inequalities reflect health statistics, it is not clear how these outcomes are understood, practised and reproduced by migrant workers in their everyday lives. This thesis, therefore, will focus on Chinese rural-to-urban migrant workers' health-related experiences, and in doing so, refer to narratives of migrant workers that contain their subjective health views, lay health knowledge and lay health practices, as well as health-related life events. By analysing these narratives, this thesis seeks to identify the mechanisms and processes through which health inequalities are reproduced in the everyday lives of Chinese migrant

workers in urban China.

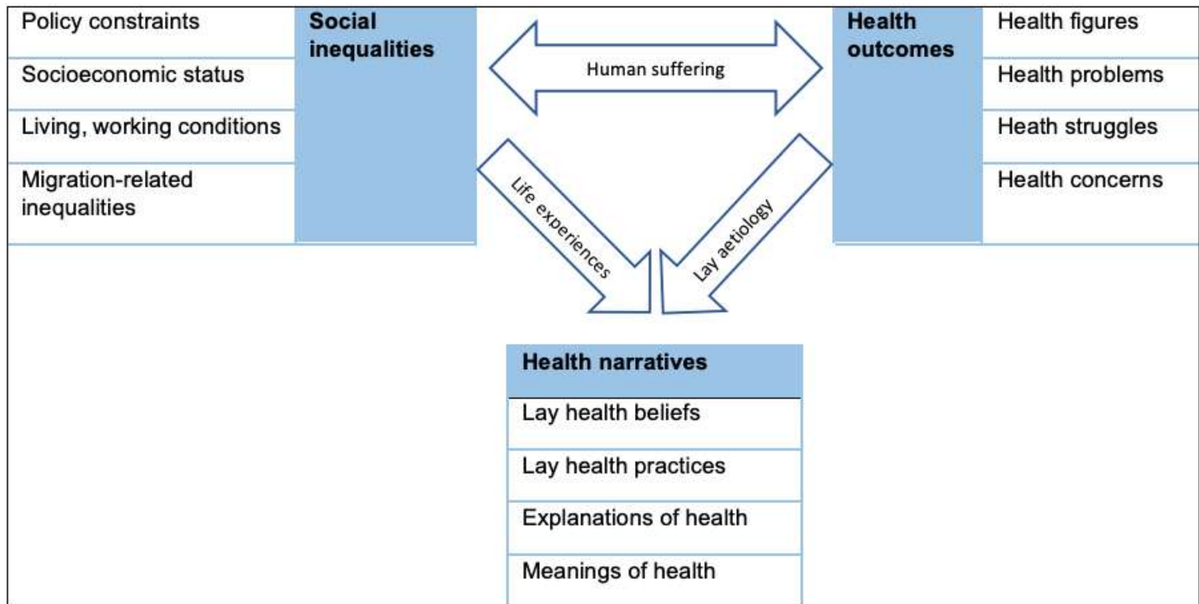

Figure 16 Theoretical framework

3.2 Understanding lay health beliefs in health experiences

This section will introduce the theoretical tools utilised in this thesis to research health inequalities experienced by Chinese migrant workers. As shown in **Figure 16**, how migrant workers interpret their lay aetiologies associated with the contexts of social inequalities is the key to clarify the mechanism of social determinants of health among Chinese rural-to-urban migrant workers. Therefore, lay health beliefs and lay health practices are the main topics explored from migrant workers' health narratives. I will review the key literature about how to research people's lay health beliefs in this section.

3.2.1 An exploration of the lay health belief model and health-related behaviours

In medical sociology, it is widely recognised that health and illness is experienced and defined individually on a base between commonly accepted knowledge and personal understanding, rather than by biomedical symptoms defined by experts (Wright and Treacher, 1982). The concept of lay health beliefs has been described in different terms, including lay views on the aetiology of disease, lay experts, and lay epidemiology; or lay knowledge, lay conceptions, lay theories and lay understandings of health and illness (Pill and Stott, 1982, Calnan, 1987, Davison et al., 1991, Dines, 1994, Prior, 2003). These different terms reflect a wide range of approaches to inspect health beliefs as a response to health and illness-related matters in medical and social realms (Shaw, 2002).

Calnan (1987) suggests three reasons why lay health beliefs are important to examine. First, lay knowledge of health is different from professional and scientific knowledge, although it may be influenced by scientific knowledge given by professionals or through the media. It is the way that sufferers to make sense of signs, symptoms, and other health problems in everyday life. The second reason is that people's health-related behaviours are often influenced by lay knowledge. For example, people make decisions for themselves in relation to patterns of food consumption, self-medication, and seeking doctors (or, alternatively, do nothing). The third reason is that lay perspectives can be used to evaluate healthcare programs in terms of assessing medical effectiveness and economic efficiency (Calnan, 1987). However, as earlier explorations of lay health beliefs were carried out for the purpose of building mutual understanding between physician and patient, lay health knowledge is therefore often considered the experience of patients, limited to aspects of self-care (Tuckett, 1985). As indicated by Freidson (1988), an individual's lay health knowledge has a significant impact on an individual's health and illness behaviour (Freidson, 1988). In the US, the health belief model is designed to explain individual's health-related behaviours when

responding to their illness symptoms. As shown in **Table 3**, seven main behavioural dimensions have been identified in this regard (Champion and Skinner, 2008).

Table 3 The Health Belief Model

Perceived susceptibility	Belief about the chance of experiencing a risk or getting a condition or disease
Perceived severity	Belief about how serious a condition and its sequelae are
Perceived benefits	Belief in efficacy of the advised action to reduce risk or seriousness of impact
Perceived barriers	Belief about the tangible and psychological costs of the advised action
Cues to action	Strategies to activate readiness
Self-efficacy	Confidence in one's ability to take action
Other variables	Diverse demographic, sociopsychological, and structural variables may influence perceptions

According to these dimensions, researchers are encouraged to inspect individual health behaviours by scaling these perceptions in the survey to predict and inform public health intervention. For example, Champion (1999, pp.344-347) applied the Health Belief Model to examine mammography utilisation by women in the US and found that while the susceptibility and benefit scale items were retained, the barrier scale was enlarged as women identified a number of barriers, including fear of finding a lump, time required for the test, forgetting to make or keep an appointment, pain and fear of radiation associated with the mammography procedure (Champion, 1999). Austin et al (2002) also used this model to explore why Hispanic women in Canada are more likely to refuse breast and cervical cancer screenings, and they found that although the severity of the cancers is acknowledged, there are certain social barriers these women have to confront, including fear of cancer, fatalistic views, linguistic barriers and culturally-based embarrassment (Austin et al., 2002).

Champion and Skinner (2008, pp.45-50) indicated that the Health Belief Model is originally a social psychological theory based on the Stimulus-Response ('S-R') theory and the Cognitive theory, which considers behaviour as consequences or reinforcement immediately following reward or value-expectancy (Spence, 1950, Skinner, 1963, Champion and Skinner, 2008). These theories suggest that individuals are assumed as being able to estimate the severity of an illness and to reduce the

threat through personal action if they regard themselves as susceptible to a condition, 'by giving individuals the information they needed, they could protect themselves by adopting healthy habits rather than counting on their doctors to restore health once it was gone' (Wikler, 2002, p.47). However, utilisation of the Health Belief Model cannot always identify the factors associated with health-related behaviours. In their review of the Health Belief Model-related investigations in the US, Janz and Becker (1984, pp.36-45) found that social structural constraints are given less emphasis but are more influential in terms of determining health-related behaviour, rather than individually perceived cognitions. As they stated in the article, some behaviours like smoking and tooth-brushing are habitual without any ongoing psychosocial decision-making process. Some health-related behaviours like dieting to appear more attractive, stopping smoking or jogging to attain social approval are undertaken for nonhealthy reasons. Some health-related actions are prevented by economic or environmental factors, such as working in a hazardous environment or residing in a city with high levels of air pollution (Janz and Becker, 1984).

These explorations provide another perspective in which to understand people's lay health beliefs – that is to examine social environmental factors rather than the individual cognitive process. For example, in the book 'Understanding Attitudes and Predicting Social Behaviour', Ajzen and Fishbein (1980, P.53) found that quitting smoking is not only an individual health decision – 'a person who wants to quit smoking might be inhibited by fear of experiencing the social disapproval of his/her pro-smoking coworkers'. They thus suggest that normative or social approval from specific individuals or groups is a determinant for smoking behaviour (Ajzen and Fishbein, 1980, Janz and Becker, 1984).

Additionally, Janz and Becker (1984, pp.36-45) indicated that the assumption that health is always a highly valued concern or goal for most individuals can be problematic, and people would have other satisfactions in life (Janz and Becker, 1984). These critiques indicated that health beliefs or drives behind health-related behaviours are not comprehensively and accurately reflected by the Health Belief Model, and individual health beliefs and health-related behaviours need to be examined in the context of material and social conditions (Williams and Popay, 2001).

3.2.2 The definition of lay health knowledge

Although there is has been an empirical research foundation which indicates the relationship between health-related behaviours and lay people's health beliefs, lay knowledge is an expression of life concerns that seeks a public forum but is often excluded from wider recognition by the 'system' forces of state and economy (Scambler, 2001). As stated by Williams and Popay (1994, pp.139-141), the

assumption that people have the freedom to make healthy choices in their daily lives is problematic. Health risks, including smoking, diet, alcohol, lack of exercise, are widely and deeply embedded in people's material and environmental conditions. It should be acknowledged that people are not able to change the surroundings by themselves although they have to bear responsibility for their own behavioural risk factors (Williams and Popay, 1994).

With an increasing focus on social factors, lay health beliefs – also called lay knowledge or lay expertise – is widely used throughout the medical sociology discipline. The concept is often interpreted as being how individuals perceive health problems concerning their living situations (Popay and Williams, 1994, Popay and Williams, 1996, Prior, 2003). In the book "Key Concepts in Medical Sociology", Williams (2013, p.120) indicated that beliefs are a second line of conceptualising health and illness as social representations and are more than just antecedents to individual behaviours, and that lay knowledge is defined as "the ideas and perspectives employed by social actors to interpret their experiences of health and illness in everyday life" (Gabe and Monaghan, 2013, Williams, 2013a). The key aspects of lay health knowledge, as suggested by Popay and Williams (1998, p.640), include the subjective meanings people attach to their health, the related social context, and the ways of dealing with health problems in the particular social context (Popay et al., 1998b)

3.2.3 Social class, socio-economic status and lay health beliefs

Before the 1980s, the majority of research about lay health beliefs was published in the medical anthropology discipline, mostly dealing with folk beliefs and practices relating to illness in the non-Western and non-industrialised world. Helman (1978, p.108) indicated that lay beliefs of illness widely existed even in a modern Western urban environment, which is assumed as being familiar with the biomedical model of disease. In exploring the popular phrase 'feed a cold, starve a fever' in the middle-class community of London, Helman (1978, p.133) suggests that the lay concepts of illness among people, the so-called "folk model", is more functional and more resistant to change, and biomedical concepts (especially the "germ theory") can be easily incorporated into the folk model without challenging its basic premises (Helman, 1978). Helman's research demonstrated that individual health behaviours are not likely to change simply by promoting modern biomedical health knowledge or education, even in a Western urban middle-class community.

Since the 1980s, there has been an abundance of research exploring the nature and the influential factors of lay health beliefs. Pill and Stott (1982, p.44) suggested that we should inspect the views held about the aetiology of illness where blame is

attributed. In their research exploring working-class mothers' concepts of illness causation and responsibility in Cardiff, Pill and Stott (1982, p.44) found that half of the 41 interviewees held fatalistic views about illness causations which are attributed to circumstances where personal changes are unlikely to be achieved. They pointed out that the nature of health beliefs is associated with education level and type of house tenure, where people with higher educational attainment and buying own homes believe they have more control of their destiny (Pill and Stott, 1982).

Pill and Stott's research demonstrated that individual lay health beliefs are associated with their expectations to fulfil their social roles as well as their living circumstances. As Williams (1983) found in his comparative study of lay logics of health held by people from a range of different countries, people from different social or cultural backgrounds often have very different lay dimensions of health (Williams, 1983). For example, influenza is an important cause of morbidity and mortality among older people in the UK. However, lay beliefs as to the fatal side-effects of the influenza vaccination has prevented many elderly people from getting vaccinated (Cornford and Morgan, 1999, Evans et al., 2007).

Pill and Scott (1985, pp.983-986) developed a research tool called the Salience of Lifestyle Index ('SLI') to describe the relationship between lay illness causation conceptions and people's health behaviours, employment, house tenure, religious commitment, education and social background. As shown in **Table 4,** the Salience of Lifestyle Index model contains a set of five questions referring to the dichotomy of illness causations from individual lifestyle factors to fatalistic views. The method adopted to utilise the SLI model in a survey is to record when participants respond to questions mentioning lifestyle factors, including habits, diet and exercise. Every response to a question attributing individual factors should be recorded as 1 point. The range of the SLI model is 0-5 point, with a higher score representing that the respondent has a greater belief as to individual factors being illness causations (Pill, 1985).

Table 4 The Salience of Lifestyle Index model questions

Questions	Individual factors mentioned
What do you think are the main reasons for people falling ill? Can you tell me a little bit more about hoe X makes people ill?	
Do you think some people are more likely to fall ill than others? What sort of people are they?	
Do you think that people can ever be blamed if they fall ill?	
Everyone becomes ill in the course of their lives, but some people do seem to get things worse than others: I wonder what you think about that?	
Do you think some types of illness are more easily prevented than others? what? How?	

In research conducted with 204 Welsh working-class mothers, Pill (1985, p.986) applied the SLI model and found that people with high scores on SLI are associated with certain social and demographic characteristics, including higher education level, regularly visiting a church, and home buyers. Higher-class working mothers were more likely to attribute illness to personal control including healthy diet and exercises, in contrast with respondents associated with lower scores often mentioning the neurotic type of person, the hypochondriac or unnecessarily magnifying every symptom in the context of blame (Pill, 1985). In other words, Pill's studies demonstrated people's health and illness perceptions are highly dependent on feelings of having control over their lives, and that the feeling of control is associated with their social and economic living circumstances, which they consider themselves to be capable of changing.

The association between socioeconomic factors and its impact on individual health has been explored through a range of different approaches. Calnan and Johnson (1985) found that people from different occupational classes held different health views. The professional women group tend to perceive health as being fit, strong, active, or energetic, and their lay illness theories were closer to biomedical models. The working-class women group tend to describe health as the absence of serious illness, and they appeared to feel less vulnerable to illness than the other group. Calnan and Johnson (1985, p.71) thus suggested that people from different occupational classes hold different health views and thus lead to different health-related behaviours, and the social constraints are thus considered as influential factors

upon people’s lay health knowledge (Calnan and Johnson, 1985).

However, Backett (1990, p.61) pointed out that the concern for good health is only one behavioural motivator amongst other priorities of everyday life, and there is always a gap between people’s lay health knowledge and their health-related behaviours (Backett, 1990). In a two-year long fieldwork study conducted among middle-class families in Edinburgh, Backett (1992, pp.501-505) found that although most people were clearly aware of health risk factors, they nevertheless did not take them seriously and found ways to legitimate their behaviours in their daily domestic lives, with health knowledge not necessarily being translated into behavioural practices. Backett (1992, pp.501-505) attributed this gap to lay knowledge that ‘respondents used to make sense of health’ which ‘was much broader and more pragmatic than that encompassed in the biomedical model’, where people are often under the pressure of work and social and domestic obligations (Backett, 1992).

3.2.4 Living circumstances and the social construction of lay health beliefs

As discussed above, research has established that different social classes with different socioeconomic status hold very different lay health beliefs. The process of constructing lay health knowledge, especially the perceptions of normal body and health, is closely related to individual social and cultural living circumstances. Since the end of the last century there has been increasing concern with respect to individual health in the socially-constructed natural environment of buildings, dwellings and habitations (Armstrong, 1993). As stated by Popay et al. (1998, p.636), health inequalities can be examined by reconceptualising the ‘place’, which is defined as an individual’s ‘temporal and historical associations with the area’, such as local health services and local social environments. Lay health beliefs are often expressed as ‘the meanings people attach to their experience of places and how this shapes social action’ (Popay et al., 1998b). It emphasises the narratives of people’s understandings about the relationship between human agency and wider social structures, as well as the social action based on these understandings.

For example, Anderton et al (1989) carried out comparative research upon Anglo-saxon and Chinese families in Canada who had caring responsibilities for chronically ill children. The study indicated that economic hardship and socio-economic positions limited the Chinese families’ time and necessary resources to care for and supervise their ill children, and the perception of normal body and health was defined as ‘fit to work’ in these families. The author thus indicated that the ideology of normalisation is a kind of knowledge that is historical, socio-culturally, politically and economically located (Anderton et al., 1989).

In the literature, lay health explanations have been extrapolated into influential factors. For example, Stainton Rogers (1991, pp.133-150) applied social construction theories in her investigation of lay health beliefs and pointed out that lay health explanations can be divided into two categories: internal explanations and external explanations. **Table 3.5** shows this categorisation of lay explanations and perceptions of good health (Stainton Rogers, 1991).

Table 5 Lay explanations of good health

Internal explanations	External explanations
Behaviour: looking after yourself, adopting a healthy lifestyle, using preventive services	Chance
Mind: positive attitudes; not worrying; taking responsibility for yourself	Social policy: public health measures, good living standards
Heredity: health constitution	Medical advances: inoculations, contraception
Body's defences: fighting off disease	--------

As shown in **Table 5**, lay health perceptions are specified as internal explanations and external explanations. The internal explanations such as individuals' choices, life chances are constrained and defined by their social positions (Stainton Rogers, 1991). Furnham (1994, p.465) applied the same explanation model and found that individual lay health beliefs are also influenced by the political views they hold. As indicated, older people with lower-socio-economic status and have predominantly left-wing political views tend to emphasise on sociological and psychological determinants of health (Furnham, 1994). The study revealed that there are a wide range of social factors associated with individual views in terms of health-related behaviours.

Williams and Popay (1995) conducted a study in Salford among inner-city residents asking them what they considered to be the main risks to their health. The study found that daily life material constraints are highly associated with residents' subjective views about health. For example, those respondents residing in poor housing high-rise accommodation experienced practical and psychological difficulties related to being depressed and isolated, and cited other factors that caused them stress, including unemployment, poverty, economic decline, and crime. The authors specifically presented a case of smoking that revealed how experiences of social inequality in living in a poor area has given people a very sophisticated understanding of their health-related behaviours and risks. The respondent advised the authors that smoking

is not simply a health habit, and for people who live in poverty and struggle with depression, if not smoking they would turn to other alternatives such as drinking (Williams et al., 1995). In other words, even if one specific health risk factor for a person is addressed, another factor would surely replace it if the social structural conditions around that person remain unchanged (Williams, 2003).

Williams and Popay's research indicated that the local environmental factors in disadvantaged areas have substantial negative impact on people's health experiences. Popay and Williams point out that a person could be debilitated by various events including unemployment, poverty, economic decline and the experience of crime. People living in disadvantaged areas might be stressed with unclear reasons as the experiences are embedded in their disadvantaged social positions (Williams and Popay, 2001). In another study titled *"Beyond 'beer, fags, egg and chips'? Exploring lay understandings of social inequalities in health"*, Popay et al. (2003) indicated that environmental factors integrated into health experiences reflect contextualised social inequalities. Based on the survey conducted in the North West of England, Popay indicated that many people are living in disadvantaged places attributing their health problems to places-based factors including poor housing, pollution and lack of play space. Popay explained this finding, which can be contrasted with other wider literature about personal responsibilities, by the different moral load in people's health accounts. Place-based factors are less readily personalised than more personal factors including poverty and unemployment, and hence carry a lighter moral load (Popay et al., 2003).

An exploration into how lay knowledge is developed and structured is essential for public health research in order to understand contemporary health problems (Popay and Williams, 1996). The approach of exploring lay people's health experiences in everyday life through their narratives enables researchers to bridge lay health beliefs with the experience of social inequalities, which can inform public health intervention by understanding the factors, lay theories, and predictions of disease causations (Popay and Williams, 1996).

3.2.5 Health subjectivities and lay health beliefs

The relationship between structural factors and determinants of creative human agency are often multi-factorial and deprived of people's health accounts (Popay et al., 1998b, Popay et al., 2003). The process of constructing social norms and social recognitions is the key approach to understand people's health-related experiences (Goffman, 1963, Anspach, 1979, Stryker and Burke, 2000). These experiences are not merely limited to living with diseases, such as cystic fibrosis and cancer, or receiving medical treatment technologies, but also includes the experiences of

subjective feelings like stigmatisation, discrimination and isolation in people's living places (Conrad, 1990). Health views and ways to respond to health problems are often associated with individual health identities and subjectivities (Van Hooft, 1997, Sweet, 2018). Whyte (2009) suggests that exploring how people identify themselves in terms of health is directly linked to the operation of power relations with respect to social differentiation and sense of self and others (Whyte, 2009). This enables researchers to emphasise individual experiences of health concerning the construction of self, and to specify the particular social structural factors that have facilitated, shaped or constrained health identities.

As Charmaz suggests, subjective stories of suffering health problems are linked to the construction of self. Through individual and subjective health narratives, we can specify the particular social structural factors that have facilitated, shaped or constrained health identities (Charmaz, 1999). The conceptualisation of health subjectivities, which is invoked by Foucault's biopower theories, focuses on how people resist and create forms of subjectification in response to the controlling power of social norms (Lazzarato, 2002). For example, in a study of lay person understandings of functional foods in Finland, Niva (2007, p.391) indicated that the social norms about healthy diet are a subjective process. Niva suggested that people may have different reasons for eating healthily, such as the dilemma of either eating for health or for pleasure, which is not related to scientific knowledge but the constructed image of self (Niva, 2007). Another example concerns how lay people have changed the social norms in relation to obesity. Kwan (2012) found that lay people theorising weight related to emotional wellbeing and ideals of happiness, and the findings challenged the biomedical claims of BMI (Body Mass Index), which fails to acknowledge a psychological dimension of health on people's weight (Kwan, 2012).

Moral and cultural factors are more often brought to the surface when research is conducted on individual lay health views and when respondents to such surveys consider, identify and situate themselves in relation to responding to health problems (Lupton, 1993, Curtis and Rees Jones, 1998, Kirmayer, 2001). For example, Papadopoulos (2000) explored the health beliefs and lifestyle behaviours in a London based Greek Cypriot community by interviewing 79 participants. This study found that in addition to identifying socio-economic factors including poverty, unemployment, poor working conditions, loneliness, and institutional structures as health determinants, some respondents also emphasised their "Greekness" (p.188) which was interpreted as the psyche of a Greek person persisting throughout generations. This "Greekness" was believed by some respondents to make a significant difference in the way health and illness is perceived as and responded to, and it generally refers to aspects of a Greek "lifestyle", including elements of eating Greek food, speaking Greek, being

Greek Orthodox, and having Greek friends (Papadopoulos, 2000). This analysis shows how cultural identity is embedded in people's health beliefs though their claimed self-identified lifestyles, and it also has the power to influence how people respond to their health problems.

3.2.6 Lay health beliefs and traditional Chinese medicine culture

There is an awareness that health practices and beliefs in non-Western countries or cultures are distinct. Fitzpatrick (1984) suggests that in non-western societies, the importance of the cultural determinants of lay concepts of illness, particularly explanations of illness, are very different from those in Western medicine (Fitzpatrick, 1984). Although some similarities have developed with the globalisation process, social and cultural identities are in part related to traditional health practices of specific cultural origins (Sheikh and Furnham, 2000, Kim-Godwin, 2003). In China, both traditional Chinese medicine ('TCM') and modern biomedical concepts are deeply embedded in everyday life (Lin, 1981, Hesketh and Zhu, 1997, Liang et al., 2008). Traditional Chinese medicine provides a range of concepts for people to explain and understand their health conditions in daily life as well as for illness. For example, Lim et al. (1994) explored how the "meridian" – a term used to describe the balance of the body between "Yin" and "Yang" – is used by patients to explain their toothaches in Hong Kong. Some patients believed that they experienced a disorder of the large intestine meridian, thereby resulting in mandibular toothache symptoms as the mandible runs along the same channel (Lim et al., 1994, Chen, 2001).

Research studies that have sought to explain illness through traditional Chinese medicine concepts are typically prominent in Hong Kong and Taiwanese literature rather than mainland Chinese literature, as mainland China has historically taken a very different route in terms of developing and integrating traditional Chinese medicine concepts into everyday life. In the book "*Chinese medicine in early communist China, 1945-1963: A medicine of revolution*", Taylor (2004) stated that traditional Chinese medicine in mainland China has been adjusted based on the political requirement to provide more sufficient and basic healing methods, especially in rural areas. Further, Taylor concluded that modern biomedical concepts had been largely mixed with TCM in mainland China during the process of combining Chinese traditional and Western medicine. Ultimately, current Chinese medicine concepts have been recreated by the Government as a more 'scientific' national treasure. This process was embedded in the social revolution from bottom to top in mainland China, which has deeply influenced the ways in which to understand and interpret medicine in mainland China (Taylor, 2004).

The integration of traditional Chinese medicine and Western medicine has required a

range of medical terms to be translated and understood differently. For example, Hsu (2008) pointed out that there are some traditional Chinese medicine concepts that have been lost in translation during the process of globalisation. For example, “Ganmao” in Chinese medicine refers to the patient being out in the wind or cold prior to experiencing symptoms – those including feeling cold, fever, diarrhoea, running nose, inflammation or sweat, which are mostly cold or flu-like symptoms (Hsu, 2008). This discrepancy caused by translation could explain the reasons why so many migrant workers are reported as having “colds” rather than other symptoms. These differences have also contributed to lay peoples’ health knowledge in terms of explaining and understanding their health problems.

In summary, literature shows that the individual cognition of health, social class, socioeconomic factors, living circumstances, cultural background, and traditional medical culture are integrated into individual health narratives. In this way, these factors are constructed as subjective explanations to show how health is understood and practised in different social contexts. By analysing these subjective explanations, we can inspect how health inequalities are reproduced with reference to the social inequalities that people live in and experience.

3.3 Health subjectivities, aspirations, and lay health beliefs of migrants

3.3.1 Health subjectivities as migrants

In general, large scale international or internal migrations are considered either “threats” to public health or rights-based health hazards faced by individual migrants (Zimmerman et al., 2011). The process of migration often involves risks like uprooting, separation from family and traditional values, confronting new social and cultural situations, and deprived employment opportunities and legal security (Carballo and Nerukar, 2001) Carballo and Nerukar, 2001). In terms of health experiences, migration often brings challenges in individual social adaptation and resilience in response to changing living environments (O'Leary and Ickovics, 1995, Almedom, 2008). These living circumstances are often experienced commonly among migrant groups, which in turn creates similar health subjectivities shared by migrant groups. For example, Sternberg and Barry (2011, p.64) researched the health experiences of transnational Latino mothers in South Florida and found that there are common themes faced by these migrant mothers, including “living in extreme poverty, having hope, choosing to walk away from poverty, suffering through the trip to and across the border, mothering from afar, valuing family, changing personally” (Sternberg and Barry, 2011).

Thematic analysis of the health experiences of migrants, which has been

conceptualised by Van Manen (1997, p.345) as “hermeneutic phenomenology”, can be identified from the interpretation and illumination of migrants’ common lived experiences, including family separation and depression (Van Manen, 1997, Miranda et al., 2005, McGuire and Martin, 2007). It emphasises on the lived experiences with its commitment and serious interests, and it balances the specific parts and the whole meanings of the narrative (Van Manen, 1997). The theoretical perspective of shared health subjectivities also provides a tool to capture the essence of shared experiences among migrants with different cultural backgrounds. Another example is the discussion of “social bonds” among migrants from diverse cultural backgrounds who have been in psychotherapy in Sweden. Lindqvist and Wettergren (2018, p.44) suggested that the loss and damage of social bonds did not arise purely from the ‘miserable’ experiences of migration, but were also caused by the new sociocultural environment they inhabited, which often brings them feelings of isolation, alienisation, displacement, shame, grief, and bereavement. The therapeutic relationship becomes to a place that their senses of belonging can be negotiated without losing face and feeling ashamed (Lindqvist and Wettergren, 2018).

However, most of these thematic analyses of migrants’ shared experiences focus on their ways of dealing with life challenges. It appears that the construction of subjective views of health and explanations of their health practices are rarely discussed in the literature. This theoretical gap between migration research and the construction of migrants’ health subjectivities, as discussed previously, means there is an absence of tangible evidence of social factors, but importantly also an absence of subjective explanations of the lay health beliefs of migrants and lay health practices, including in particular the social context in which their migration journeys have taken place. In this way, this thesis proposes to address this gap by exploring the aspirations of migrants with respect to undertaking migration and their associated meanings of health in their everyday lives.

3.3.2 Migration aspirations and meanings of health

“Aspiration” and “desire” are the common terms that have been conceptualised in order to describe a subject’s relation to migration possibilities. They are also likely to be the most established terms for describing the common justification that leaving would be better than staying (Creighton, 2013, Alpes, 2014, Carling and Collins, 2018). For example, researchers have found that migration is perceived as the only means to acquire a good life among some of the younger populations in Cape Verdean, Mexico and Morocco (Carling, 2001, Kandel and Massey, 2002, de Haas, 2003). These high expectations could lead to heightened frustrations when migrants come to the realisation that the reality of life in a new country is more difficult than imagined

(Van Heelsum, 2017). Health-related lay knowledge and behaviours of migrants are not only subject to their current social environments and living circumstances, but are also determined by their expectations of migration, which is deeply rooted in their desires of the expected good life.

However, although the literature has recognised the contrast between aspiration and desperation among migrants, there appears to be an absence of research that addresses how migrants themselves deal with these frustrations and health challenges which are so closely connected to their meanings of life (Horton, 2016). As Suttiratana's (2017) research on the Caribbean diaspora in the US found, the exploration of migration and lifestyles must be carried out by way of theorising the relations between migration, health, adaptation, and citizenship based on an analysis of the personal, social, and institutional processes that comprise immigrants' adaptation to the US (Suttiratana, 2017). In other words, the subjective aspirations of migrants – which comprises the motivation to migrate from one place to another – will also deeply affect migrants' health-related arrangements, including the meanings they attach to health and their health behaviours in everyday life.

It has been widely observed by migration theorists that in most developing countries, internal rural-to-urban migration is driven by two main factors: rural surplus labour and the wage gap between rural and urban areas (Lewis, 1954, Ranis and Fei, 1961). This dimension is demonstrated in my research by the following argument that is made – that the health subjectivities of migrants are inevitably associated with their sense of self, of being rural-to-urban migrant workers who are driven to migrate by aspirations to change their lives. Since rural-to-urban migrants in China are often marginalised and discriminated in urban settings, their living circumstances with compromised social rights and social adaption must be calculated into their health experiences.

Herzlich (1973) suggested that cultural factors influence the perception, labelling and explanation of illness, and people in the West apparently seek out an explanation for illness, such as disease, environmental factors, stress and so forth, much more than people in non-Western societies (Herzlich, 1973). Considering the lived experiences of migrant workers, some researchers suggest that the exclusion of state-provided entitlements in urban cities have also created a certain extent of "autonomy" for rural migrants in urban settings. The situation so being that many rural migrant workers are living in urban/urbanising villages located in the peripheral areas of megacities, which can provide low rent housing and some network benefits (Zhu, 2016). Mackenzie (2002) states that Chinese rural-to-urban migrants are able to 'enjoy great autonomy from state control than any other group within Chinese society'. By taking the Zhejiang village in Beijing as an example, Mackenzie points out the "autonomy" is that the

village is not recognised by any Governmental documents – that it ‘does not exist in most official senses’. Instead, unlicensed doctors and teachers reside there that provide community services for the residents who are without local hukou (Mackenzie, 2002). However, these researchers did not undertake any investigation as to how migrant workers organise and experience this “autonomy” in terms of health. By exploring the aspirations of migrants without limiting them to economic desires, we can discover new meanings surrounding the values, meanings, and cultural aspects that are interwoven in the very fabric of migrant workers’ health experiences. For example, by analysing a survey of migrants from Guangdong province, Fan (1996) points out that in China the educated adolescents of a relatively younger age are more likely to migrate to urban cities from rural areas, and economic opportunities are not the only reasons fuelling internal migration in China, with other factors such as traditional culture and values leading young migrants to stay in the city (Fan, 1996). In light of this, it is important to examine not only how social constraints are contextualised in migrants’ health knowledge and health behaviours, but also how prevalent social values, life meanings and aspirations of Chinese internal migrants factor into their health subjectivities.

The research as summarised in this chapter has therefore found, among other key findings, that the theoretical approach to examining migrants’ health beliefs and health-related behaviours as a subjective and interactive process are determined by people’s social constructed aspirations in marginalised social positions. The influence of migration on individual health subjectivities is dependent on individual aspirations, which are constituted by multiple levels of social structural factors based on individual living experiences and circumstances. Therefore, health-related issues are negotiated by Chinese internal migrants in accordance with their unique ways of constructing meanings of life. In order to understand how health is perceived and practised in migrants’ everyday lives, it is necessary to inspect subjective meanings of health as well as the intersubjective processes in which health is constructed, taking into consideration the cultural values of migrants and the meanings they attach to their lives.

Part III

Methodology

Chapter 4
Research Methods and the Fieldwork in two Migrant Urban Villages in Shanghai and Beijing

Chapter introduction

In this chapter I will introduce the methodological framework used for this thesis, and also present my own reflections throughout my research, including on research design, sampling, carrying out the fieldwork and dealing with the fieldwork data. This chapter is comprised of four sections. The first section introduces the research design framework, indicating the direction of my thesis and unpacking my chosen research questions with ethnographic approaches. This section will explain why I have chosen Shanghai and Beijing as the main research sites and how I developed my interview outline for participants. The second section then addresses the processes through which I accessed research participants in Shanghai and Beijing. In this section, I reflect on my failed attempts to gain access to socially excluded migrant workers in “urban villages” in Beijing and Shanghai, in turn illustrating how these barriers themselves represent the discrimination levelled against migrant workers and the level of risk and danger they experience in urban settings. The third section of this chapter explores the consent and privacy challenges. I found that informed consent is sensitive to migrant workers’ perspectives, and interview settings also have impact on narratives. The fourth section concerns the ethnography process and will involve an explanation of how I sought to immerse myself in the environment, and eventually withdraw from the research sites, taking into account how I addressed the emotional stress I experienced as a researcher dealing with and observing human suffering in person.

4.1 Research design: research questions and approaches

To reveal the micro-mechanisms between social inequalities and health-related experiences among Chinese rural-to-urban migrant workers, this research needs to locate suitable contexts and suitable research participants, and then investigate their health experiences in relation to their migration-related living circumstances. The investigations, which are conducted as an ethnography, must answer the following key questions:

a) Why do migrant workers manage their health problems in a particular way?
b) How do migrant workers themselves explain their health beliefs and practices?
c) How do migrant workers themselves explain the meanings they attribute to their health beliefs and practices?

This section provides the research design component of this thesis, including how I conducted my research drawing on comparative cases in Shanghai and Beijing, including sampling methods, analytical approaches, and the interview outline.

4.1.1 Sampling

4.1.1.1 The selection of research sites: Shanghai and Beijing

The health characteristics and statistics of Chinese rural-to-urban migrants workers are often available from national databases in China, including the annual Chinese Migrant Workers Dynamic Monitoring Survey[10] held by the National Bureau of Statistics of P.R.China and the annual China Migrants Dynamic Survey[11], including the CMDS survey, held by the Migrant population Service Centre of the National Health Commission of P.R.China. Notwithstanding the diversity of Chinese rural-to-urban migrant workers, these databases can provide a fundamental epidemiological “portrait” of Chinese migrant workers, as presented and discussed in the previous social background chapter of this thesis. However, although we are able to ascertain the aggregate position of migrant workers’ health outcomes at the national level, including health insurance enrolment, popular types of diseases, and basic health-related behaviours, we are not able to examine how these inequalities are experienced by migrant workers in urban settings. From this data alone, we are therefore not able to ascertain the key connections between social inequalities and health inequalities. To identify what these health problems in reality are, a shift in perspective is needed from the very beginning, focusing on the following question – what health problems are considered to be “problems” as perceived by migrant workers?

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[10] Refers to <农民工监测调查报告>.
[11] Refers to <中国流动人口动态监测调查>.

Chinese rural-to-urban migrant workers comprise approximately one-fifth of the whole population of mainland China. They reside in wide range of different regions and have different ages, ethnicities, origins, social status, family backgrounds, inhabit various employment sectors, and have other different characteristics. However, in China, rural-to-urban migration, in its initial stages and throughout the duration of the process, is driven by economic and employment opportunities (Fan, 2007, Sun, 2010). I have selected the two most popular destination cities for Chinese rural migrants in recent years – Shanghai and Beijing – as the research sites for this thesis (Lancet, 2014).

Shanghai and Beijing are the two of the most developed cities in China, which respectively record the highest GDP per capita (Beijing) and second highest (Shanghai) of all cities throughout mainland China. The similarities and differences between Shanghai and Beijing provide a useful comparative perspective to inspect how Chinese rural-to-urban migrant workers deal with health problems in different living circumstances and urban settings. Although both Shanghai and Beijing are popular destinations for rural migrants in China, the two cities encompass many different social environments with respect to geographic, economic, cultural and policy characteristics. The general historical cultural background of the two cities are quite different. As many urban observers have described, Shanghai and Beijing have very different faces based on their respective historical trajectories: Shanghai, as an “open window” of China, has a long history of integrating Western culture and fostering international connections with Western-style infrastructure; while Beijing has always been considered a conservative political centre maintaining its traditional Chinese heritage (Yuezhi, 2019). Nevertheless, with respect to rural-to-urban migration, both Shanghai and Beijing maintain a hostile policy environment towards rural migrants, both continuing efforts to control population size and reduce numbers of low-income migrant workers residing in the cities (Roxburgh, 2018).

Table 6 shows the basic demographic information for the two cities. Both cities have a very large population size. Migrants, which refer to people who live or work in the city for more than 6 months and who are not registered with local hukou (who are mostly rural-to-urban migrants), comprise 40.3% of Shanghai’s population and 35.5% of Beijing’s population in 2018. In terms of differences, Shanghai and Beijing are economic centres of different regions and attract rural migrants from different places of origin. Shanghai is the centre of the Yangtze River Delta economic zone located in South-eastern China, and Beijing is the centre of the Capital economic zone located in Northern China (Huang, 2010, Lancet, 2014, SMBS, 2020, BMBS, 2020). Statistics show that Chinese rural-to-urban migrants tend to migrate to cities in closer proximity to their “hometown” locations, as reflected in Shanghai and Beijing. Rural migrants from Anhui and Jiangsu province are the largest rural migrant groups in Shanghai; and

Shandong and Hebei province are the two main resources of rural migrants for Beijing. Henan province, as the largest source of rural-to-urban migrants in China, and situated in the middle of Shanghai and Beijing, is one of the main origins of migrants in both cities (Zhou and Yao, 2016, Peng, 2020). Migrant workers from different origins and provinces often also have a different lifestyle, health habits and cultural background, which can in turn provide comparative research for different individual settings. In terms of medical resources, Shanghai has more hospital beds but lower numbers of physicians when compared with Beijing.

Table 6 Comparative demographic characters of Shanghai and Beijing

* Data source: Shanghai Municipal Statistics Bureau; Beijing Municipal Bureau of Statistics Survey office of the NBS

	Shanghai	**Beijing**
GDP per capita (Yuan, 2018)	135,000	140,000
Economic zone radiation	Yangtze river delta	Capital economic zone
Minimum-wage guarantee (Yuan per month, 2018)	2420	2120
Population (million, 2018)	24.2 million	21.5 million
Proportion of Migrants (2018)	40.3%	35.5%
Top three origin provinces of migrants (top three provinces)	Anhui, Jiangsu, Henan	Shandong, Hebei, Henan
Hospital beds (per 1000 people, 2018)	6.07	5.7
Density of physicians (per 1000 people, 2018)	3.1	5.1

As discussed at the end of chapter one of this thesis, Shanghai and Beijing have very different social and policy environments with respect to rural-to-urban migrant workers. Beijing has more policy constraints compared to Shanghai; however, based on population health indicators, including the Infant Mortality Rate ('IMR') and Maternal Mortality Rate ('MMR'), it appears that migrants residing in Beijing perform better on health indicators. As previously discussed, further comparative migration-related health outcomes in Shanghai and Beijing can be identified from the official health statistics.

In terms of locating research sites, I initially carried out further sampling to identify appropriate sites within the two cities. As many scholars have indicated, most rural migrant workers in Shanghai and Beijing reside in the outskirts of the city, far from the city centres, typically in semi-urbanised "urban villages" (Shen, 2017, Chai and Choi, 2017, Ouyang et al., 2017, Liu and Wong, 2018). I was required to locate these "urban villages" on the outskirts of the city. The next step involved locating suitable participants from the selected research sites in line with my key research

considerations. One of the key research considerations of this thesis is “health” – in particular how migrant workers deal with their health problems in their everyday lives. In this way, I needed to narrow my targets to those migrant workers who are considered to have more opportunities to deal with health problems. As previously discussed in the literature chapter of this thesis, migrant workers are generally younger and healthier compared with the general population in their origin and receiving places, and an increasing number of migrants are bringing their young children or older parents along with them to destination cities (Lu and Qin, 2014, Han, 2017).

4.1.1.2 The selection of research participants

For the purposes of my research, I identified potential migrant worker participants who are part of married couples and who live with their children or older parents in the destination cities. As previously discussed, due to the hukou-related schooling restrictions, most migrant children are not able to enrol in high school in cities without local hukou, leading to migrant parents often arranging for their young children to live with their grandparents in their hukou registered places (Fan, 2016). As can be expected, these policy implications limited the range of participants available given Years 1 to 9 of school are typically only available for most migrant children (Han, 2017). My research as proposed required participants to meet the following parameters:

a) Rural-to-urban migrant workers who migrated to Shanghai or Beijing without local hukou registration;
b) Currently working in Shanghai or Beijing;
c) Residing in an “urban village” situated on the outskirts of the cities;
d) Between 30-55 years of age; and
e) A parent who lives with either their child/children or older parent(s).

According to Weber’s social action theory, which explains how actions proceed and effects are produced (Weber, 2017), my proposed investigations in these two research sites will focus on how migrant workers perceive, manage, and explain the health problems they experience in everyday life in different settings. It will focus on the subjective meanings that migrant workers attach to health events. This focus on subjective meanings and interpretations of health events – categorised as lay health knowledge or lay health beliefs – particularly examines how lay peoples manage their health problems and why they choose to adopt particular approaches or methods.

As summarised in Table 7 and Table 8, The total number of participants in the study was 51 (14 from Shanghai and 37 from Beijing), and the total number of interviews was 67. There were 6 NGO workers (2 from Shanghai and 4 from Beijing) participated in the research with 6 informal interviews.

Among the interviews with migrant workers, 13 of these interviews were conducted in Shanghai and 48 of these, in Beijing. The total number of individual interviews was 16 (13 in Beijing and 3 in Shanghai) with 29 joint family interviews, including husband and wives (24 in Beijing and 5 in Shanghai) and 16 group interviews, including people from different households (11 in Beijing and 5 in Shanghai).

All interviews conducted in Shanghai are in-depth interviews, and 23 of them participated in the in-depth interviews in Beijing, with the rest 10 participants preferring I just took notes in group interviews and not engaging in in-depth interviews (as indicated in the **Appendix C.1** form).

The majority of research participants are Han ethnicity. There are only three participants with minority ethnicity backgrounds, one from Shanghai and two from Beijing. Their ethnicity is noted in table 7 and table 8.

Additionally, some of the research participants' children were also involved in the family group interviews in Shanghai and Beijing; however, they were not formally invited and were not recorded in any materials.

Table 7 Research Participants in Shanghai

Case ID	Participants	Age	Gender	Occupation	Ethnicity	Interview type
SHN1	Ms li	35~40	Female	NGO worker	Hui	Informal interview
SHN2	Ms Ying	40~50	Female	NGO worker	Han	Informal interview
SHM1	Ms Ling	30~35	Female	Homemaker	Han	Family interview
SHM2	Ms Fei	30~35	Female	Factory hand	Han	Family interview, group interview
SHM3	Mr Jia	30~35	Male	Welder	Han	Family interview
SHM4	Ms Hui	40~45	Female	Accountant	Han	Family interview; group interview, individual interview
SHM5	Ms Weng	35~40	Female	Manager	Han	Individual interview
SHM6	Mr He	35~40	Male	Businessman	Han	Group interview
SHM7	Ms Liu	40~45	Female	Shopkeeper	Han	Group interview
SHM8	Ms Fang	40~45	Female	Businesswoman	Han	Group interview
SHM9	Ms Lan	35~40	Female	Manager	Han	Group interview
SHM10	Ms Juan	30~35	Female	Office worker	Han	Individual interview
SHM11	Ms Fu	40~45	Female	Homemaker	Han	Family interview
SHM12	Ms Ping	40~45	Female	Engineer	Han	Family interview

Table 8 Research Participants in Beijing

Case ID	Participants	Age	Gender	Occupation	Ethnicity	Interview type
BJN1	Mr Hua	50~55	Male	NGO worker	Han	Informal interview
BJN2	Mr Miao	35~40	Male	NGO worker	Han	Informal interview

BJN3	Ms Yao	35~40	Female	NGO worker	Han	Informal interview
BJN4	Mr Deng	25~30	Male	NGO worker	Han	Informal interview
BJM1	Ms Gu	35~40	Female	Migrant worker (temporary NGO worker)	Han	Family interview, group interview
BJM2	Mr Pan	35~40	Male	DIDI driver	Han	Family interview, individual interview
BJM3	Ms Jian	35~40	Female	Homemaker	Han	Family interview, individual interview
BJM4	Mr Wen	35~40	Male	Upholstery material dealer	Han	Group interview
BJM5	Ms Tan	40~45	Female	Quality inspector	Han	Family interview, individual interview
BJM6	Mr He	50~55	Male	Kitchen hand	Han	Family interview
BJM7	Mr Yao	35~40	Male	property manager	Han	Family interview
BJM8	Ms Shu	35~40	Female	Salesperson	Han	Family interview
BJM9	Ms Wei	30~35	Female	Café shop manager	Han	Family interview, individual interview
BJM10	Ms Nan	35~40	Female	Teacher	Han	Individual interview, group interview
BJM11	Mr Li	35~40	Male	Office clerk	Han	Family interview, group interview, individual interview
BJM12	Ms Yi	35~40	Female	Salesperson	Han	Family interview, group interview, individual interview
BJM13	Ms Ming	40~45	Female	Supermarket Salesperson	Han	Family interview, group interview
BJM14	Mr Wan	50~55	Male	garbage recycler;	Han	Family interview, individual interview
BJM15	Ms Mei	50~55	Female	Kitchen hand	Han	Family interview, individual interview
BJM16	Xiao Wan	20~25	Male	NGO worker (with migrant worker parents)	Han	Family interview, individual interview
BJM17	Ms Ye	35~40	Female	Factory hand	Han	Family interview, group interview
BJM18	Mr Chen	35~40	Male	Security officer	Han	Family interview, group interview
BJM19	Ms Jia	40~45	Female	Factory hand	Han	Family interview, group interview
BJM20	Ms Kun	30~35	Female	Supermarket Salesperson;	Han	Family interview, group interview
BJM21	Mr Yuan	30~35	Male	Welder	Han	Family interview, group interview

BJM22	Ms Su	45~50	Female	Kitchen hand	Han	Family interview, individual interview
BJM23	Ms Zi	35~40	Female	Office clerk	Zhuang	Family interview, individual interview (online)
BJM24	Ms Zong	35~40	Female	Property manager	Han	Family interview, group interview
BJM25	Mr Qi	35~40	Male	Factory hand	Han	Family interview, individual interview
BJM26	Ms Xian	35~40	Female	Office clerk	Han	Family interview, group interview
BJM27	Mr Tang	35~40	Male	Chef	Han	Family interview
BJM28	Ms Hao	35~40	Female	Nails shop manager	Han	Family interview
BJM29	Ms Guo	40~45	Female	Salesperson	Han	Family interview
BJM30	Ms Tao	35~40	Female	Factory hand	Han	Family interview
BJM31	Ms Xin	35~40	Female	Factory hand	Han	Family interview
BJM32	Mr Da	35~40	Male	Manager	Mongolian	Family interview
BJM33	Ms Jun	30~35	Female	Factory hand	Han	Family interview

4.1.2 Research approaches: an ethnography of lay health beliefs and health practices

It is well-recognised that lay health knowledge and practices represent an important approach to understand how health inequalities are shaped in individual everyday life contexts (Popay et al., 1998b). It ‘refers to the ways in which these views are shaped in response to particular events and experiences which undermine security and are shaped by the conditions or circumstances in which people live’ (Williams and Popay, 2001). The criteria adopted to theorise lay peoples’ health knowledge in qualitative research studies relies on interrelated interpretations divided into three aspects: the subjective meanings people attach to health; the description of related social context; and particularly attention to lay knowledge (Popay et al., 1998a). I have applied these criteria as an essential outline in my fieldwork in order to obtain migrant workers’ lay health knowledge narratives regarding their living circumstances in urban settings. The fieldwork carried out for the purposes of this thesis has been designed as a narrative-oriented ethnography among selected Chinese rural-to-urban migrant workers in urban settings. Rather than carrying out ethnography in a professional medical and healthcare setting, my fieldwork was designed to understand how health is understood and conducted in “everyday life”, including in participants’ homes, communities and/or workplaces.

My thesis seeks to examine how social inequalities have facilitated lay health beliefs and lay health practices among Chinese rural-to-urban migrant workers in urban

settings of contemporary China, with a particular focus on the construction of health subjectivities and lay health beliefs in the context of rural-to-urban migration. As previously discussed in **Figure 16**, the fieldwork data collection follows a mechanisms-based analytical model to explain observed associations between events and to understand how social structural factors feature in peoples' emotions and motivations, social interactions, and discourses in everyday life (Scheff, 1990, Hedström and Swedberg, 1998).

4.1.3 Interview outline

As I reviewed in the third chapter, there three key dimensions to research people's lay health beliefs, including personal health beliefs, lifestyle factors, health subjectivities and associated social inequalities. According to these dimensions, researchers are encouraged to inspect individual health behaviours by scaling these perceptions in the survey to predict and inform public health intervention. In accordance with the behavioural dimensions which was summarised in **Table 3** as the health belief model, the lifestyle factors dimensions which was summarised in **Table 4** as the salience of lifestyle index model questions, and the explanations of social factors which was summarised in **Table 5** as the lay explanations of good health, my fieldwork was carried out with the two following goals in mind:

a) Interviewing migrant workers to obtain their health-related narratives in order to understand their interpretations of health; and
b) Attempting to immerse myself in the particular social contexts to understand how and why things are problematic from their perspectives.

To prepare for in-depth interviews, I carefully designed, practised and reflected on interview questions in order to ensure they matched the research questions, and more importantly, were practical when speaking with research participants (Kvale, 2008, Banner, 2010). The ultimate goal, according to Holstein's concept of the active interview, is to make sense of interview questions so that narratives can be expressed interactively (Holstein and Gubrium, 2016). The interviews were conducted in Mandarin Chinese, my native language. Some interviews were also conducted in Henan dialect (which is the dialect of my home province and shared by others from Henan). I continually refined and amended my interview questions throughout the fieldwork process. My interview outline as translated into English from Mandarin Chinese is replicated in **Table 9.** This translated copy was the final version that I used throughout my fieldwork and was significantly different from the original version that I designed before conducting my fieldwork.

The process of editing and refining my interview outline can be summarised in three key steps. The first step was to generate an interview outline which covers all aspects

of the research questions. This step is reflected in the first column in **Table 9**, which shows the interview divided into ten sections. I designed the order to follow the logic of everyday interpersonal conversations, which starts from a general base and then goes to health-related topics. As shown in **Table 9**, the first section is a general introduction to inform participants what the interview is for and is about. It always includes the process of obtaining the informed consent of the interviewee, introducing myself, and introducing the main topics of the interview, in order to build a base to continue the rest of the conversation. The second section covers general questions with respect to an interviewee's basic social background, including hometown, employment circumstances, and particular migration journeys. The third sections contain questions in relation to the interviewee's current living circumstances and family arrangement. The fourth section is designed specifically for migrant mothers who are willing to share their reproductive health stories since it is often the most significant health event considered by many young migrant mothers. The fifth section is primarily concerned with the subjective experiences of interviewees in relation to using healthcare facilities in urban settings. The sixth section focuses on the experiences and stories of dealing with health problems, and the seventh section developed further once I came to understand common lay medical terms and is included to encourage participants to share more of their lay health knowledge using their own expressions. The eighth section asks interviewees to share their subjective feelings regarding their own health or that of their family members, which was designed to encourage them to talk about their health arrangements and habits. The ninth section concerns general subjective meanings, distress and expectations which are related to their total wellbeing. The tenth and final section continues the discussion of subjective meanings but focuses particularly on the interviewee's definitions and views of "good health".

The second step was to design and categorise groups of expressions and questions that articulate my research concerns. In order to achieve this, I practised my initial questions with my colleagues first in order to refine my approach with respect to greetings, use of vocabulary, emotions, and body language. For example, I redesigned my questions from initially "asking for answers" to storytelling and experience sharing forms, since I found that it felt strange and uncomfortable – to an extent, unfriendly – for the respondent to keep answering questions.

The third step was to continue to reflect on the expressions, knowledge and responses from participants as the fieldwork progressed. These reflections were used to further refine my interview questions as well as interview settings, such as place different questions into different interview sections. For example, I found that the term "kang" (a Chinese term) was frequently mentioned in the first few cases of my interviews, and

many participants became easily engaged in the conversations when I used the same term in my interview questions. Since my interviewees were migrant workers who are parents, most interviews were conducted in family settings with a group of family members. There were also some interviews that were conducted individually in different settings such as at the NGO offices and outdoor places. It was important that my interview questions were semi-structured and capable of adjustment in different interview settings to follow participants' topics, stories and narratives.

The fourth step is to understand, grasp code the qualitative data. The approach of this study was largely shaped by the key concept of social bonds. That was due to the change of research context, which informs researchers how to grasp the common theme from participants with various socio-cultural backgrounds. These two approaches refer to the popular approaches widely applied in qualitative research: meaning-focused and discovery-focused analytical. While the meaning-focused method emphasises the subjective meaning of experiences and situations for the participants themselves, the discovery-focused approach depends on how the researcher theoretically and thematically codes and builds the original data approaches (Fossey et al., 2002). According to these works, the research approaches adopted should be changed to adapt to the changing research context.

Table 9 Interview outline[12]

Interview aspects	**Common interview interactions and questions**
Section 1: Introduction	Let's mainly talk about yourself and your family's health, illness, health-seeking experiences and stories, some interesting things and ideas. For example, the first time you fell ill in Shanghai/Beijing and went to the doctor, or a time you were very pleased with something you achieved by migrating, or some precautions you took in your daily life.
Section 2: Background information	Where is your hometown? When did you come to Shanghai/Beijing? Why did you come to this place? What kind of jobs were you doing before? How were they? What do you currently do for a living?
Section 3:	How many family members are living together with you now? Are there any relatives or friends you often contact here? Do you often

[12] This is a translated version. The original interview outline is in Chinese and is attached as the **Appendix B**: Semi-structured Interview Questions in Chinese.

Family life	spend time here with your family and friends on working days/weekends or days off work?
Section 4: Reproductive health	How old are your children? When were they born? Were they born here or at your hometown? Are there any things that have particularly troubled you when you gave birth or looked after your children?
Section 5: General impression of medical services	In terms of medical services, where do you think is more convenient to access these – here or your hometown place? Why do you feel this way?
Section 6: Health experiences	After you came to Shanghai/Beijing, do you have any experiences of becoming ill here? Is there any time you feel like very unforgotten, for example, very difficult to solve or did know how to deal with it? How did you finally get over with it? When is the most recent time you or your family became ill here? How did you get over it?
Section 7: Popular lay medical terms, such as “kang”	Do you have experiences of “kang” when you get ill? How did you use “kang” to deal with illness? Do you know any good medicine to treat illness or medical methods? What kind of health problems do they seek to treat? In your experience have you felt that any healing methods have worked efficiently and impressed you? Do your relatives or friends introduce you to doctors, medicine or healing methods at times?
Section 8: Self-perceptions of health	How do you feel about your own and your family’s health conditions? If you can give a rating from 1 to 10, what score would you give? Why did you choose this score? Are there any health habits or things that you often remind yourself and/or your family?
Section 9: Meanings, expectations, aspirations	What are the things that worry you the most? What do you expect in future? What is the ideal life that you would like to have?
Section 10: Ideal health image	What do you think the ideal or best health status should be? Do you think you can achieve it? How and why?

4.2 Accessing socially excluded people: barriers and reflections on health

In this section, I will introduce the methods I used to access the Chinese rural-to-urban migrant workers in the "urban villages" in Shanghai and Beijing. As disadvantaged and low-income groups, migrant workers are often excluded from urban life and reside in environments that are dominated by "informal rules", including informal businesses, employment, housing conditions, and healthcare providers. It is not easy to build mutual trust and equal relationships as a privileged researcher with migrant workers in their living communities. In my fieldwork, I adopted different roles to assist with integrating myself into the migrant workers' communities: a volunteer teacher for migrant children; a university-educated child of parents who are themselves migrant workers; and a researcher and PhD student who needs to conduct research fieldwork. These identities assisted me to find a position among migrant workers in the two urban villages I visited in Shanghai and Beijing, and they also influenced my perspectives in terms of observing and attempting to understand migrant workers' health issues in their everyday lives.

4.2.1 Barriers to gaining access to Chinese rural-to-urban migrant workers

4.2.1.1 Locating channels: volunteering at an NGO that provides services for migrant workers' children in Shanghai

In recent years, many low-skilled migrant workers have left Shanghai due to the gentrification of "urban villages" and the "industrial upgrade" whereby many labour-intensive factories have left and moved elsewhere as ordered by the Shanghai Government (SMG, 2018, Zhu et al., 2019b). Although it is not difficult to identify some "urban villages" in Shanghai, gaining access to potential research participants was a challenge. Some of my Chinese friends volunteered to help me by introducing me to migrant workers they know, but they all refused to participate in the research, and the reasons were quite understandable – they do not have much free time outside of work. There has been extensive research in relation to building strategies for conducting fieldwork in China, wherein on many occasions assistance from local government and authorities has been essential (Heimer and Thøgersen, 2006, Thurston and Pasternak, 2019). There are many factors involved in building a good relationship with the local government, including funding resources, existing links, and the identity of researchers. A Western researcher from a prestigious university may have more privileged access since their visit or participation may be valued as an opportunity of "diplomacy" by grass-roots level government bodies (or at least at one point may have been) (Stanley, 2013). However, in recent years, many Western researchers have found that the

political environment has changed, and it has become more difficult to gain fieldwork access in China. As a returning Chinese student from a Western university, my complex identity became another barrier to gain access to the field, especially when facing the local government bodies.

Based on past volunteer experience with NGOs, I focused on NGOs in Shanghai that provide free services for migrant workers. When conducting my searches online, only one NGO appeared in the results called “Shanghai DX Community Health Promotion Organisation” (‘DX’), which provides different health-related services to both Shanghai local residents and migrant workers. DX is a health-promoting NGO founded in 2006 and sponsored by a few international health promotion foundations. The “New-workers Club” is one of DX’s departments which aims to “improve the floating population’s health and social integration”. I contacted the New-workers Club and was told that they held a reproductive health survey among migrant workers authorised by the Shanghai Municipal Healthcare Commission. I was accepted to volunteer for this survey as one of their surveyors.

4.2.1.2 Failed access in XF village: “I am sorry, but we must be careful”

As one of the migrant villages covered by the reproductive health survey, XF village is a typical “urban village” located in the D district of Shanghai. The name of this village means “happiness” in Chinese, but it has appeared to me as a stigmatised place filled with informal houses and low-income migrant workers in many local media platforms. The village is far away from the city centre but is still connected to the city by a long subway line, and of course, the village is at the end of that line. When I enter the village, a “floating population regulation station” is situated right at the entrance of the village. Since the station is designed in a police-station style, it is hard to miss. (However, it is not a police station – it is a local government administrative station.) The village is filled with crumbling and damaged two-floor rural houses with what appear to be small independent rooms beside the houses. There are lots of items of clothing outside and hanging out of windows. A dirty river passes close by the village, and it is filled with waste and sewage. This village is surrounded by many new high-rise apartment buildings, and only about 200 meters always there is a modern shopping centre full of popular international brand shops. The surroundings make this village look more like a “reserve” for migrant workers, and the time they have in this “reserve” is running out – the noticeboard outside the “floating population regulation station” bears a number of notices about the demolishment of the village in the next few years.

An informal employment agency is located in the centre of the village. It does not bear any signs and is only a small room with a table and a few chairs. A Chinese lady comes out from this room and approaches me to ask if I am looking for jobs and informs me

that a delivery company is recruiting packers for 100 Yuan per hour (approximately 11 GBP). I told her that I am a student looking for people to interview for my research, and she then changed the conversation and asked me to help her set up her phone for games because she could not read. I helped her set up her phone and spoke to the people sitting in the employment agency about my research. They all recommended that I search for local landlords since they were just “outsiders” (外地人) and do not know anything about here, although I explained many times that my research was about migrant workers.

This kind of avoidance-behaviour and responses continued to happen in this village. It seemed that people stopped talking to you immediately once you mentioned your research. My encounter with a couple who make and sell shoes in this village explains the reason why they may be so scared of participating in my research. The small shoe store is located on another side of the village where most shoes are made by the couple. The couple’s bedroom is in the same room of the shoe shop but blocked from the display section. When I visited them, the wife was selling shoes and the husband was sleeping in the bedroom with a TV on. I purchased a pair of shoes from them, and we started to talk a lot about their business and living conditions in this village. She told me that this whole village will be knocked down soon, and the landlords increased the rent a lot in recent years since there are no other cheaper places to go. She also complained about the living conditions in that shop: “if you have more money, you should rent the formal apartments to live, a place like here, no bathroom, no hot water, everything is inconvenient.” At that moment I had to tell them who I was and what I am doing in this village and asked if the wife would be interested in participating. She hesitated for a while but agreed when I promised there is no personal information involved in the participation, and the participation can end or stop anytime as she wishes. Her husband interrupted our conversation aggressively from the inner room from his bed: “there are too many kinds of fraud around here, who knows what you are actually doing here, if you don’t want to buy shoes then just leave”. I apologised to them, withdrew the invitation and promised them I would only buy shoes here and would not continue our conversation any further. The wife apologised to me for her husband’s bad temper, and her husband softened his voice and muttered from the inner room: “there are too many liars and frauds, I am sorry, but we must be careful”.

I realised that the whole status of this village is precarious – people live here because it is the cheapest place they can find, and they cannot predict what would happen or when things could happen here. Understandably, distrust is a natural form of self-protection in such precarious situations, and it is not only directed in a single way – it is also how migrant workers themselves are treated by other people.

4.2.1.3 Refusal from the local grass-roots level government bodies in Shanghai: “who would be interested in these migrant workers?”

When I first met the staff of the “floating population regulation station”, they were initially puzzled and vigilant of my identity, saying to me “there is no proof to support what you are saying here, who knows what you are going to do”. After I presented more of my identity documents to them, they believed that I was a student undertaking research, but did not want to be involved. A male staff member who introduced himself to me as a retired soldier, advised me:

> ‘I am a veteran and I believe what you said, I just don’t understand, who would be interested in these migrant workers? What’s good to research about them? You are a Chinese student and should publish more about Shanghai’s progress. Don’t think that other countries are good, and China is bad, don’t be a traitor and say bad things about your own country. We cannot help you with anything because what if you carry out some illegal activities here? What if you are a part of some kind of cult or spread illegal religions here?’ [Fieldwork note 1]

The second time I visited the village committee, which was recommended by the staff who I talked to in the first place, I brought an introduction letter from the demographic research centre of Shanghai University. I met the Deputy Secretary of the village committee, and he rejected my proposal to carrying out research in the village, although I told him I was also a volunteer for the XT organisation which would be conducting a survey in the village shortly. He stressed: “we do not have any responsibilities to help you, especially for your PhD thesis, and we must listen to the higher authorities. If the District Health Commission called us, we would arrange people immediately – as many as you wish – to assist with your survey”. The purpose of my visit was to obtain some form of authorisation from the local government bodies that I could then show potential research participants to assist in building fundamental trust between them and I, but I realised that my identity was too problematic and my research was not welcome in this village. In fact, the XT organisation told me that the XF village committee also rejected their proposal to conduct the Government organised survey – the village committee instead insisting to conduct the survey themselves. Therefore, my attempt to access research participants in this village was a failed attempt.

4.2.1.4 Barriers in Beijing: replacement in a migrant village

The lessons from Shanghai helped me in many ways when conducting fieldwork in Beijing. I identified an “urban village” located on the outskirts of Beijing called Slope

village, which has a well-developed NGO that assists migrant children with after-school study. I tried to maintain a distance from the local village committee, but barriers still appeared unpredictably. One time I was walking down one of the central streets in the village and took some pictures of the fruit and vegetable market that I learned that migrant workers in the village often frequented. A shopkeeper – not of the market, but the surrounding shops – advised me to stop taking pictures here. Soon after I was stopped on the street by a local man (no uniform) to check my fieldwork notes and asked why I was taking pictures. The conversation did not end well – I threatened him that I would report to the police if my fieldwork notes were taken away.

The NGO staff later explained to me why the locals were nervous about me taking pictures. They explained there was a shift in power in the village to the locals who are taking control of the whole village's business benefits. The man who approached me is actually the son of the head of the village and owns an unregistered fruit and vegetable marketplace in the middle of the village and all sellers who wish to sell their fruits and vegetables must pay rent to him. I was told there once was a larger fruit and vegetable marketplace at the end of the street which was removed by the local government six months ago. This larger marketplace was closed down along with many other shops in the central street that were owned by migrant workers on the premise they were unregistered and therefore illegal to operate in this village. However, as I was advised, all business opportunities still existing in the village were then occupied by local residents who had personal relationships with the village committee members, including the son of the village head, but remained operating on the same unregistered, informal basis. I was advised that this son of the village head owns the unregistered vegetable marketplace, as well as purportedly other unregistered parking spaces and businesses in this village, all owing to his father's relationships. Although these particular residents have been able to protect themselves and their business interests, they seem afraid to be "caught out" because of a very simple question: if they can run businesses in this way, why then cannot migrant workers?

Many scholars refer to the unequal social policy entitlements that Chinese migrant workers experience (Ingrid and Russell, 2008, Wang et al., 2016, Xin, 2016). However, the question as to whether, and if so, how, disentitlement has become internalised in migrant workers' everyday lives is rarely mentioned in the literature. In Slope village, this disentitlement appears to be reinforced by the formal government bodies who set the rules to control the number of migrant workers in Beijing as well as the local residents (who, assumedly, hold Beijing hukou) who had usurped any business opportunities available in the village. Based on my interactions with both villages, it would appear that the attention that I sought to give migrant workers as an outsider made the local authorities quite uncomfortable. This was further illustrated by the fact

that the NGO that I volunteered in, which assisted the children of migrant workers with after-school study, was shut down by the local government about one year after I carried out my fieldwork. As I understand it, the NGO was not welcome in Slope village for quite some time as their work attracts far too much attention from the public. In 2015, the leader of the NGO submitted an open letter to the Chinese People's Political Consultative Conference ('CPPCC') about the difficulties faced by migrant children gaining admission into local primary schools in Beijing. The open letter was published on the Official Newspaper of the CPPCC and eventually was instrumental in changing some of the strict schooling regulations with respect to migrant children in Beijing.

I found that the sense of disentitlement carries over to the ways in which migrant workers organise and plan their livelihoods, earn money, and also deal with their health problems in this village. As will be explored in further detail in Chapter 5, many migrant workers prefer to visit informal clinics because they do not feel like they are entitled to formal treatment, which is too expensive and too luxurious for migrant workers. To quote those migrant workers I initially encountered in Slope village, "we are just outsiders" can explain many things that they are not willing to engage in.

4.2.2 Positionality and identity in the field: developing a mutual trust with migrant workers

As Chinese rural-to-urban migrant workers are marginalised and stigmatised social groups in China (Wong et al., 2007, Lu et al., 2016), it is difficult to reach them, not only because of their living status, but also because exposure to migrant workers is not welcome in urban spaces dominated by non-migrants. Connecting with socially excluded people is challenging work without pre-connections. As Emmel et al (2017, p.43) stated, many strategies to access socially-excluded groups have focused on how potential gatekeepers can be brought into the researcher-participant relationship (Emmel et al., 2007). I realised that I am also an "outsider" in this city, and I started to reflect on myself beyond what I seek to achieve with my research, to what participating in research may mean for migrant workers. My experience searching for potential gatekeepers illustrates that methods to gain access to the field in turn shapes the role of researcher with participants. In my two research sites of Shanghai and Beijing, I eventually built up trust with research participants through my involvement with NGOs. However, my role in the field was not only then a researcher, but also a volunteer, a homework tutor, and as a child of migrant workers myself, I recognise that I may also be perceived as a positive example of how children of migrant workers can achieve a better future through education. Sharing my own background story appeared to make my role more understandable and acceptable among the participants. I recognise that the combination of these different roles also facilitated my research about health. My

research focus was not something assigned to me by the authorities, it was my own choice. In this way, I was not a powerful person who may be able to change the situation for migrant workers; I entered the research field as a student, relatively powerless, and merely a son of migrant workers who cares about their health and their experiences.

4.2.2.1 Gatekeepers and building trust in Shanghai: Interviewing migrant workers

Migrant workers are more interested in their children's education rather than other programs offered by the NGO, such as reproductive health knowledge or masseuse training. I made an agreement with two staff members of the NGO – who I will refer to as Y and C – to set up a new training program for migrant children in the NGO, which would deliver benefits for all of us – I would have opportunities to develop trust with migrant parents, the NGO would have more training services with a small amount of extra income charged from clients, and their clients would be happy to have an overseas PhD tutor for their children on the weekends. According to this arrangement, I become a voluntary tutor teaching a one-hour Classic Chinese class on Saturdays.

The NGO helped me to advertise my class to their clients, and I asked the parents to join the first class to examine my teaching as well as to get to know me in person. In the first class, I gave a short introduction about my background, advising the students and parents that my parents are migrant workers as well, that my rural hometown in Henan province is where I finished my education before college, and I am currently doing my PhD research about migrant workers. I also presented pictures of my old rural house, my relatives who are migrant workers, and my own graduation photos. I believe that this introduction helped me to first establish a foundation to build trust between myself and the participants as I could then be recognised as someone they know. Many migrant parents approached me after the class and told me that they have similar rural houses back in their hometowns, or some of their relatives are also studying overseas. I invited them to participate in my research voluntarily, which I explained as an assignment from my university. The NGO also provided us with a WeChat group (messenger group) for all of the migrant parents who attended my class so that we could communicate anytime online.

This combination of roles I held appeared to help me to build trust with the migrant workers who were initially clients of this NGO. Most of them used to live in Harvest village but moved to other places after the village was demolished. I regularly joined in on their conversations in the NGO when they were waiting for their children to finish the tutorials on the weekend, and I also invited them to join my research through WeChat when they are available. Although I only had weekends to meet these migrant

parents, the WeChat group helped me to book an interview on other days.

4.2.2.2 Gatekeepers and building trust in Beijing: immersing myself in the field

The experience of gaining access to migrant workers in Shanghai helped me to develop my fieldwork in Beijing in a more efficient way. I completed my Master's degree in Beijing and many of my past teachers have good relationships with migrant workers-related NGOs in Beijing. They recommended a list of NGOs to me, including NGOs with a health-promotion focus and others that focused on tutoring migrant workers' children. I contacted a social work organisation called Future Community which provides afterschool tutorials for migrant children every day, including weekends. It is located in the centre of Slope village, which is a remote outskirt rural village of Beijing next to the city's boundary mountains. Future Community has been providing services to migrant workers in the village since 2007 and are sponsored by multiple channels, including the China Youth Development Foundation. There are six full-time staff members working in the Future Community, and two of them were recruited from migrant workers in this village. The organisation focuses on helping the children of migrant workers develop study skills. Most of their clients are migrant workers living in this village who have children that study in the village's primary school.

The Future Community provides a place for the children of migrant workers to stay after school to do their homework until their parents come home from work. There are many volunteers, and most are college students from universities in Beijing, to help these children with their homework every day. On the weekends, the Future Community has different training programs/classes, including English and mathematics courses, among others. I applied and was accepted as one of the organisation's homework tutors and, with the consent of the organisation, was able to communicate with migrant parents every day that I was working at the NGO. As the NGO also delivers programs designed for parents, they carry out family visits and parenting-related interviews. I became a part-time staff member assisting in this project, which allowed me to immerse myself in the village at a greater level.

There were two important "gatekeepers" (staff members) with the NGO who helped me to develop my fieldwork in this village, who I refer to as Ms Dan and Xiao Wan. Ms Dan is a migrant mother from Shandong province, her son is a primary school student who is one of the clients of this NGO, and her husband is a migrant working as a DIDI driver (online app taxi company, like Uber) in Beijing. Ms Gu became a full-time staff member in this NGO after she lost her job as an electronic seller in the Zhongguancun electronic market in 2016. Since she used to work as a primary school teacher in her hometown, she became a homework tutor for migrant children in the NGO. Ms Gu's family moved into Slope village in 2009, and they made many friends, especially who

are from the same hometown of Shandong province. While I assisted Ms Gu to carry out family visits, Ms Gu assisted me to communicate with other migrant parents about my research, and sometimes she also helped me to conduct my group interviews since we have communicated many times about my research content. Ms Gu helped me to adapt my questions and language during the interview which made my expression more local and understandable to migrant workers.

Xiao Wan is a young male who just graduated from a college in Henan province. His parents are migrant workers who lived in this village for over 10 years, and he used to be one of the volunteers in the NGO during school holidays. Like many other migrant workers from Henan province, W's father has a small recycling business in Beijing, and W's mother is a kitchenhand working in a busy internal canteen which belongs to a big company close to the Slope village. W's family and I share the same hometown city, and this helped us become good friends in a short time. They invited me to stay with them for two weeks when my original accommodation was unavailable for a while. This short period of stay provided me with an opportunity to immerse myself in the environment as migrant workers. In contrast to the fieldwork I conducted in Shanghai where interviews were the main methods, my fieldwork in Beijing was more ethnographical in nature, involving more observations and participation. Both Ms Gu and Xiao Wan were very helpful gatekeepers who had developed strong networks with migrant workers in the Slope village. In addition to visiting migrant families, we also visited different facilities in this village, including health-related facilities like local hospitals and pharmacies.

4.3 Consent and privacy: research ethics and interview settings

Statement of Ethical Review Approval

This research has been approved by the **ESSL, Environment and LUBS (AREA) Faculty Research Ethics Committee University of Leeds**.

Ethics reference: AREA 17-064

Ethical review application document:

Document	Version	Confirmation Date
AREA 17-064 amendment May 2018 Amendment_form.doc	2	24 May 2018
AREA 17-064 amendment May 2018 Information sheet_juntao.doc	1	24 May 2018
AREA 17-064 Ethical_Review Form_Juntao.pdf	1	30 March 2021
AREA 17-064 Information sheet_juntao.pdf	1	30 March 2021
AREA 17-064 Participant consent forms_juntao.pdf	1	30 March 2021
AREA 17-064 Verbal consent_juntao.pdf	1	30 March 2021
AREA 17-064 Fieldwork assessment form MED-RISK.pdf	1	30 March 2021

The Information Sheet and Consent forms (both English and Chinese versions) are attached in **Appendix A**.

Implementing research ethics can be complicated when interviewing migrant workers in China. My first, and also the biggest challenge I faced, was obtaining informed consent. In my fieldwork in Shanghai and Beijing, most migrant workers were afraid of signing the consent form or were afraid of being recorded. In this section, I will explain the barriers that arose as well as the benefits of implementing research ethics when conducting ethnographic research among Chinese rural-to-urban migrant workers in Shanghai and Beijing.

4.3.1 Verbal consent: informality as a way to avoid uncertain risks

Informed consent is rooted in a range of disciplines with different considerations for different purposes (Thorne, 1980, Faden and Beauchamp, 1986, Shannon, 2007). It is first a compulsory requirement for conducting a PhD ethnography study in any and all contexts. There were many occasions throughout my fieldwork where I found that obtaining the informed consent from participants interrupted commencing the interview. For example, one migrant mother in Shanghai told me that my research procedure was too formal compared with other interviews she participated in before. However, as my fieldwork progressed, I found that the settings and environment in which I sought to obtain informed consent of participants, and the ways that I explained the concept of informed consent were very important in terms of developing trust.

The "fear of informed consent" has been explained in different ways. One popular explanation is "embodied fear" – where people are scared of speaking out under authoritarian regimes to avoid potential harm (Geros, 2008, Joniak-Lüthi, 2016). In a similar way, people under authoritarian leaderships are not encouraged to speak out or speak up (Gongying and Lirong, 2014). In my fieldwork, I found that the fear was more directed to the process being too formal, since many of my participants were not afraid of complaining about the authorities in the actual interviews. As previously discussed, the internalised "informality" has had a profound influence on the everyday lives of migrant workers. They are not formally accepted as residents in the urban cities where they reside, and their fear appears to be associated with potentially facing ramifications (eg, being dragged into a formal process) they cannot afford to deal with. For example, one migrant mother explained to me her experience of signing her name on the form in the hospital when her daughter was ill, and how that signature represents that she agrees to take on all responsibility for her daughter's treatment, including financial costs. For this reason, she was apprehensive of signing. From her perspective, and this was shared by many other migrant workers, signing your name is akin to bearing responsibility for that which is signed. The way to overcome this barrier was to informalize the consent process.

Most migrant workers were not willing to actually sign the informed consent form, but

were willing to give verbal consent to me. The verbal consent was addressed in an informal way where the most important points were stressed: confidentially, anonymity, and the autonomy of participating in the research, meaning they can withdraw at any time. In fact, I found that explaining the concept and obtaining verbal consent was a good starting point for conducting the interviews in terms of explaining my research and assuring the safety of their personal information. Running through the printed interview outline with the participant was also very important, which was a good way to ensure that all topics were politically safe and easy to understand. The most important part of verbal consent was to ensure that all participants were aware that they were able to withdraw participation. As stressed in the consent form, “you can stop or suspend our conversation at any time, you don’t have to answer all of my questions but only the ones you feel like you can respond to. After our conversation and before the thesis is submitted, you can ask me to delete any part of our conversations or all of our conversations”. However, in some cases the participants were not afraid of signing the consent forms, especially those from a better education background. Some expressed to me they trusted my explanations, and some were confident in their own judgment based on the information provided on the consent form.

4.3.2 Interview setting matters: places and occasions

Interview settings are closely related to interview questions about health experiences. My interview settings were different according to different types of people and questions, and of course, requests from research participants. In summary, there are four types of interviews conducted in my fieldwork: private individual interviews in the NGO office; private individual interviews at a migrant workers’ home; group interviews at the NGO office; or group interviews at a migrant worker’s home.

In private interview settings, migrant workers tend to talk more about their own health-related experiences and difficulties they have experienced in their life. Particularly for migrant mothers who live together with their family members, they tended to participate in the NGO office interview where they could express freely their thoughts about their family relationships and health responsibilities. For example, one migrant mother explained that her intense relationship with her husband was the main reason that she experienced ill health, including skin conditions and indigestion. Individual struggles and subjective feelings were stressed in private interviews conducted in the NGO office, but the health of their children was always the most important topic. When the private interview was conducted in the migrant worker’s home, the family members would always be around, and the topic would focus more on family responsibilities and expectations about family members’ health, especially their children’s.

In group interview settings, migrant workers tended to seek a sense of agreement with

each other. For example, when two or three migrant workers were talking together in a group interview, they tended to talk about another person who was not in the group. In the NGO office, the group interviewees often tended to discuss other people who were also clients of the NGO. In the migrant worker's home, the group interviewees often tended to discuss their family members who were not in the village. One example being that migrant workers tend to discuss their older parents' health to each other when they were interviewed as a group at one of the migrant worker's homes. The responsibilities of family members' health became a comparable topic in the group interviews conducted in migrant workers' homes. Additionally, the group interview format also allowed migrant workers to share their common struggles with their situations. It was also the case that social structural influences were mostly discussed and described in these group interviews.

4.4 On ethnography: immersing, empathising and distancing

This chapter explains how I immersed myself in my fieldwork, empathised with the migrant workers, and distanced myself from the research site. The health conditions and living status inhabited by migrant workers were emotionally heavy topics which created lots of pressure and emotions in the field. The attitudes of some research participants and the data I collected were also significant in my experience of emotional stress.

The fieldwork I conducted in Shanghai and Beijing was carried out in different ways due to the settings. In Shanghai, I only visited the NGO on weekends and had very limited contact with the migrant workers who did not participate in my research. Even for the migrant workers who participated in my research, we did not meet one another other than for the purpose of the interviews. However, I still developed some good relationships with the participants during my fieldwork in Shanghai. One migrant family from Shandong province made a kind gesture and invited me for dinner after an afternoon interview at their home (which was a redecorated former office room inside a container-making factory). However, it was overall quite difficult for me to immerse myself with the migrant workers in Shanghai since most of the time I was separated from them and most of the interviews were conducted in the NGO.

4.4.1 Immersing in the village life

Slope village is an isolated rural village located in the far west of the Beijing region. It is hard to reach since there is only one bus stop in the village, and all other public transport connections are far away from the village. The village is a mix of small farms, rural houses, informal storage buildings, and shops. As it is situated in the shady side of a mountain, the sunlight and warm air from the south is blocked, while cold air from the north accumulates, resulting in a perpetually wet and cold environment. In other words, it is not a pleasant place to live. Ms Gu believes that the extremely bad geographic location and bad “Fengshui” was the most important reason for the bad morality in the village. She believes that most of the local people are evil because migrant workers are always bullied in this village by local villagers/residents. For example, her husband has to park his car outside of the village in an unsafe area because the village does not allow migrant workers to park their cars in the village unless they pay a monthly fee of 300 Yuan per month. The first day I arrived in the village, one of Ms Gu’s friend got her car locked at the wheel by local villagers and she had to pay 200 Yuan to unlock it. However, as a Buddhist, Ms Gu believes that the immorality of the local villagers has consequences for their own lives – the evidence she pointed to being that a few of the local villagers’ children have been born “mentally retarded” and a few old villagers have been abandoned by their children.

The relationship between local villagers and migrant workers is intense in this village. As previously discussed, many migrant workers are fixated on ideas of disentitlement because they are reminded of this environment every day. As migrant workers, they live in informal rooms which are specifically built-in rough conditions separated from local rural houses. They need to pay more expensive electricity bills charged by their landlords. When they purchase the kitchen gas tanks, they need to pay double the price of local residents to the gas station since they are not entitled to the subsidies from the Beijing Government. Further, their children are not entitled to enrol in the local public school unless they can provide up to 28 certificates from their hometown government, their employers, their landlords, and the local village administrative committee. They have to pay for the sanitation fee to the local village committee because they have been considered an extra burden for the village's sanitation. The way that the sanitation fee is charged is also quite harsh. As I witnessed one evening at 9:00pm in the evening, a group of security guards hired by the village committee knocked on migrant workers' doors one by one to urge them to pay the sanitation fee immediately. That night I was working with the NGO staff to deliver gloves as gifts to the older parents of migrant workers residing in the village. As Ms Gu explained, only at that time all migrant workers would be at home. Xiao Wan's father described these security guards as "ghosts" since these people were originally village people who were jobless and were hired by the village committee specifically to "regulate" the migrant workers in the village.

The living conditions are harsh for migrant workers; most of their informal housing do not have heating facilities since it is not permitted to install them in informal houses due to safety hazards. Beijing winter is extremely cold, and many migrant workers have to bear the cold every year. I stayed at W's place at the end of November, and I experienced the cold night myself in the rough informal house built on a piece of wet farmland. Notwithstanding, W's family is better-placed than many other migrant workers since they have three-rooms and their own front-court. Most migrant workers only have one single room to live in, and they have to put everything inside one small room. Many informal houses do not have water pipes, so some of them have to share a temporary outdoor water tap which constantly is frozen in cold winters. Most of the public toilets are dry toilets without running water, which exhibit a terribly bad smell in summer days, and are extremely cold in winter days. Since most local villagers have indoor toilets, these public toilets are only used by migrant workers in the village. There is only one public bath outside the village for migrant workers to have showers in, and it is extremely suffocating (literally) since people always smoke inside the concealed space.

While I was conducting my fieldwork in the village, a migrant mother who lived in the

village and worked at the factory next to the village died from Leukaemia in the hospital. Although there are some suspicions that her disease was related to the X-Ray machine that she regularly used in her workplace, she did not obtain any compensation from the factory and left a big amount of hospital bills to her family. On some occasions, I felt like talking about health was a "luxury" for migrant workers since there were too many basic survival issues they faced in their lives.

However, the NGO provided me with another angle in which to inspect migrant workers as ordinary people who have considerations and priorities in their lives. These different aspects of migrant workers are important in terms of understanding their health. For example, many of them have purchased new houses in their hometowns or another city, but they are not willing to give up their current jobs and move to their comfortable homes in another place. Their aspirations, including economic success and a better future for their children, have been prioritised over their personal health concerns. There are about 40 primary school students who do their after-school homework at the NGO and the program is as follows: the NGO charge 300 Yuan per month for each student; the after-school tutorials are provided Tuesdays to Fridays from 4-7 pm; weekend training is designed to include English, Chinese Calligraphy, Painting, Mathematics, and outdoor activities like city exploration, farm collection, etc. The NGO sometimes also prepares a simple dinner for the children after school. I tried the food a few times – porridge mixed with vegetables and flour, not very luxurious but enough to warm the body up in cold winters. The vegetables are collected from the NGO's vegetable farm which is rented from local villagers close to the mountain. They have many connections with different college student organisations so that there are always volunteers at the NGO, including some international students. These connections and volunteers have inevitably influenced migrant workers' high expectations for their children, and these expectations also become a drive that encourages them to dismiss their own health considerations.

4.4.2 Distancing from the field

I have different fieldwork experiences in Shanghai and Beijing. My fieldwork in Shanghai was only conducted every Saturday, and I spent most of my time reflecting and refining my interview strategies. The research environment in Shanghai University also provided me an opportunity to communicate with other researchers about my research. The distance was not only between the research participants and me, but also between research participants since most of them only see each other during the weekends. The interesting findings from the first stage of my fieldwork in Shanghai was that many migrant workers have developed similar lay health beliefs despite the lack of communications between them.

In Beijing, I spent most of my time in the village. It was difficult to distance myself from the fieldwork regarding the good relationships I built with people in the village. The relationships between my research participants are also very close due to the everyday encounters and communications. However, my mental health was challenged by the traumatising experiences and sad stories from the migrant workers in Slope village. When I am interviewing the participants, I can feel the intense relationship between the expectations they hold and the harsh reality of life. Their health narratives are produced in this environment, and they have to deal with the dilemmas and hesitations, the expectations and disappointments. I often felt powerless and hopeless when they shared their stories with me, especially those migrant workers who frankly shared their stories of migration and health. When I attempted to switch into their position in my mind, I realised that I could not change anything in this situation. I could not go back to my hometown, and I could not stay longer in hostile and rough living conditions. It seemed that migrant workers have been effectively “locked in” by different considerations and have no way out except passively bearing everyday life – a phenomena which many migrant workers expressed as “Kang”. I felt guilty because many of them treated me warmly, like their own children, but I could not help them with anything.

One time I helped the NGO to assist a visitor who arrived in Beijing who could not speak standard Chinese but only his Shandong dialect. My brain became overloaded, and I almost collapsed on the return subway trip. I kept messaging my friend in Peking University in case anything happened to me. The messaging itself helped me to escape from the overwhelming fieldwork stories. I realised it was important to maintain distance (both physically and mentally) when dealing with data collected from the migrant workers in Beijing. Each week I spent at least one or two days in the library to reflect on my fieldwork progress and the interviews. Since many of the interviews are recorded, I gave myself a short break after finishing my fieldwork and before beginning to manage the fieldwork data for my thesis. Since all the data was collected according to my research questions and interview outline, it was not difficult to manage and analyse my data when I returned from the field.

Part IV

Analysis and Findings

Chapter 5
Mistrust and Informality: Understanding the Health-seeking Patterns among Chinese Rural-to-urban Migrant Workers in Shanghai and Beijing

Chapter introduction

The comparative analysis contained in this chapter reveals how poor understandings of health, particularly the prevalence of mistrust held by Chinese rural-to-urban migrant workers towards urban healthcare systems, and the relative absence of health-seeking activities, is linked to the socioeconomic disadvantages experienced by migrant workers in addition to their lay health practices. Migration is one of the most critical risk factors associated with health rights and health risks (Boyle and Norman, 2009, Abubakar et al., 2018). In China, the mainstream research approaches used to address Chinese rural-to-urban migrant workers' health risks often focus on the utilisation of healthcare services, which assumes that Chinese rural-to-urban migrant workers' health-seeking pathways are mostly determined by economic status, especially their medical insurance status in cities (Hong et al., 2006, Mou et al., 2009, Peng et al., 2010, Mou et al., 2013). Nation-wide, Chinese rural-to-urban migrant workers have a younger population structure, and the most common health problems appear to be everyday ailments such as cold and fever. As shown in **Figure 10**, the primary health challenges identified from the survey data suggests that migrant workers are not seeking medical treatment for common health complaints, and many of them prefer addressing everyday health problems by themselves. By exploring how Chinese rural-to-urban migrant workers deal with health problems in everyday life, I will introduce the factors that have influenced their health-seeking behaviours from their perspectives, and particularly, how migrant workers perceive and explain their health-seeking patterns concerning their living conditions in urban settings.

The first section will explore the health-seeking patterns and lay perceptions among Chinese rural-to-urban migrant workers in Shanghai. It will focus on the prevalence of mistrust held by migrant workers towards urban healthcare and the development of health-seeking patterns, taking into account the different socioeconomic backgrounds shared by migrant workers. As will be shown, there are common concerns shared by migrant workers in relation to the formal urban healthcare system, and the medicine prescribed by them. I will summarise the perceptions and reasons provided by different groups of migrant workers.

The second section will focus on the health-seeking patterns and preferences among Chinese rural-to-urban migrant workers in Beijing. Compared with Shanghai, migrant

workers in Beijing have different perceptions of urban healthcare systems but similar health-seeking patterns. The comparative study results demonstrate that some critical social factors must be recognised as influential in shaping the health-seeking patterns of disadvantaged rural-to-urban migrant workers in urban settings.

Through a comparative analysis, the third section will explain how the compromised medical needs of migrant workers are socially constructed. I focus on the expectations of health-seeking among migrant workers in Shanghai and Beijing, which in turn reveals the links between healthcare needs and the precarious social conditions for rural-to-urban migrant workers living in urban settings. These associations will help us to understand why migrant workers accept certain types of lay health beliefs and lay health practices in Shanghai and Beijing.

5.1 Health-seeking channels and trust Issues: rural-to-urban migrant workers' health-seeking preferences in Shanghai

My fieldwork in Shanghai found different health-seeking patterns and explanations among Chinese migrant workers subgroups. In Shanghai, migrant workers appear to share a general mistrust of formal healthcare providers. Many lower-income migrant workers tend to use informal healthcare channels, including informal healthcare providers, lay experts or self-medication for their health struggles, while some of the migrant workers with higher incomes place more trust in formal healthcare providers, particularly in the top tertiary hospitals in Shanghai. This section focuses on such contrasts and, in particular, how lay health practices are spoken and explained by Chinese rural-to-urban migrant workers in their everyday, ordinary settings. There is a clear association between socioeconomic disadvantages and the prevalence of home remedies without formal medical interventions. The significance of these lay health practices is about how certain kinds of beliefs are generated and reinforced in particular socio-economic and political contexts. More importantly, by comparing the similarities of these lay health beliefs, I will demonstrate how lay health knowledge is socially reproduced in a phenomenological way, where the precarious living circumstances always generate similar lay health beliefs and pathways.

5.1.1 The forms of mistrust: migrant workers' perceptions of doctors and medicine in Shanghai

'Avoid getting injections where you can, avoid taking pills where you can[13]'

This is a quote from a Chinese rural-to-urban migrant mother when describing her

[13] Translated from a common expression in Chinese “能不打针就不打针，能不吃药就不吃药”.

health-seeking habits. During my fieldwork in Shanghai, this was a common expression used among the migrant workers when discussing the different methods, they use to deal with health problems in family life. It expresses the lack of trust held by migrant workers towards formal healthcare systems in Shanghai. Literature suggests that the poorer health outcomes of migrants are often associated with low levels of health-seeking behaviours, due to the lower rates of medical insurance and lower quality of medical services offered to migrants (Derose et al., 2007, Maneze et al., 2015). My fieldwork in Shanghai reveals there are more social factors relate to migrant workers' precarious living and working circumstances in urban settings. During my fieldwork in Shanghai, ten migrant mothers and some of their family members attended in-depth interviews discussing their significant health and illness experiences throughout their migration journeys. The majority of those of relatively lower socioeconomic backgrounds, such as the couples who work in manual labour and have a lower income, are more likely to deal with their health problems outside of formal healthcare systems and are more likely to develop home remedies. Three migrant mothers expressed their preference for visiting big hospitals in Shanghai to deal with most of their health problems. They had a higher income and what appears to be a better family background when compared with the majority of migrant workers.

As shown in **Table 10**, most of the significant and distressing health problems faced by research participants in Shanghai were minor diseases, which is the same outcome as the national survey outcomes I examined in the first chapter. **Table 10** shows that there are two types of health-seeking patterns following preferred methods to deal with their family health problems in everyday life. There are seven migrant mothers (SHM1, SHM2, SHM4, SHM10, SHM11, SHM7, SHM8) who preferred home remedies over visiting formal hospitals when dealing with distressing health problems of their own or their family members, and most of them were chronic diseases or ailments. The other three migrant mothers (SHM5, SHM9, SHM12) preferred to deal with their health problems with selected formal hospitals or physicians regardless of the types of illness, and they did not mention any self-developed health practices in their illness narratives.

Table 9 Illness events and solutions among the migrant workers in Harvest village, Shanghai

Case ID	Significant illness events	Relevant solutions
SHM1	Mother's urticaria	Red bean soup, hometown recipe medicine.
	Children's fever and rhinitis	Fever: drinking lots of water, wiping hot water on the back, boiling radish, pear and lily soup; Rhinitis: washing the nose with sea salt.
SHM2	Children's skin allergy and flu	Skin allergy: unknown ointment from the underground clinics; Flu: purchasing febrifuge and Anti-inflammatory medicines or ignoring it
	Mother's low back pain (disc dislocation)	Massage at the community health centre or ignoring it
SHM4	Children's fever	Purchasing cephalosporins and cough medicines, hot water foot bathing, sweating under a warm cover.
	Mother's pregnancy and childbirth	Taking progesterone and Ginseng decoction
	Daughter's eye surgery	None
SHM10	Children's flu and fever	Pigeon and chicken soup boiled with Chinese herbs (Solomon's-Seal and Lady bells)
	Mother's depression and "sub-health" status	Taking Traditional Chinese medicine and participating in online exercise activities
SHM11	Children's fever	Taking Children's MOTRIN and Tylenol, wiping the body with alcohol
	Mother's cervical spondylosis	Pinching with own hands or ignoring it.
	Father's sub-health status (slight hypertension and hyperlipidaemia)	Reducing eating outside, eating plain food
SHM7	Mother's mammary fibroma	Visiting hospitals
	Children's pneumonia and fever	Taking Children's MOTRIN, drinking more hot water, taking the nutritional supplement
SHM8	Father's pneumonia	Taking nutritional supplements
SHM5	Mother's kidney stones	Visiting well-known large hospitals
	Children's fever	Visiting well-known large hospitals (purchasing the 999, a popular Chinese patent medicine, if it is a mild cold)
	Father's haemorrhagic gastropathy	Visiting well-known large hospitals
SHM9	Children's accidental injury (foot scalded by boiled water);	Visiting selected well-known large hospitals
	Mother's headache and toothache	Visiting selected well-known large hospitals
SHM12	Children's fever	Visiting the selected "chief physician" in well-known large hospitals
	Children's accidental injury (arms were broken)	Visiting the selected "chief physician" in well-known large hospitals

There are different facilitators and barriers for migrant workers in relation to developing different types of health-seeking behaviours and lay health practices in Shanghai. However, although the health-seeking patterns and social actions are very different, the interpretations are focused on one thing – trust. As indicated by Kleinman (1988), lay experiences of illness particularly emphasise the distress caused by pathophysiological processes and ways of coping with distress (Kleinman, 1988). It is well recognised that people have very different perceptions about symptoms, as the likelihood of perceiving an event as a symptom is influenced by various personal, cultural and social variables, as well as the mode of responding to a symptom (Koos, 1954, Stoeckle et al., 1963, Zola, 1964, Bishop, 1987, Malterud et al., 2015). The distress of illness among many migrant mothers appears to be an issue of managing uncertainty and risks in an uncertain urban environment. These discrepancies between two different groups of migrant mothers also demonstrate how socioeconomic disadvantages can influence health-seeking patterns among migrant workers by shaping their perceptions and trust about healthcare systems in urban settings.

There is an association between socioeconomic disadvantages and the preference of alternative health-seeking channels among migrant workers. This is understandable considering the rapidly increasing price of healthcare services during the market-oriented healthcare system reform in contemporary China. As summarised in Zhou's article "Changing of China's health policy and Doctor-Patient relationship: 1949 — 2016", four main problems have resulted from the reform of healthcare systems: funding shortages, excessive market-oriented operation, health insurance limited reimbursement amounts, and the negative media image of "for-profits" (Zhou et al., 2017). Zhou's review suggested that these four problems have exacerbated mistrust of formal healthcare and patient-doctor conflicts in urban China. At the same time, Baum (2014) indicated that there is also an ideological shift from welfare liberalism to a neoliberal stance in several Western countries which has resulted from the global atmosphere to highlight the personal responsibilities of people's health (Baum et al., 2014). It is therefore inevitable to consider the lack of social welfare protection and increasing medical expenditure in a megacity like Shanghai and Beijing for low-income rural-to-urban migrants (Wu and Li, 2014). These reasons consist of the socioeconomic barriers between low-income rural-to-urban migrant groups and formal healthcare systems. However, there is still a research gap in terms of examining how low-income migrant workers address these socioeconomic barriers when dealing with health problems from their own perspectives.

As quoted at the beginning of this section, the seven low-income migrant mothers clearly expressed their mistrust of the formal healthcare system in Shanghai, including

the doctors, the hospitals and medicine. In their narratives, their home remedies, especially for minor ailments like cold and fever, are much more reliable compared with the formal public or private hospitals. However, it is not rare that people use their own methods to respond to minor health issues regardless of economic considerations. For example, Helman (1978) indicated there were prevalent lay health beliefs and practices outside of the formal healthcare systems in a suburb of London in the 1970s although the NHS provided free healthcare (Helman, 1978). The seven migrant mothers' explanations of their lay health practices are mostly related to the mistrust they have developed towards formal healthcare systems in Shanghai. A trust crisis between patients and doctors in China has rapidly materialised over the past decades (Tucker et al., 2016). According to a survey conducted by two public hospitals in Shanghai (Zhao et al., 2016), the mistrust of physicians is more likely to occur among young patients with low income, low education levels, and who have inadequate medical insurance. However, the authors did not explain how this distrust was developed among the patients, and the explanations provided by the author are also uncertain. The seven migrant mothers provided their narratives of mistrust which will reveal the forms and reasons for their mistrust from their perspectives.

Case SHM2 is a migrant family from Shandong province including the wife Ms Fei, her husband, and their 8-year-old daughter. Ms Fei and her husband have been living and working in Shanghai since 2011. Before that, they constantly moved and worked between Guangdong, Beijing and other cities between 1997 and 2011. Ms Fei's husband found a stable job as a welder in a container making factory next to the Harvest village in 2011, and since then he has been working in the same factory. They lived in an office-like bedroom provided by the factory, and the kitchen area was in the corridor and was shared by other five families who live in the same building. Each family has a single office room for living, and they share a corridor for a kitchen and a bathroom in another building.

Ms Fei's daughter is enrolled in a local primary school. As one of the very engaging clients in the NGO, Ms Fei's daughter attended my classic Chinese literature class, and Ms Fei occasionally spoke with me about her daughter's study as well as my research about health at the NGO. Ms Fei is a manual labourer working at a cable factory close to her husband's factory – her work requires a long time standing and moving heavy items. Ms Fei told me that in 2017 she developed very serious low-back pain from her work, which made it very painful for her to stand up. She described that this low-back pain was the first time that she felt that she had to visit hospitals to seek help. However, Ms Fei stated that the health-seeking experience was not helpful and was not satisfying. She believes the medicine given to her by the doctor was useless and harmful because she presumed that the medicine was temporary and did not

solve her problem, and the doctor who prescribed her the medicine did not care for her long-term health.

> ‘I went to the YS hospital, and the doctor was just an idiot. He gave me a steroid injection after I got there. I had a CT scan, and they said it was a disc dislocation. The doctor did not tell me that the injection is just a steroid injection, I did not ask if it is the steroid injection. If I knew it, I would not get the injection. Other people told me the steroid injection is not good. It only cools down the pain temporarily, and the real problem is still there.’ [SHM2, Ms Fei]

Ms Fei explained that only a few months later the lower-back pain returned again, which made her very disappointed. She blamed the recurrence on the steroid injection she received from the doctor, who she believes was careless and was not good at his job. The steroid injection Ms Fei received is a type of anti-inflammatory medicine which is widely used for joint pain. It is often perceived ss a kind of pain killers, and many patients have complaints over the loss of control of pain and the uncertain recurrence of pain (Pouli et al., 2014, NHS, 2018). In Ms Fei’s narratives, the steroid injection was described as a kind of pain relief medicine which only covered up her real problem rather than solving it. She, therefore, described the doctor she met as an “idiot” (translated) who did not fully inform her of the information and did not care about her condition – she had to solve the problem to go back to work. After that reflection, she turned to a massage place in a community health centre recommended by her friends. From Ms Fei’s perspective, the massage place does not involve any medicine, and she could visit there every week after work. She believes that the massages slowly cured her low-back pain although it took about one year. Based on her experience, she summarised her lay knowledge about the way of treatment by avoiding medicine in the following way:

> ‘In recent years I am influenced by many other people, they said, you should not take any medicine when you got a cold, just resist (kang) it to see if it gets better. If it gets better, why would you need to take medicine? I said this to my husband as well, I told him not to take medicine after he got sick, just try to resist it.’ [SHM2, Ms Fei]

Ms Fei did not explain where she got this idea, only quoting that “many other people said”. She believes her views are also shared by many other friends of hers. The lay health belief that Ms Fei concludes with is that medicine, especially the medicine prescribed by doctors, is not trustworthy or at least not good for people’s health, and doctors are not reliable.

This same mistrust of medicine and lay health beliefs were also expressed in cases SHM11, SHM7 and SHM8, who were generally against taking medicine especially that prescribed by doctors. Cases SHM7 and SHM8 are two migrant mothers who participated in my interview at the same time in the NGO office. They are new clients in the NGO and just sent their children to the NGO for classes for a few weeks before they met me. Both of them have small businesses in Shanghai, and they are also doing a franchise business for an American nutritional supplement product called "Usana" together.

In case SHM7, the mother Ms Liu is from a northern city in Jiangsu province. She runs a small grocery shop in Shanghai, and her husband has a job in another city. Her seven-year-old daughter is living with her in Shanghai. Ms Liu frequently uses the expression "avoid getting injections where you can, avoid taking pills where you can" when I interviewed her and she explained that she developed this belief after her daughter was treated for pneumonia in a hospital in Shanghai. She blamed her daughter's aggravation of her condition on being prescribed too much medicine by the doctors in the hospital, which in her view transformed her daughter's simple cough to serious pneumonia. She believes that the 20 days of drips her daughter received in the hospital was absolutely unnecessary and harmful.

> 'The children's hospital was just cheating us – my daughter's condition became worse after she received treatment in the hospital, and I think these doctors are all just trainees. I spent so much money, and my daughter suffered a lot. After that time, I feel like I would never visit the hospital again. Sometimes even when my daughter's fever has developed up to 40 degrees, I would just let her have some Children's MOTRIN and drink lots of hot water. All the diseases would be urinated out of the body, and she would recover soon. This is my personal experience.' [SHM7, Ms Liu]

Ms Liu also found other supporting evidence for her conclusion. She said a doctor (of old age) working in a Traditional Chinese Medicine hospital explained that her daughter's pneumonia developed as a result of overusing antibiotics in the hospital, and the doctor also told her to stop using medicine for her daughter. She believes this doctor because from her perspective that doctor was older, experienced, retired, not driven by profits, conscientious and therefore trustworthy. However, Ms Liu also stressed that all medicine, including Traditional Chinese Medicine, is not good for people's health, and the reason behind the overuse of medicine is profits. Ms Liu concluded that the Children's hospital she visited was "cheating" people for money, especially after she was told by the older doctor to stop using any medicine. She has

her own lay health belief that the body would naturally rid itself of disease without medical intervention. Sometimes when the symptoms are too threatening, for example, when the body temperature is over 40 degrees, Ms Liu would use Children's MOTRIN for her daughter. She explained that the Children's MOTRIN is an OTC (over the counter) drug which does not need to be prescribed from the doctor, it is therefore perceived as less harmful compared with the prescribed drugs from the hospital. In case SHM8, the narratives and beliefs are very much similar to Ms Liu's experiences. Both of them believe that nutritional supplement products are better and safer than medicine, and this is why they decided to do business together in Shanghai with nutritional supplement products.

In these cases, mistrust appears to have been formed as result of interactions with doctors, who are perceived as "careless", combined with "harmful" drugs prescribed by these doctors, and sometimes the drugs are perceived as "harmful" for the reason that the doctor was perceived as "careless". For example, case SHM11 is a 39 years old migrant mother from Anhui province, who is a full-time home-maker looking after her four children in Shanghai. She explained that she does not trust hospitals because the doctors have never paid good attention to her children's symptoms and their distress. She concluded that the medicine prescribed by the "careless" doctors are untrustworthy, and Children's MOTRIN, which she purchased herself, was used as a last resort to deal with her children's fever symptoms since it was perceived as a safer option.

However, in other cases, this mistrust is explained with lay knowledge of Traditional Chinese medicine and Western medicine. For example, in cases SHM1, SHM4, and SHM10, they preferred to draw on Traditional Chinese Medicine because it is perceived as a safer option. In Case SHM1, Ling is a migrant mother from Zhejiang province. Ling, her husband and her 7-year-old son live in a small rented apartment located in a gated community. Her husband is a construction material businessman and spends most of his time outside with his business. Ling had to take care of her son all by herself when he suffered from fevers and rhinitis. Ling explained that she preferred to use the Chinese Traditional Patent Medicine for herself and her son. The reason for this is based on consideration of potential side-effects as Traditional Chinese Medicine is perceived as less harmful than Western Medicine. In China, the Chinese Traditional Patent Medicine[14] is a form of modernised Traditional Chinese Medicine which is widely used in traditional Chinese medicine hospitals (Xu and Yang, 2009). Ling explained that she has developed this preference through her own experience of treating her serious skin allergy symptoms after the time she ate some

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[14] Referring to <中成药>.

sea crabs in 2013. She was diagnosed with urticaria at a hospital in Shanghai, and her nettle-rash was not treated properly although she visited different hospitals in Shanghai. After about half a year, Ms Ling's relatives recommended that she visit a traditional Chinese herbalist at her hometown, and she advises that her pain and suffering stopped after she consumed the special herbal medicine made by that herbalist. Ling concluded from her experience that Western medicine is not as useful as traditional Chinese medicine, although she could not provide any detailed information about the special herbal medicine that she received from the mysterious hometown doctor. Since then, Ling opted to use sea salt rather than medicine from hospitals to treat her son's rhinitis.

Similar to Ling, in Case SHM4, Ms Hui's husband is a construction worker working in another city, while Ms Hui and her 12-year-old son live together in the same factory dormitory building with Ms Fei. Ms Hui explained that her preference for Traditional Chinese medicine developed due to having been subjected to what, in her view, was unnecessary examinations, expensive useless drugs, and carelessness in hospitals in Shanghai. Ms Hui's preference is also supported by her lay health knowledge about the nature of health and illness. She explained that most of the symptoms that she and her son have experienced are rooted in their body naturally, which is explained as "the lack of Qi and blood"[15] and the "cold body nature"[16]. These two terms are common aetiology concepts in traditional Chinese medicine system, which sees the human body as special material consisting of "Qi" and "blood", and the nature of the body system as a balance between cold and heat (Qi, 2005).

In Case SHM10, Juan explained that her preference for traditional Chinese medicine developed after witnessing how hospitals overuse antibiotics. Juan is a migrant mother from Guangdong province. Although she has been married to a local Shanghai man for 8 years, she does not have a Shanghai hukou and still sees herself as a migrant. Shanghai has strict regulations in relation to obtaining a hukou by marriage – a person from another province who gets married to a Shanghainese local person needs to wait 10 years after the marriage and be older than 35 years to obtain a local hukou in Shanghai (Li et al., 2010). Juan is an office worker who works at a Japanese company in Shanghai. She explained that she was very stressed when her daughter repeatedly experienced fever symptoms when she was around 2 and 3 years old. She believes that all of her suffering resulted from her daughter's first-time visit in a hospital in Shanghai. She explained that her daughter received too many antibiotics at that time, and the antibiotics damaged her daughter's bodily defence immune system. Juan

[15] Translated from the traditional Chinese medical term "气血不足".

[16] Translated from the traditional Chinese medical term "体寒".

believes that all hospitals overuse and overprescribe antibiotics because it has become the only way to quickly and effectively cure children's fever symptoms and to calm parents' anxiety.

> 'They (hospitals) have no choice because they could not control antibiotics anymore. Once you use it for the first time, you would have to use it again next time. When the doctors see you are so worried about your kids' symptoms, they want to give you fast treatment. Otherwise, you would consider that the doctors are useless. All the doctors like to use cephalosporin in the drips since they are more expensive than penicillin. The doctors can recognise the children that have been using antibiotics, and next time they would give the child more antibiotics.' [SHM10, Juan]

The overuse of antibiotics is a pivotal issue in China that is widely reported and discussed in media (Xiao et al., 2013, Li, 2014b, Sun et al., 2015, He et al., 2019). Although the use of antibiotics is currently discouraged by health authorities in China (Currie et al., 2011), Juan believes that all hospitals inevitably overuse antibiotics since they are unable to cease antibiotics dependence immediately. Juan developed her mistrust of hospitals based on her understanding that doctors are overusing antibiotics, and her solution is to avoid visiting hospitals and to rebuild her daughter's immune system by herself. Juan explained that her home practice is to treat her daughter's fever symptoms through what is called "food therapy", which consists of eating slow-cooked chicken or pigeon soup mixed with several traditional Chinese herbs, such as Shashen[17] and Yuzhu.[18] Juan believes that these traditional Chinese herbs can stop coughs and clean the lungs without any side-effects, and the chicken or pigeon soup can also provide nutrition to improve her daughter's immune system.

A consistent thread running throughout the interviews with seven migrant mothers in Shanghai is that their avoidance of formal urban healthcare system, especially urban hospitals, is borne out of a form of mistrust rather than unaffordability. These forms of mistrust can be categorised into three types: first, the mistrust of careless doctors; second, the mistrust of prescribed drugs; and third, an apprehension of the potential side-effects of drugs, particularly the antibiotics. In China, there is a strong folk belief of avoiding medicine in general since it is commonly perceived as not good and sometimes harmful among lay people, which is reflected by a Chinese saying "every medicine has a side effect"[19], which is discussed in many Chinese public health

[17] A kind of Chinese herb called "沙参" which refers to the dried roots from Adenophora stricta plants.
[18] A kind of Chinese herb called "玉竹" which refers to the dried Solomon's-Seal plants.
[19] Translated from Chinese "是药三分毒".

promotion journals (Leng, 2006, Dao, 2010, Li, 2010, Qiu, 2012, Li, 2016). Chinese medicine history researcher Yu (2005) suggests that the strong suspicion of doctors and drugs in Chinese folk medicine systems is a result of uncertainty since many people are unable to find or select a trustworthy doctor in ancient China (Yu, 2005). Bishop (1991) suggested that the ways that a person perceives health threats is key to understanding that person's health-related behaviours (Bishop, 1991). Throughout the seven mothers' narratives, the mistrust of doctors and medicine have been perceived as the main concern of their health care practices. Their mistrust was interpreted as a tangible experience based on their encounters with hospitals, doctors and the treatment they received from them in Shanghai. Their descriptions of lay health practices, especially self-medication methods, was borne from distrust of, and avoidance from, urban healthcare systems.

5.1.2 The forms of trust: uncertainty, risks and the selection of hospitals

> 'I think the doctors in big hospitals have better medical skills, they are more trustworthy in many ways.'

This quote is summarised by a Chinese rural-to-urban migrant mother when discussing treatment in hospitals. In contrast with the seven migrant mothers discussed in the previous section, the other three migrant mothers I interviewed in cases SHM5, SHM9, and SHM12 expressed their fondness for formal hospitals and did not refer to any "home remedies" when discussing the ways they deal with their own and their families' health problems. It is important to note that these three migrant families were from different socioeconomic backgrounds than the other seven. All three migrant mothers have college degrees, earned higher incomes, and inhabited higher occupational classes. However, their trust in hospitals was conditional, and was often interpreted as a way to avoid more uncertainty and risks. Their experiences demonstrated that their preferences were borne not only as a matter of affordability, but also of trust, particularly coping with the uncertainty and risks inherent to migrants who live in urban settings. These three cases show that people with different socioeconomic conditions can generate different patterns of trust in health-seeking behaviours.

In Case SHM12, the mother Ms Ping described herself as a wealthy Anhui person in Shanghai, rather than Shanghainese, although she obtained a local Shanghai Hukou once she started her work in Shanghai. Ms Ping is a website engineer who graduated with her master's degree in the 1990s, and her husband is an IT professor at a university in Shanghai. Ms Ping has two children, one boy and one girl who are 9-year-old twins. She explained that she still sees herself as a migrant because her

identity is determined by her childhood memories rather than her current hukou registration. She was recommended by her friends who are “real” migrant workers to participate in the classes and activities in the NGO, and she was happy to participate in my research because she assumed that I was a well-educated person, like herself, and we would have mutual understandings. Ms Ping expressed that she was very satisfied with her current situation with property ownership and comfortable wealth in Shanghai. She emphasised that all of her family members have full-cover healthcare insurance. However, Ms Ping expressed concerns in terms of selecting a trustworthy hospital with high quality care. She explained that before finding a good hospital for her childbirth and teeth care, she tried many different hospitals in Shanghai to compare the quality of medical services. This consideration was particularly emphasised in her illness narratives with the repeated expression of “chief physicians” who she specifically trusted to deal with her and her children’s health problems.

> ‘The medical services are very good in Shanghai. They are very precise. Like my son, the time he broke his arm and had surgery at night-time. The chief physician came straight from home to the hospital and operated the surgery himself. Afterwards, the chief physician regularly checked the ward himself as well.’ [SHM12, Ms Ping]

This is an excerpt from Ms Ping’s illness narrative when she advised her son had to have surgery after he accidentally broke his left arm in a park. She was very distressed due to her son’s pain after that accident, but she dramatically placed emphasis on the “chief physician” who conducted her son’s surgery and regularly examined her son post-surgery. In her narratives, the emphasis on the “chief physician” was the only supporting evidence she used to conclude that “the medical services are very good in Shanghai”. In other words, it is the distinctive service that she received from the “chief physician” in Shanghai, rather than other regular doctors, that informed her judgment that medical services in Shanghai were good. She believes that this is a means to find out what is best for her and her family. Her narratives reflected two main points: the first is that she is economically capable of selecting different hospitals herself; the second is that she has had to examine the quality of medical services herself. As discussed previously, the trust crisis between patients and doctors is still increasing in urban China (Hou and Xiao, 2012, He et al., 2016). The emphasis on “chief physician” is not an expression of economic superiority, but a solution to solving trust issues in Shanghai by way of her economic advantages.

The same logic can be found in cases SHM9 and SHM5. In case SHM9, the migrant mother Ms Lan is from Anhui province. Although Ms Lan has a college degree and works as a manager for a large company, she does not have a Shanghai local hukou.

However, Ms Lan and her husband have met the requirements of Shanghai's residence points system[20], which grants their children full schooling rights in Shanghai. The residence points system of Shanghai is a path for people to apply for local hukou or obtain social rights similar to locals in Shanghai. It often requires employers' support, education degrees, accumulative social insurance contributions and other contributions made by the applicant (Baofu, 2014). Compared with the 7 previous cases, Ms Lan is a successful migrant since she is a manager who has free accommodation and good medical insurance provided by her company. More importantly, Ms Lan's son can enrol in the local school and continue his education in Shanghai without the other various conditions that other migrant workers are subjected to. However, unlike the case SHM12, Ms Lan does not have a local hukou or own a property in Shanghai. Ms Lan's health-seeking preference is for the top hospitals in Shanghai, and her strategy is to experience different big hospitals in Shanghai to select a trustworthy one. Ms Lan does not trust the top hospitals in general – she told me stories where she sought treatment for a toothache and headache in different hospitals in Shanghai, and was unsatisfied with some treatment she received.

> 'That time my headache and my toothache came together, and I couldn't even eat food. I went to the HS hospital, I thought it is famous. The doctor told me it's nothing, just like a cold. I was confused. Then I heard that the doctor told another patient who has suffered her headache for three years the same thing "it's nothing, just like a cold". I thought this is not right, I can't have the medicine from the doctor, how could a patient with three years headache get the same medicine as me? I chucked out all the drugs from the doctor although it's from the famous general hospital. After that, I went to the CH hospital, which is another top general hospital in Shanghai.' [SHM9, Ms Lan]

Ms Lan explained her experience selecting good hospitals in Shanghai, and she emphasised that not all top hospitals have good quality healthcare, and not all top hospitals are trustworthy. Ms Lan explained that she receives good medical insurance from her workplace although she does not have a local hukou in Shanghai. This economic advantage has allowed her to experience different top hospitals herself in Shanghai, and she wants to send a message to other migrant workers that not all top hospitals are good and trustworthy. In case SHM12, Ms Ping expressed the same idea that not all big hospitals are trustworthy, but only selected "chief-physicians". Both Ms Ping and Ms Lan assumed that there are many migrant workers who trust big hospitals

[20] Referring to <居住证积分制度>

in Shanghai; however, it appears that case SHM5 was the only person who corresponded with that assumption that migrants trust the large general hospitals in Shanghai unconditionally. Case SHM5 is a migrant mother called Ms Weng who works as a market manager in a telephone company in Shanghai. Both Ms Weng and her husband are from Henan province, where they completed their college education. Both of them have not met the requirements for obtaining a Shanghai hukou or equivalent education rights for their children, meaning their 8-year-old daughter will have to transfer to another school (usually back in home-town province) to complete the "gaokao" (Chinese National College Entrance Examination) once she finishes her primary 9-year education, in accordance with the regulations (Montgomery and J., 2012, Zhang, 2012). Ms Weng, her husband and her daughter live together in a rented apartment close to the Harvest village. She advised they have changed their accommodation a few times due to the increasing rent. However, Ms Weng sees herself as a migrant worker in a better position than other migrant workers. She emphasised that she prefers the large general hospitals although they are often more expensive than other small hospitals or clinics.

> 'Some people think that these large general hospitals are too expensive. Actually, they would not sneakily charge you more than other people, they just follow the regulations, and they are more trustworthy. I believe in them. Some people told me it is too troublesome to visit a large general hospital, but I think the doctors in these large hospitals have better medical skills and they are more trustworthy in many ways. They are absolutely my first option.' [SHM5, Ms Weng]

Ms Weng explained that she trusts the large general hospitals because they can guarantee professionalism, and the higher price is reasonable considering the quality of healthcare services they can provide. She explained that about 10 years ago, one of her college friends died from receiving unprofessional treatment for his kidney stones in a small hospital, and there were also a few times where she was unhappy with her visits to small hospitals close to her residence in Shanghai because, she advised, the doctors there were careless and the drugs did not work. The term "large hospitals" in Ms Weng's narratives refers to the limited number of top tier hospitals[21] in Shanghai. These hospitals are always busy but open for everyone with any symptoms as long as you are willing to pay the significantly higher bills (Liu et al., 2009). As a migrant mother from Henan province in Shanghai, Ms Weng is also aware that her working conditions as a market manager are much better than other migrant

[21] Referring to <三甲医院>

workers who do manual labour. A good income and proper medical insurance have made the large general hospitals affordable for Ms Weng, and the perceived "regulations" that she says the large hospitals follow is considered as a guarantee for her to build her trust and avoid uncertainty and risks. Ms Weng also mentioned the medicine called "999" that she purchases to treat her daughter's mild cold symptoms. She explained that the "999" is a famous OTC drug that is a non-harmful Chinese Traditional Patent Medicine. This trust in Chinese Traditional Patent Medicine is similar to Ms Ling's narratives in Case SHM1, but the difference is that Ms Weng is not relying on this medicine but considers it as an option for very mild symptoms.

Of note, the trust that Ms Weng places in big hospitals in Shanghai is indefinite, which is different to the narratives of Cases SHM12 and SHM9. In the health belief model discussed previously, the important factors associated with taking health-seeking actions only involve people's lay illness cognitions such as perceived susceptibility, perceived benefits and perceived barriers (Champion, 1999, Champion and Skinner, 2008). However, as indicated by Rosenstock (2005), social class differences are not explained in the health belief model since it is more applicable to middle-class groups, and people of lower status often have different patterns of health beliefs (Rosenstock, 2005). For example, Ms Weng expressed that she is distressed about her daughter's schooling rights in Shanghai since her family does not meet the requirements of the residence points system in Shanghai. This distress is not mentioned in Cases SHM12 and SHM9 since they have obtained education rights for their children in Shanghai, which is considered as a significant successful outcome for most migrant workers who have children in Shanghai. This distress reflects Ms Weng's socioeconomic constraints compared with cases SHM12 and SHM9, the latter illustrating health-seeking selections from large hospitals, to selected large hospitals, and finally to chief physicians in selected large hospitals.

This narrowing of selections reflects a wider range of distrust of healthcare providers as perceived by these three mothers. Indeed, trustworthiness is also the main concern of migrant workers with better socioeconomic conditions, not only in healthcare providers, but also in confronting the uncertainty and other risks they face as migrants in Shanghai. For example, in case SHM12, although Ms Ping can enjoy the top medical services from chief physicians, she still expressed that she experiences uncertainty and risks in Shanghai. For example, Ms Ping described her anxiety in relation to obtaining a trustworthy nanny for her children, and she advises it has become the biggest worry in her life since she has never found a good one. In Case SHM9, Ms Lan also lacked personal support to look after her son, but this problem was solved by developing a good personal relationship with her landlord. Her landlord is a local older woman who has provided trustworthy care for her son when she worked

full-time and her son was too young to be left alone. As Zou (2018, p.45) indicated in the anthropological study about the patient-physician trust in China, *"Patients who emphasized the positive effects of guanxi on patient-physician trust believes that it facilitates access to experienced medical specialists, enhances clinical communication, and reduces the financial and medical risks of overdiagnosis and overtreatment by physicians".* The core of trust is relying on personal and informal relationships, which are called "guanxi". (Zou et al., 2018). The mistrust Ms Ping has developed is reflected by her self-identity as an "outsider" in Shanghai. Despite the fact that her hukou status has changed, she still suffers from a lack of family and social support in this city. However, it is rare to see migrant workers seeking doctors through personal relationships in Shanghai. The informal and personal relationship and support often requires a long-term social network, which is mostly a privilege obtained only by local people who have developed their various social relationships at one place over time. The absence of "guanxi" can explain the approach adopted of selecting the "chief physician" in Case SHM12.

Overall, the health-seeking preferences and lay health practices can be conceived as being matters arisen from the "trust crisis" that migrant workers have developed in Shanghai. The health-seeking patterns among migrant workers in my fieldwork are polarised – whether it be self-medication and informal healthcare providers for the poor, or top-level tertiary hospitals for the wealthy. However, although it is possible to identify the correlations between these different health-seeking patterns and migrant workers' socio-economic conditions, it is still unclear how the mistrust is widely formed among migrant workers in Shanghai. The various lay health beliefs and practices among migrant workers also need further explanation. In comparison to Shanghai, the similarities and differences of health-seeking activities and lay health beliefs among migrant workers in Beijing, as explored in the next section, will assist in understanding how these correlations are formed.

5.2 Informality in the Migrant Village: Health-seeking Patterns among Migrant Workers in Beijing

As illustrated in the previous section, different socioeconomic conditions have created two very different patterns of health-seeking activities and various lay health practices among the participants in Shanghai. A very important feature is their mistrust of the majority of urban formal healthcare providers. However, as this section will demonstrate, migrant workers in Beijing have very different health-seeking patterns and interpretations compared with the migrant workers in Shanghai despite their similar socioeconomic backgrounds. Rather than trust issues, migrant workers in Beijing appear to have greater concerns about the economic cost-effectiveness and other impacts to life from visiting different healthcare providers. As a result, although migrant workers in Beijing have different interpretations of their health-seeking activities, the informal healthcare providers and lay health practices are still popular among these low-income groups. Therefore, their health accounts will indicate how the correlations between the living and working circumstances and their health-seeking habits, health perceptions and lay health beliefs in urban environments. This section will examine the different types of different health-seeking options, in particular, self-medication and use of informal medical services among migrant workers in the Slope village of Beijing. In comparison with Shanghai, the health-seeking activities of these migrants reveals a clearer link between health-related decisions and migrant-related considerations and social factors in the everyday lives of migrant workers.

5.2.1 Health-seeking patterns among migrant workers in Slope Village

My fieldwork in Beijing was conducted in a village located at the outskirts of Beijing beside one of the border mountains. The name of the village “Slope” describes the cold underground water that streams from the mountainside land of the village. As the village is covered in shadow due to the mountain, the natural environment in this village is wet, cold, and unpleasant. Before it became a hot spot for migrant workers, Slope village was just one of many hidden and underdeveloped remote rural mountain villages of Beijing of a relatively far distance from the city centre without convenient public transport connections to the city. In the recent 20 years, with increasing rent and expanding urban development from the city centre to outskirt areas, many migrant workers, particularly low-income migrant workers in Beijing, started to migrate to this village to find a cheaper place to live. With the increasing number of incoming migrant workers, the local famers in this village have built many informal and rough residential buildings to rent. These overcrowded informal buildings are mostly unlicensed, small one-floor rooms built with cheap and rough materials. In Government documents,

Slope village is described as the population-overthrowing[22] village, as the number of migrant workers in this village outweighs the local village residents.

In contrast to my fieldwork in Shanghai, where the migrant workers I interviewed live in different communities and villages, all of my research participants in Beijing live in the same village. Among the 21 migrant families who participated in in-depth interviews, there are different types of pre-existing social relationships between them – some of them are colleagues from the same state-owned factory next to this village, some of them share the same hometown (the majority of them are from Shandong province), and some of them are even relatives. All of them are clients of the Future Community Organisation located in the centre of the village. My role in the village was a volunteer of the Future Community Organisation, which provides after-school tutoring services to migrant workers' children in this village. Similar to Shanghai, my research participants in Beijing are the migrant parents of children in primary school who are the clients of the NGO, and most of them are between 30 - 45 years old. However, the significant illness experiences and health accounts collected from Beijing are different from Shanghai. Although cold or fever symptoms of children were frequently mentioned in their health accounts, they were not the most significant and distressing health-seeking experiences among Beijing's migrant workers. They are also different from the general health characteristics of migrant workers (as shown in **Figure 7** and **Figure 8**) – Beijing migrant workers talked more about work injuries, chronic diseases, infectious diseases and serious illness, including long-term headaches, insomnia, leukaemia, Tuberculosis and some other long-term illnesses/ailments.

The health-seeking patterns among migrant workers in Beijing proved also to be different from Shanghai. In Shanghai, the health-seeking preferences were polarised between either top hospitals or informal healthcare providers (including home remedies), and many of the regular healthcare providers were not trusted and consequently excluded from migrant workers' health-seeking options. However, the trust crisis proved not to be a key issue among the research participants in Beijing. Instead, along with trust, the main considerations that featured in the health-seeking decisions among migrant workers in Beijing were convenience, affordability and perceived severity of the illness/ailment. Geographic factors were also considered by many migrant workers since the village is isolated in the outskirts of Beijing where it is not convenient to travel. According to the health-seeking accounts I gathered, I summarised five levels of health-seeking options among the migrant workers in Slope

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[22] Translated from Chinese "人口倒挂" used by Beijing Municipal Government to describe the places where the migrant population is larger than the local population.

village. As shown in **Figure 17**, the order of health-seeking options is as hierarchical as the formal urban healthcare system in China but slightly different in the context of this specific village. It includes the individual level (not seeking or some home remedies), village-level (a government-owned village clinic, four private pharmacies, an informal unlicensed clinic), township-level (a community hospital which is owned by a state-owned factory next to the village), district level (several district specialised hospitals), and the top-level (several national-level hospitals in Beijing). A particular feature of many migrant workers' health accounts was that travelling back to their hometowns for treatment was as troublesome as visiting the top tertiary hospitals in Beijing and would only be justified for long-term serious illness. For this reason, I put this option at the top-level together with visiting tertiary hospitals in Beijing.

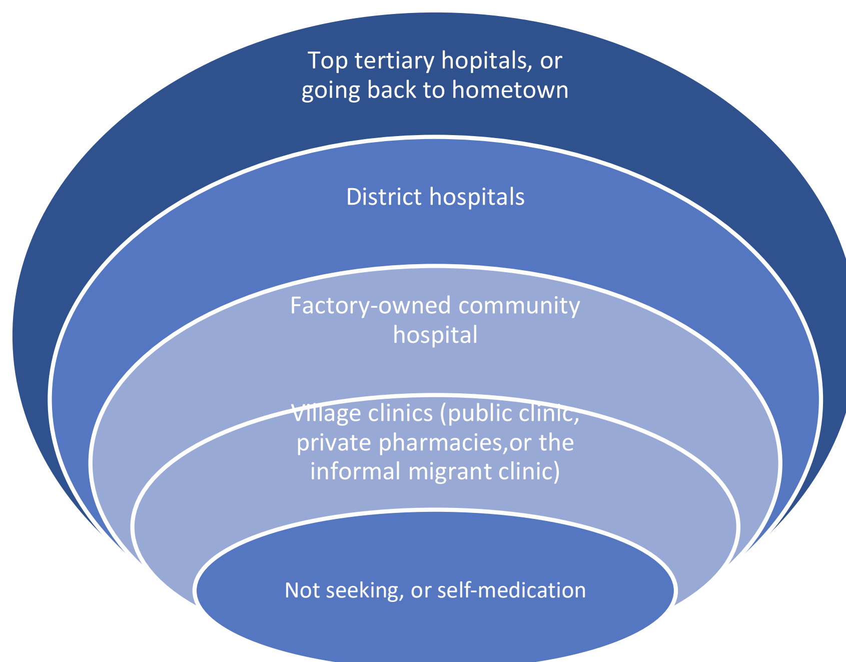

Figure 17 Health-seeking patterns among migrant workers in Slope village, Beijing

A key difference between the health-seeking considerations among migrant workers in Shanghai and Beijing is that mistrust of healthcare providers was not a key determinant in health-seeking decisions in Beijing. For example, some of the migrant workers would still visit the nearby informal unlicensed clinic to purchase drugs despite

expressing their strong mistrust in, and concern for, the quality of the medicine and the doctor's medical skills in that clinic. As shown in **Figure 17**, the different levels of health-seeking options correspond with different perceptions and explanations among the migrant workers in the village of Beijing. However, although the structure is hierarchical, the health-seeking decisions do not follow the order from bottom to top. For example, some of the migrant workers are employed in the state-owned factory next to the village, and the community hospital would be the first and best option for them to visit. There is also a large proportion of the migrant workers in the village who prefer not to seek any medical treatment when falling ill, and a large number of them never visited any of the village clinics or pharmacies. The perceptions and explanations of health-seeking are influenced by many individual and social factors, and they are not always coherent. In the following section, I will explain these perceptions and explanations in turn to reveal the links between migrant workers' living circumstances and their health-seeking preferences.

5.2.2 Individual health practices: explanations for failing to seek healthcare services among the migrant workers in Slope village

In **Table 10** I have introduced different types of lay health practices as cited among the lower-income migrant workers in Shanghai, including drinking hot water, food therapy, or taking the specific OTC drugs. Similar lay health behaviours are also significantly popular among the migrant workers I surveyed in Beijing. For example, Peng et al (2010) analysed the health-seeking behaviour survey involving 2478 migrant workers in Beijing in 2010 and found that 33.3% of them chose self-medication, 30.3% of them chose no measures when they fell ill, and 19.7% of the sick migrants who should have been hospitalised failed to receive professional treatment. The authors suggest that the high cost of health service is the most significant obstacle perceived by these migrant workers, and their unstable jobs, unstable residence and lack of social support often discourages them from investing time and money in their temporary living spaces and employment-based insurance programs (Peng et al., 2010). However, the authors did not explain under what circumstances the migrant workers in Beijing would choose self-medication or no measures and under what circumstances they would seek professional medical services.

My fieldwork in Beijing found that inaction or self-medication practices are particularly popular for lower-income groups when dealing with mild symptoms of illness in everyday life. Perceived severity plays an important role in health-seeking decision making. However, since the symptoms are often evaluated by the migrant workers themselves at an individual level, there is always large scope for different perceptions, explanations, and lay health knowledge to understand and interpret the perceived

severity. However, I argued that the perceived severity is not a simple reflection of illness symptoms; it is a subjective perception which evaluates the impact of a specific illness event in their lives. The case BJM5 is a good example to demonstrate how migrant workers' subjective perceptions would impact their health-seeking decisions.

In Case BJM5, Ms Tan is the migrant mother in her forties from Shandong province. She works in the state-owned factory next to the village as a quality inspector. Ms Tan, her husband, and her 12-year-old son have lived together in Slope village since 2006. Ms Tan's son is enrolled in the local primary school. She also has a 15-year-old daughter who is "left behind" at their hometown from a very young age. As migrant workers, they do not have a Beijing hukou or the equivalent education rights for their children to stay in Beijing for high school education or the future National College Entrance Examination. Their daughter, however, did not have the same opportunity to have a primary school education in Beijing like their son. This is very common among the migrant workers from Shandong province where the boys appear to be more valued. Ms Tan explained that males are more valued in her hometown because they used to do heavier manual labour, such as carry water for the family in the hometown village since there was no tap water available. She compares the current life with her earlier life in her hometown and concludes that both hers and her husband's health has benefited from the heavy physical labour they used to do before they migrated to Beijing. She explains that they inherited their healthy bodies from the genes of their parents, who also used to do heavy physical work, and that cold or fever symptoms are not things that they need to be worried about.

> '(My husband) and I are similar, people like us at our age often have been through a more bitter life. We did more physical exercises at an earlier stage in our lives – our parents as well, we have good genes. My husband sometimes complains about being tired or hurt, but I am better.' [BJM5, Ms Tan]
>
> 'Do any cold or fever problems bother you?' [Researcher]
>
> 'Sometimes, but it's not a big deal, sometimes I just take some drugs. I would not take any medicine, just resist (kang) it, have more sleep, drink more water, eat more food, when you eat more your immunity would be stronger, and the diseases would be scared off.' [BJM5, Ms Tan]

According to Ms Tan, cold or fever symptoms are not things that she needs to worry about. She explains that the body is healthy enough to resist these symptoms by itself without any medical interventions, and these small problems can be ignored in

everyday life. Ms Tan described herself as very healthy to me when she attended the interview. Ms Tan has good medical insurance in the community hospital since she is a formal employee at the state-owned factory – therefore, the high cost is not a barrier and concern for her to seek medical services. Her explanations for not seeking healthcare services are focused on the perceived severity and perceived immunity. According to Ms Gu, Ms Tan had headaches and urinary problems for a long time, which she did not want to mention in the interview. Ms Gu suggested that Ms Tan was embarrassed to mention her urinary health problems to a male interviewer. Based on my interviews with Ms Tan, the emphasis she placed on her “immunity” present her capacity to resist illness as a migrant worker and a mother who requires a healthy body.

Similar health accounts can be identified with many other migrant workers in Beijing; many of them mentioned their lay health practices and home remedies as a way of preventing diseases rather than treating them. Case BJM7, who are migrant parents from Shandong province, is an example of this. These migrant parents expressed that they were very proud of both their own health and their 9-year-old son’s health, stating that their son looks bigger and stronger than the other boys of the same age in the village. When they discussed health and illness problems, they emphasised that they have been taking care of their health in a good way and have a strong immune system to defeat minor flu-like symptoms. Therefore, for most of their symptoms, they do not need to take drugs or visit hospitals. The father (Mr Yao) explained how they have learnt from their older generations in terms of taking care of their health, and they do not need to seek medical services. The mother (Ms Shu) also has her own methods to deal with her son’s flu-like symptoms. They explained their methods of keeping healthy in their health accounts.

> ‘I learnt from the older generations, always have some millet porridge to keep your stomach warm, drink more water. Also get your autumn fat because people are often getting too skinny in the summer, so you should have more meat in the autumn, more fat meat. This is for the winter; in this way, you won’t get sick in the winter.’ [BJM7, Mr Yao]

> ‘Exercise is also important; my son is very good at it. If he got a cold, I would just boil some pear soup for him, some pear soup with radish and rock sugar.’ [BJM8, Ms Shu]

Mr Yao and Ms Shu first came to Beijing for work in 1999. Mr Yao is a property manager and Ms Shu is a salesperson. They are optimistic about their future when talking about their son’s education. Like other migrant children in this village, although

their son is currently enrolled in the primary school, he will not be able to continue his education in Beijing and will have to go back to their hometown. Mr Yao and Ms Shu explained that they are doing everything for their son to have a better future. They purchased accident insurance for their son, which covers 90% of the medical cost for accident injuries, but they do not have medical insurance for themselves. In contrast to the migrant parents in Shanghai, their reference to self-medication in their health accounts refers to health maintenance and illness prevention as part of their family responsibilities. These family responsibilities include their child's health and the parents' health (their own). As explained by another migrant mother Ms Wei, who lives in the village with her son and is separated from her husband, looking after her health is not only for her own good but also to reduce the future burden for her son.

> 'If I am healthy when I am about sixty years old, my child's burden will be reduced a lot. My understanding of health is that I can't be ill, it's not because I am scared of death or illness, it's because I know that if I become ill I would drag my loved ones down. I feel like I shouldn't drag them down, it is a kind of responsibility.' [BJM9, Ms Wei]

Ms Wei is from Gansu province and works at a café in the city centre of Beijing since 2007. She has to look after her 9-year-old son herself since her relationship with her husband deteriorated and she decided to live separately from him. The way she interprets health is very popular among the migrant workers in Slope village. She spoke about seeking medical services as a result of bad health or serious illness, and that it would mean family responsibilities cannot be fulfilled properly. In this way, the perceived severity is often easily underestimated in their health accounts, and many health problems can be seen as mild symptoms that can be defeated by their own healthy bodies that they have maintained and looked after. The verb "resist" and the concept of "body resistance" was frequently used in many migrant workers' health accounts in Beijing. The lay health knowledge attached to these kinds of lay concepts is very important for outsiders to understand their health views and health-related activities, particularly inaction as a response or decisions to self-medicate.

5.2.3 Clinics in the village: the mystery paper bag and the role of informal healthcare providers

The results of my fieldwork in Shanghai illustrated that many migrant workers prefer informal healthcare providers, including relatively unknown hometown-based traditional Chinese doctors and unlicensed migrant clinics. However, due to the demolition and forced closures of unlicensed clinics in Shanghai, I did not get the opportunity to examine to what extent these migrant workers trust informal migrant

clinics. In comparison to Shanghai, the Slope village in Beijing still possesses many features of informality as a remote migrant village, including informal residential buildings, informal street markets, informal car parks, and in particular, an informal unlicensed clinic operated by a rural doctor from Henan province. There are also other formal clinics in this village, including one government-owned public village clinic and four private pharmacies which also provide clinical services. All of them are unpopular among the migrant workers in this village, since there are better hospitals in close vicinity to the village. They were rarely mentioned by migrant workers. However, there were some migrant workers who expressed their preference for informal clinics over village healthcare providers.

In Case BJM27, the father Mr Tang is from Shanxi province. He has worked as a cook in Beijing since 2000. Mr Tang, his wife and his 8-year-old daughter live together in a small room separated from a rural residential house in the village. There are also four other rooms rented by other migrant workers in the same rural house but separated with barriers. Mr Tang's daughter is one of the clients in the NGO. I was advised that she experiences flu-like symptoms very often compared to other children in the same class. Mr Tang visits the informal clinic regularly for her daughter's symptoms. He showed me the pills he received from the unlicensed doctor. As shown in **Figure 18**, these pills are wrapped in several paper bags without any symbols, instructions or explanations to indicate what the pills are. However, Mr Tang did not express any concerns about these unnamed/unlabelled pills he received from the unlicensed clinic. Instead, he used this expression to describe his trust: "just the same as in my hometown".[23] He explained to me that each bag has a set of different types of pills matched by the doctor, and his daughter only needs to take one bag of pills after each meal.

[23] Translated from a common expression in Chinese "跟老家一样".

Figure 18 The unlabelled pills and paper bags from the migrant clinic

* This photo is provided by the research participant Xiao Wan.

In many migrant workers' health accounts, the government-owned village clinic and the four private pharmacies are not their preferred options. Many migrant workers complained about the careless and arrogant doctor in in the government-owned clinic as a snobbish local villager who is particularly rude to migrant workers. The other four private pharmacies in the village are considered as profit-driven and only selling expensive drugs. However, the informal migrant clinic is different from other healthcare providers and is used by some of the migrant workers in Slope village. Compared with other village healthcare providers, the informal clinic offers much cheaper drugs and can be called at any time. The doctor in the informal clinic is also a migrant worker himself, which makes him more familiar than other village healthcare providers. Case BJM16 – Mr Xiao Wan – illustrates this. Xiao Wan is a social worker who works in the NGO of Slope village. His family is from Henan province, and his mother, who is also a migrant worker and works in the factory canteen in the village, trusts the informal clinic very much. She explained that although some other people say the doctor does not seem very skilled and sometimes is even drunk at work, she likes going there because the drugs she receives from him are always effective.

In the literature about the mistrust between patients and doctors, the misunderstanding of medical information is often considered an important reason (Zhao et al., 2016). However, similar to the low-income migrant parents in Shanghai, Mr Tang's explanation of trust in the informal healthcare providers is built on convenience and familiarity rather than the information or medical communication he receives. The unlabelled paper bags and pills does not provide any medical information to the patients. It is a typical form of selling Western medicine inherited from the "barefoot doctors" system in rural China during the 1970s. In the book "Barefoot Doctors and Western Medicine in China", Fang (2012, pp.94-124) states that the "barefoot doctors" provided effective, low-cost care to poor peasants and promoted the use of Western medicines in rural China (Fang, 2012). However, due to the lack of medicine, the rural doctor often only gives bulk pills wrapped in small paper bags to patients. Many of them have come to know the specific types of pills for cold or flu symptoms, including the antipyretics and anti-inflammatory pills.

The informal clinic in Slope village is still selling drugs in this form, which is familiar to many migrant workers from rural China. This is different from the formal hospitals, where migrant workers are fully informed but sometimes find they are subjected to excessive medical examinations and are over-prescribed drugs. The informal clinic is widely used among the migrant workers in Slope village despite its inconsistent reviews and reputation. This preference is built on its familiarity, cheap price, convenient medical services, which are all absent from the formal urban hospitals.

Compared with Shanghai, trust is not the main consideration in seeking different healthcare channels for migrant workers in Beijing. In fact, there are many prestigious national level hospitals in Beijing, and many migrant workers also consider them as the best healthcare providers. However, some of them still do not seek healthcare services when they fall ill, and some of them still prefer to use informal healthcare providers. Through their health accounts, we can identify the associations and links between migrant workers' lay health views and health-seeking habits in the village. These lay health views and health-seeking habits are rooted in their lifestyles as migrant workers in the village, but they are clearly inadequate in meeting the essential healthcare needs for migrant workers and often cause more problems in their everyday lives.

5.3 Social reproduction of informality: migrant workers' perceived barriers and perceived benefits on heath-seeking channels in Shanghai and Beijing

As demonstrated by different groups of migrant workers in Shanghai and Beijing, although the perceptions about formal urban healthcare systems are very different in Shanghai and Beijing, the prevalent health-seeking patterns among the lower income groups appear to be similar. Informal but more familiar healthcare practices are widely chosen by these disadvantaged migrant workers in both research sites. However, migrant workers' health experiences are directly related to the different living circumstances in two cities. Literature shows that the health utilisation and health-seeking patterns are often broadly discussed with their precarious living conditions in urban settings, including inadequate medical insurance policies, social and economic exclusion, discrimination and stigma, and the relatively prevalent work injuries and poor health performances (Biao, 2004, Peng et al., 2010, Gong et al., 2012, Yip et al., 2012, Lancet, 2014, Yang et al., 2015, Müller, 2016, Li et al., 2018). The missing piece is that how these wider socioeconomic disadvantages are considered by migrant workers when dealing with health problems. Adopting the Health Belief Model analytical tools (**Table 3)** provided by Champion and Skinner (2008), I will compare migrant workers perceived barriers and perceived benefits of formal and informal health-seeking channels in Shanghai and Beijing. I will demonstrate that although the informality in migrant workers' health practices are historically connected to their rural lifestyles, they are reproduced and reinforced by the current urban living circumstances.

5.3.1 Longstanding exclusionary health policies in Shanghai and Beijing and perceived barriers

Healthcare insurance is considered as the most important factor which ensure equal access to healthcare services and to promote public health in China's health system reform agenda (Wang et al., 2007). As I previously discussed in the preliminary exploration (**Figure 9**), in 2017 there are only 20.4% of Chinese rural-to-urban migrant workers enrolled in the healthcare insurance in their work cities. The majority of migrant workers are only covered by the healthcare insurance schemes from their hometown places, but only about 0.5% of them (**Figure 10**) would return to hometown for their health-seeking actives. The national wide statistics indicate that the majority of migrant workers do not benefit from the healthcare insurance schemes due to the migration and entitlement attached in hukou systems.

As the most popular destination cities for Chinese rural-to-urban migrant workers, Shanghai and Beijing have different exclusive policies regarding migrants' health, housing and schooling rights. My fieldwork found that many migrant workers do not benefit from the urban healthcare schemes even if they are covered by urban healthcare insurance in their work cities. It reveals the fact that healthcare insurance only works when it suits migrant workers' living circumstances and life patterns in urban settings, and it also answers why participating in urban healthcare insurance schemes is not popular among the rural-to-urban migrant workers.

5.3.1.1 Understanding migrant workers' mistrust in Shanghai: 'rich people only'

In Shanghai, healthcare insurance is rarely mentioned throughout the low-income migrant workers' health accounts. Shanghai included rural-to-urban migrant workers within its comprehensive social insurance system in 2002. As a specific category in Shanghai's policy context, migrant workers were named as "outside employees",[24] which is a neutral term to describe rural-to-urban migrant workers and is still in use today. However, the 2002 version of social insurance only gave migrant workers very limited medical reimbursement for serious diseases, and very few migrant workers were registered in that insurance scheme. In 2011, the Shanghai Municipal Government changed its social insurance policy for migrant workers by including them in the urban employee medical insurance scheme. Although migrant workers do not have the same entitlements as local employees, they are reimbursed for a proportion of outpatient care and hospitalisation expenses. Migrant workers are able to use medical insurance credits to pay for outpatient care and drugs from authorised medical

[24] Translated from the Chinese term " 外来务工人员".

services providers (SMG, 2013). According to the CMDS (2017) survey data, about 41.1% of Chinese rural-to-urban migrant workers are enrolled in the Urban Employees Basic Medical Insurance in Shanghai in 2017, which is much higher than the average level (17%) in all Chinese cities. However, more than half of migrant workers are excluded from urban healthcare insurance.

The health accounts given by the two groups of migrant families in **Table 5.1** shows that there is a clear correlation between socioeconomic conditions and health-seeking preferences. Since the URBMI is employment based, migrant workers are easily excluded from urban healthcare insurance if they do not have a formal contract with their employers, or their employers refuse to pay for their social insurance. Most low-income migrant workers are not formally employed, and many of them are willing to give up their social insurance to obtain a higher disposable salary (Gao et al., 2012). Healthcare insurance is often perceived as a privilege for "rich" people, including the migrant workers who have a good job with a high income in Shanghai, rather than social security to ease the burden of illness on poor people. For example, some low-income migrant workers in Shanghai described hospitals as health-seeking channels specifically designed for rich people who have good healthcare insurance. As described in Case SHM2:

> '(The large) public hospitals, they are only for the rich and powerful people who have good healthcare insurance, they can get in there easily. Common people like us, we need to line up for a long time, sometimes if you are lucky, you can see a doctor, sometimes if unlucky, you just wait for a long time and then get ignored. These rich people have their green channels.' [SHM2, Ms Fei]

The health accounts of lower-income groups and higher income groups of migrant workers in Shanghai also reflect this division. Healthcare insurance is frequently mentioned by the richer groups, but never features in the lower income groups' health accounts. As shown in Ms Fei's account, her perception of hospitals was reinforced by her occasional visits to hospitals, where she would get confused by the complex medical and administrative procedures and leave disappointed with the expensive and rushed medical consultation. Doctors in formal hospitals are widely perceived as too careless and hurried among low-income migrant workers, and the perceived mistrust is often extended to the drugs and medication they receive from the doctors. It appears that low-income migrant workers often have much higher expectations from hospitals considering their high medical cost, interruptions in life and potential loss from work. Rather than reducing the health inequalities, the privileged healthcare insurance schemes in Shanghai have made the urban healthcare systems more hostile and

exclusive for these low-income migrant workers.

5.3.1.2 Healthcare insurance barriers in Beijing: the 1800 Yuan threshold

The Beijing Municipal Government uses "peasant workers"[25] in its official policy text to categorise rural-to-urban migrant workers. Beijing allowed migrant workers to participate in its social insurance system in 2004, about two years after Shanghai. The conditions were similar to Shanghai where only very few migrant workers were entitled to limited medical reimbursement for serious diseases. In 2012, about one year after Shanghai, Beijing changed their migrant workers' comprehensive social insurance to reflect its urban employees' medical insurance scheme, which includes both outpatient care and hospitalisation expenses. However, migrant workers are not able to use their medical insurance card credits for outpatient care and drugs unless they have spent more than 1800 Yuan within one year (SHAO et al., 2016). According to the CMDS (2017) survey data, about 37.7% of Chinese rural-to-urban migrant workers are enrolled in the Urban Employees Basic Medical Insurance in Beijing, which is slightly lower than the proportion in Shanghai.

Although migrant workers are allowed to enrol in the Urban Employee Basic Medical Insurance Scheme, they benefit differently from the scheme compared with the local residents. One of the biggest barriers is the 1800 Yuan threshold which was discussed many times among the migrant workers in Slope village. According to the healthcare insurance policy issued in 2012 by the Beijing Municipal Government, the migrant workers who are formally hired in Beijing can enrol in the URBMI, and it requires both the migrant workers and their employers to pay for the insurance. However, to claim the reimbursement from URBMI in Beijing, migrant workers have to meet the minimum medical expense requirement: 1800 Yuan for outpatient expenses and 1300 Yuan for inpatient expenses each visit in the authorised hospitals (Beijing Municipal Health and Family Planning Commission, 2018). For example, in Case BJM7, the parents are aware of the importance of medical insurance and purchased accident insurance for their son, but they cancelled their healthcare insurance from their employer. They explained that the 1800 Yuan threshold is the reason they cancelled their medical insurance since they rarely spend that much in one time for mild complaints, especially considering their monthly salary is only around 4000 Yuan each person. They have to pay for the URBMI but can rarely claim any benefits from the insurance scheme. Therefore, they decided to quit the medical insurance, and the employers are happy to do so since the basic employee medical insurance also requires contributions from the employer.

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[25] Translated from the Chinese term "农民工".

The same reasons are mentioned in many other migrant workers' health accounts in Beijing, and it can be seen to directly link to a health-seeking preference for informal healthcare providers. In another Case BJM11, the migrant parents' Mr Li and Ms Yi have worked in Beijing since 2004. They are from Hebei province, and both of them have college degrees. Compared with other migrant workers, their income is slightly better. However, they still prefer the informal clinic in the village for their own and their 8-year-old son's health problems. The high cost of medical expenses is a very important reason why they avoid using formal hospitals. Although they both have enrolled in the URBMI in Beijing, they have to pay out-of-pocket for most of their visits to the hospital due to the 1800 Yuan threshold. They also expressed the view that most doctors in the hospital are too busy to diagnose the health problems they have and expressed disappointment with the services they have received.

> 'Hospitals are just fast procedures, they didn't even look at us properly, just one minute and then let you go, the doctors never take us seriously.' [BJM11, Mr Li]

> 'Yes, that's why we prefer just taking some drugs from the (informal) clinic in the village, we also did an infusion once there, that was when he had a high fever, almost 39 degrees. It was fine after the infusion.' [BJM12, Ms Yi]

> 'Yes, our son got more problems back that time, we are all working in the company and did not have time to look after him, we just pick up some drugs from the clinic and let him have it himself at school.' [BJM11, Mr Li]

In their narratives, they compared hospitals to the informal clinics by way of cost-effectiveness. The 1800 Yuan medical insurance spending threshold significantly affected their willingness to attend hospitals. More importantly, from their perspectives, the hospital did not provide their expected medical services in exchange for the price they paid. Although they do not trust the informal clinics, the clinic can provide the same medical services at a much lower price in a more convenient way. To visit hospitals, they have to sacrifice a whole day off from their work, whereas that would not be the case if they visit the clinic in the village. Consequently, there are many migrant workers who prefer to keep their health-seeking activities in the village, including ignoring mild symptoms or seeking a convenient and familiar informal village clinic. However, migrant workers in Beijing would still consider visiting hospitals when the estimated expense is higher than 1800 Yuan and the symptoms are perceived serious. Since the issue of trust is not a concern among the migrant workers in Beijing, as shown in **Figure 17**, they often choose to visit the close formal hospitals which are

convenient to travel to rather than attend top-level hospitals.

5.3.2 Preference for Informal Health Practices in Shanghai and Beijing: perceived benefits

5.3.2.1 Reliable and convenient: preference for informal health practices in Shanghai

As discussed previously, in Shanghai self-medication and informal healthcare are valued because of the convenience in which they fit into migrant workers' work schedules. If we compare Cases SHM1 and SHM12, we find that they adopt very different approaches to dealing with health problems and the "trust crisis" of urban healthcare systems in Shanghai. Ms Ling turns to her hometown healthcare providers and alternative medicine, and Ms Ping turns to the highest tier of healthcare providers in Shanghai. Additionally, lower-income migrant workers have stronger traditional Chinese medicine beliefs and are more likely to use informal healthcare providers, and these beliefs and patterns are often more popular in rural regions of China (Chen et al., 1989). It raises concerns about precarious living circumstances that have reinforced the disadvantages and widening inequalities for Chinese rural-to-urban migrant workers in urban environments. In terms of health, these uncertainties and risks have been socially reproduced by shaping migrant workers lay perceptions about medicine, health and healthcare in the urban environment.

For instance, in Case SHM10, Ms Juan not only expressed her concern over the antibiotics used in hospitals, but also emphasised the inefficiency of visiting hospitals considering the time wasted when waiting and energy spent navigating "unreasonable" procedures of the hospital. She specifically complained that visiting hospitals can be so painful and unbearable for her and her daughter, including tiredness and feeling of loss.

> '(My daughter and I) had to visit the hospital almost every two months, her body was not good. And when you visit the hospital there are always too many people, your whole day would be gone. Also, the doctor only prescribes you medicine for five days, after five days you have to come back again. I had to visit the hospital and look after her every day, and you know, when we are out, the child could not eat well or rest well. That's why I thought that maybe we should not rely on medicine from the hospital.'
> [SHM10, Ms Juan]

The very important reason that Ms Juan tries to avoid visiting hospitals is the cost, not only of money, but time and energy. She also blames the failure of treatment by overusing antibiotics. However, Ms Juan only attempted to inform herself about

antibiotics after she, as described by her, suffered these unbearable visits to the hospital. Ms Juan's lay health knowledge and health-seeking interruptions are therefore interrelated and interwoven together for Ms Juan, resulting in her decision to abandon hospitals and turn to her own food therapy.

5.3.2.2 Familiar and accessible: preference for informal healthcare providers in Beijing

As discussed previously, although migrant workers in Beijing place more trust in formal hospitals, many still choose self-medication or informal healthcare providers over them. Notwithstanding the low cost and convenience that informal clinics provide in the village, migrant workers have proven to be willing to compromise their healthcare needs for other life priorities, especially to reduce time off work.

In this way, informal migrant clinics are common in migrant workers' communities in urban China (Hong et al., 2006, Peng et al., 2010). Most of the informal doctors in these clinics are rural doctors who have migrated to cities, but are unable to obtain licenses (Lyu, 2016). From the perspective of migrant workers, informal migrant clinics are considered a form of continuity of their previous rural lifestyle in urban settings. As expressed in Mr Tang's health accounts in Slope village, the informal clinic is similar to the healthcare providers in his hometown, including use of unnamed and unlabelled paper bags. However, these informal clinics are not permitted by urban authorities. As stated by Wu (2013), the demolition and redevelopment of urban villages in peri-urban areas is an attempt to eliminate informal institutions and to create more governable spaces through formal land development (Wu et al., 2013b). The authors specified that this informality primarily refers to low-cost informal settlement, and the removal of this "informality" has created and/or aggravated precarity in terms of health for low-income rural-to-urban migrant workers in urban settings. The preference for self-medication and informal healthcare providers among Chinese rural-to-urban migrant workers, as demonstrated in my fieldwork, is a historic continuity of dealing with "formality" – a hostile and harsh Chinese urban system built since the Mao era that discriminates against rural-to-urban migrant workers.

Chapter summary

Chinese rural-to-urban migrant workers are required to confront their socioeconomic disadvantage when faced with health-related decisions. Longstanding discriminatory urban policies, lack of social and family support networks, and unfamiliar urban environments, have led to widespread mistrust and misunderstandings of formal urban healthcare systems among migrant workers. As a result, informal health practices and informal healthcare providers are preferred among them.

In summary, the prevalence in uptake of various forms of informal “folk” medicine practices among migrant workers is not simply a matter of expedience and avoidance of urban hospitals. Rather, these practices appear to be considered by migrants as a reliable way of resisting illness in response to well-recognised social inequalities in urban settings. The informality that features in migrant workers’ health approaches is socially reproduced and reinforced by exclusive urban health policies and various forms of other social inequalities.

Since these social inequalities have been embedded in migrant workers’ health approaches, it is important to explore the lay health knowledge that has been constructed in their everyday lives. Self-medication and informal healthcare providers are often utilised to address mild symptoms among migrant workers in Shanghai and Beijing, and lay health practices often involve traditional Chinese medicine, OTC drugs, and lay health beliefs about the nature of health, illness and self-recovery. My research illustrates that these lay health beliefs are often expressed as a common lay health concept called “kang” to justify their actions in both Shanghai and Beijing. This lay health knowledge, along with lay practices, must be associated with particular social contexts that the group of migrant workers deal with.

Chapter 6
Lay Health Beliefs of "Kang": Negotiation between Health, Migration and Gender

Chapter introduction

As discussed in the previous chapter, many migrant workers in Shanghai and Beijing tend to distrust and avoid formal urban healthcare systems, and prefer self-medication and informal healthcare, especially among low-income migrant workers. This chapter will seek to demonstrate that, rather than a simple response to their precarious living and working conditions, migrant workers' health-seeking patterns and health-related decisions are a result of their lay health knowledge systems that have been developed throughout their rural-to-urban migration journeys. The folk medical term "kang" is a lay health concept that is often used by migrant workers to explain and justify their negative health-related decisions, such as ignoring sickness and continuing to work. In migrant workers' health accounts, "kang" is often expressed as the verb "resist" in English to describe a person's immunity and the ability for self-recovery that a human body possesses to deal with diseases. Particularly for migrant parents who are in the "prime" of their life, "kang" is used to balance their family responsibilities and health risks, with family responsibilities always outweighing health risks. It is deeply embedded in the sense of family responsibilities in that migrant fathers and migrant mothers often have different understandings of the lay health logic of "kang" due to their different family roles.

There are three sections in this chapter. The first section introduces the popular lay understandings of "kang". "Kang" is one of the popular folk medical terms in China but has never been recognised in formal medical education systems. It emphasises the "natural immunity" of the human body, which is widely accepted among rural-to-urban migrant workers as a justification to ignore illness. The second section examines the health accounts of migrant fathers, focusing in particular on gendered interpretations of "kang". As will be shown, reference to "kang" in their health accounts is not only understood as resistance and resilience, but also strikes a balance between their sense of family responsibilities and their workload tolerance. The third section focuses on the gendered lay aetiology of "dampness" ("Shiqi" in Chinese) interpreted by some of the migrant mothers. "Dampness" is understood as a kind of "accumulative" damage to a person's health (usually women), caused by living in a cold or wet environment in combination with experiencing negative emotions towards family members. It was used by some of the migrant mothers who participated in my research to justify their inaction in addressing their health problems. They believe that the "accumulative"

damage sustained from living in damp living conditions and from experiencing negative emotions towards close family members are not curable by medical professionals. Bad health is often perceived as a result of disappointment and dissatisfaction in female migrant workers' family lives, which directly bridges health and life expectations and aspirations for family.

6.1 Explanations of "kang": lay knowledge of health resistance and resilience among the migrant workers in Shanghai and Beijing

6.1.1 Understanding the folk medical term "kang" in the Chinese context

As indicated by Mabry (1964), people often incorporate scientific aetiology into their own health subsystems to explain why they experience certain symptoms (Mabry, 1964). Furnham (1994) found that people's lay beliefs on the nature of health and illness are associated with demographic factors including the experiences of alternative medicine, age, religion and political beliefs, and younger people who believe in alternative medicine tend to stress personal and internal control over illness rather than external factors (Furnham, 1994). In my fieldwork in Shanghai and Beijing, the folk medical term "kang" is frequently mentioned by migrant workers when explaining or justifying their health-related decisions. For example, in Cases SHM2 and BJM5, "kang" was used by the two migrant mothers to explain that the body can resist the cold or fever symptoms itself, and therefore medical interventions are not necessary. This is understandable as it is proven that some flu-like symptoms are not very threatening and sometimes can disappear themselves (Prior et al., 2011). However, lay understandings of "kang" are used by migrant workers in different health and illness scenarios to explain their lay aetiologies and healthcare practices.

"Kang" is a popular verbal expression in the Chinese language that can be translated into English as anti- or resisting. In migrant workers' health accounts, it is often pronounced in two ways with reference to two Chinese characters "抗" (kàng, the fourth tone) and "扛" (káng, the second tone). Although both pronunciations are used in their health narratives, they refer to the same definition. For example, in many of my interviews, even if I used kàng to ask questions, the participant would still use káng to answer and explain throughout the conversation. In the Xiangya medical dictionary,[26] "kang" is translated as anti-, counter- or resisting. However, it has different meanings in Chinese folk medicine. According to several Chinese folk health promotion journals, "kang" often refers to medical beliefs and medical habits which encourage people to ignore symptoms or pain caused by illness, including colds or

[26] Xiangya Medical Dictionary (湘雅医学专业词典) is one of the most popular Chinese medical translation dictionary.

fevers, diabetes, skin diseases or other diseases (Ai, 2005, Song, 2013, Zuo, 2015, Zhu, 2017). “Kang” is often interpreted as the health belief that the human body can resist disease and can recover from illness without (or with minimal) medical interventions, and this self-recovery capacity can be acquired or reinforced by some folk methods, including alternative practices, specific food or specific Traditional Chinese Medicine (Pan, 2013, Editor, 2014, Li, 2019). It is often used to describe general self-care practices outside of formal medical services when dealing with perceived mild symptoms.

The lay belief of “kang” rarely features in health research literature in both English and Chinese language. Some research conducted among the Chinese diaspora in Western countries indicated similar health patterns, including various self-care and treatment methods such as diet therapy, herbal remedies and exercises (Rawl, 1992, Washington et al., 2009, Bray, 2013). However, the authors often categorise these health-related behaviours as the products of Traditional Chinese Medical culture, which cannot capture the characteristics of Chinese rural-to-urban migrant workers’ folk medical practices. As indicated by Krieger, Traditional Chinese Medicine is “a syncretic amalgam forged throughout millennia through the present day” (Krieger, 2011). In contemporary China, Traditional Chinese Medicine and modern western medicine are practised alongside each other at every level of the healthcare system (Hesketh and Zhu, 1997). The integration of Chinese medicine and western medicine throughout the contemporary Chinese medical system is an official longitudinal objective. For more than half a century in mainland China, the so-called “Traditional Chinese Medicine” has been systematically modified with western medicine (Taylor, 2004, Barnes, 2003).

Lin (2011) and Li (2013) have shown that the poor understandings of health and medicines found among Chinese rural-to-urban migrant workers are a result of living in inadequate socioeconomic environments (Lin et al., 2011, Li, 2013). My research has found that interpretations of the folk medical term “kang” by migrant workers in Shanghai and Beijing consists of three main aspects: a) the human body’s self-recovery capacity; b) ignoring perceived mild symptoms; and c) pain management strategies. These lay health beliefs expressed by migrant workers were not supported by any tangible scientific knowledge; they vary according to the migrant workers’ subjective health beliefs and living circumstances.

6.1.2 Self-recovery: lay understandings of immunity among migrant workers in Shanghai and Beijing

6.1.2.1 Shanghai: strengthening weakened “immunity”

In the previous chapter, I identified and discussed the pattern of avoidance among

migrant workers in Shanghai with respect to medicine. In addition to expressing their disappointment in urban healthcare systems, they also emphasised their concerns for the potential side-effects of using medicine, particularly antibiotics. Some of the migrant mothers' health accounts focused on how they sought to recover their children's weakened "capacity for resistance".[27] Their adoption of lay health practices was explained as a way to improve the weakened immunity of their children to ensure they would not fall ill so easily again.

For example, in Case SHM7, the migrant mother insisted that her daughter's past pneumonia developed as a result of receiving excessive medical treatment from the hospital they attended. She expressed the view that over-use of medicine, including antibiotics, damaged her daughter's immunity against illness and turned her daughter's simple coughs to serious pneumonia. Her methods to strengthen her daughter's immunity were to use less medicine, take nutritional supplement products, and drink more hot water to facilitate the urination of harmful substances out of the body. In Case SHM10, the migrant mother believed that her daughter's repeated cold and fever symptoms were a result of using antibiotics, which damaged her daughter's immunity to defeat illness. She advised that she used home remedies, such as ensuring her daughter drinks more hot water and the food therapy of eating slow-cooked pigeon soup, to rebuild and strengthen her daughter's immunity at home. She also used the same theory to explain the health problems that she suffered herself after childbirth. She advised that she took traditional Chinese medicine and joined an online exercise program to rebuild and strengthen her immunity after childbirth.

The story of Case SHM11 is slightly different. The migrant mother Ms Fu has four children. They live together in Shanghai, and she is a full-time home-maker for her children. Like Case SHM2, Ms Fu enjoyed the medical services offered by the informal clinic in the migrant village while it existed. After the informal clinic was closed down and demolished, she had to visit formal hospitals instead. She expressed her frustration at her visit to the hospital, advising that the hospital was over-crowded, the doctor did not care, and the treatment she received there was ineffective. As a result of her experience, she explained that she opted to rely on self-care methods rather than visiting the hospital, and the lay health beliefs related to "kang" support this decision. She explained as follows:

> 'We are not worried when our children get coughs, we just take it easy then. We are only worried about fevers. One time I remember my first child had a fever, and the colour of his body almost turned purple. We were very

[27] The capacity of resistance is translated from the expression "抵抗力". It is similar to the concept of immunity but only focuses on the aspect of self-recovery from illness.

> scared, my mother wiped his body with alcohol to reduce the heat, and we quickly sent him to the hospital. However, the doctor in the hospital was not very caring, he told us that the body needs time to recover itself, and it's useless to be anxious. After that time, we would just let him resist (kang) the fever slowly for about three to four days and wait for the body to recover on its own. Sometimes we also gave him drugs, like the ones called Motrin pills, but only for the higher degree fever. Another drug we use is called Tylenol for the lower degree fever. So, we give him those drugs by turn, and eventually, the body would recover itself, and the fever would be gone.' [SHM11, Ms Fu]

By her account, the lay health belief of "kang" was adopted based on the doctor's suggestion to let the body heal itself. She developed her own perception that fevers are not very urgent and serious and do not have to be dealt with in the hospital. Therefore, she largely adopted self-care practices at home for cough and fever symptoms, developing her own combination of drugs for fever symptoms: Tylenol pills for lower degree fevers and Motrin pills for higher degree fevers. The lay knowledge of "kang" was interpreted as a process or mechanism in the body to defeat illness, which external medical interventions can only *assist* with. In another story about herself, she expressed similar lay health beliefs of "kang" prior to her children's illness events, back when she was pregnant in Shanghai.

> 'One time when I was pregnant, I didn't know what was going on, it was cold, and I developed fever and cough symptoms. I went to the community health centre, but they refused me. They told me that I was pregnant, and it's risky to take any medicine. They recommended that I go to another bigger hospital. I went there, and the doctor in the hospital gave me some drugs, but I was scared to take the drugs. So, I just drank a lot of hot water, resisted (kang) it.' [SHM11, Ms Fu]

Ms Fu explained her previous health-seeking experience and drew upon supporting evidence again from the doctor to support her beliefs around "kang". By her account, hot water was not her first option and was not recommended by any doctors, but it became her only way to deal with illness risks during pregnancy. Although she was provided with medicine from the formal hospital (which is senior to the community healthcare centre that refused to give her medicine) she did not take them and returned to the lay health method she perceives as most unharmful – drinking hot water.

The perceived benefits of boiled hot water can be traced back to the patriotic health

campaign rolled out in rural China in the 1950s. At that time, the Chinese Government promoted boiled hot water as the most efficient way to obtain safe and hygienic drinking water (Alderman and Reader, 1979). In Chinese folk medicine, hot water is also interpreted as the most unharmful and universal treatment to preserve immunity from disease and to recover from illness.

6.1.2.2 Beijing: preserving immunity from disease and illness

Similar lay health beliefs of "kang" are also popular among migrant workers in Beijing. The Beijing research participants tended to stress home remedies for preserving immunity from disease and illness. For example, as discussed previously in Case BJM7, migrant parents suggested millet porridge, "Autumn fat" (eating more fatty foods in Autumn so that these extra layers of fat will keep you warmer in Winter), exercises and pear soup as home remedies to preserve the resistance capacity of the body to protect them from winter diseases. The same lay logic is also expressed by many other migrant parents, who believed that illness could be prevented from preserving immunity in everyday life. By their health accounts, there are many other external and internal factors that can lead to weakened immunity, including poor diet, a cold living environment, negative emotions, and non-harmonious interpersonal relationships.

As Popay (2003) stated, lay health knowledge needs to be contextualised in order to understand the relationship between environmental factors and health-related behaviours (Popay et al., 2003). In Beijing, the perceived benefits of preserving immunity are always influenced by their living conditions. For example, in Case BJM14, Mr Wan believed his back pain arose from a particularly cold Winter's night he spent in his newly-built informal house that he rented in the Slope village. His landlord built a small brick bungalow to rent in the middle of a vegetable farmland, and Mr Wan decided to live there because he preferred the bigger space of the bungalow for his garbage recycling business. He decided to move in when the building materials were still too wet and cold to inhabit in Winter. He described that he felt like he was sleeping on ice that night and advises he developed chronic back pain from that cold night. He believed that a part of his immunity was destroyed that cold night, and it is the reason that his back pain has become chronic and he is unable to recover.

In other cases, the damaging factors are believed to be people's emotions which are mostly related to personalities and interpersonal relationships. For example, some migrant mothers attribute their own or their children's health problems to their bad relationships with their husbands, and the accumulated bad emotions are believed to be harmful to the bodily resistance capacity. In Case BJM20, the mother Ms Kun complained about her husband's laziness after his small informal upholstery shop was

forced to close down during the crackdown on informal businesses in Beijing. Ms Kun's husband lost his business and could not find another job in Beijing. As a well-trained welder he sometimes accepted some casual work around the village but developed an addiction to playing video games at home. Ms Kun is working in a supermarket next to the village. She expressed that she was very disappointed with her husband's contribution to the housework, and that they have always fought at home.

> 'I feel like I am bullied at home. I work in the supermarket and have to come back home for lunch. He sometimes just makes some rice, and I have to make my own food myself, sometimes he just plays video games and leaves everything to me. We have a kid at home, and everything is so messed up, I am always very angry, so I would say: are you still a human? Can you do something like a normal person? It's so dirty and messed up, can't you see it? I do not speak gently, and we always fight…My son was very smart before, but one day he complained he got a headache and cried and vomited. We went to the 309 hospital and the Children's hospital; they could not find anything wrong. My heart also got problems; doctors said it is the insufficient supply of blood. I told him that I probably would just pass away if he kept doing this, so we are not fighting that much anymore.' [BJM20, Ms Kun]

Ms Kun explained that her heart problems were caused by negative emotions, and her seven-year-old son's headache is associated with their stressful family environment. However, she does not want to blame her husband for their son's problem because she does not want to put too much guilt and pressure on her husband. In her narratives, she also reflected on her own personality and ways of communicating with her husband. Both Ms Kun and her husband want their relationship to "cool down" and to improve their family relationship together, and they see this as the only effective way to cure their health problems.

6.1.3 Ignoring mild symptoms

As shown in **Figure 8**, 17.1% of Chinese rural-to-urban migrant workers choose not to seek medical services when falling ill. In both Shanghai and Beijing, ignoring mild symptoms and not seeking medical services is a common social phenomenon among migrant workers. Besides the harsh work conditions and the compromised health needs, the lay knowledge of "kang" is also widely mentioned by migrant workers to explain the reasons why they ignore their health problems. For example, in Case SHM2 the mother Ms Fei explained that her health knowledge was influenced by other people, and she believes that the first thing to do is wait and ignore illness when

experiencing flu-like symptoms. The period of waiting and ignoring and observing the symptoms was called “kang” in her health narratives. She explained her understanding of “kang” to me in the interview.

> ‘So, what do you mean by “kang”?’ [Researcher]
>
> ‘It was like, at the beginning of the cold or fever, it would not be very serious, and it often started with a runny nose, so be it. If you have tears and runny nose, just ignore it. I don’t think these symptoms can last for over one week. Even if it’s continuing, it would eventually get better, and you don’t need to take any medicine since it would recover eventually. However, you can’t do this when you have a high fever; fever is a problem. For my daughter, a runny nose is fine, I would just ignore it, and it would naturally recover.’ [SHM2, Ms Fei]

Ms Fei interpreted “kang” as a kind of lay knowledge for her to evaluate when they can ignore symptoms and when they should take extra actions. In her narrative, the inaction of ignoring symptoms is limited to treating perceived mild symptoms, including runny nose and tears or coughs. Her understanding of “kang” is a lay division line she has drawn between bearable symptoms and serious symptoms. However, the division is not a clear line and is always influenced by other factors, including the convenience of informal clinics and other knowledge of alternative medicine. For example, Ms Fei bought honey-suckle water (a popular Chinese herbal medicine) to treat her daughter’s repeated nose-bleeds at home, and she also insisted on visiting a massage place to treat her low-back pain. These health-seeking options are affordable, convenient and do not conflict with her lay health beliefs.

The previous cases demonstrate that the lay health beliefs of “kang” are often used by migrant workers to justify their actions to address minor illness in everyday life. Based on their understandings, the natural “immunity” possessed in human bodies is more important than external medical interventions, and minor illnesses and mild symptoms can be ignored or tolerated. However, the lay definitions of “mild symptoms” and ways of tolerating illness are very different throughout migrant workers’ health accounts.

As I demonstrated in the former chapter, inadequate healthcare insurance, the harsh working conditions, and perceived cost-effectiveness are all considered in migrant workers’ health-seeking decisions. As indicated in Backett’s work about the construction of health knowledge in middle-class families, the knowledge of health did not necessarily translate into behavioural practices (Backett, 1992). With reference to my fieldwork, I would respond to Backett’s conclusion by saying that the behavioural

practices examined in this thesis are not necessarily consistent with their lay health knowledge, they are changed around according to the specific needs and circumstances. The lay understandings of “kang” show that migrant workers’ health-related explanations are strongly connected to their family concerns. These family concerns are key to understanding the subjective meanings that migrant workers have attached to their health explanations and justifications. I found that although the lay health beliefs of “kang” are common among migrant workers, there are some gender differences in their lay aetiology and lay health practices between the fathers and mothers.

6.2 Resistance and tolerance: gendered lay health perceptions among the male migrant workers

6.2.1 Ignoring symptoms and carrying on work

Throughout my fieldwork in Shanghai and Beijing, most migrant fathers emphasised their bodily resistance as key to dealing with everyday health problems. In my view, this is understandable since most of the migrant males I surveyed were between 30 to 45 years old. According to the health selection theory, most of them would have a better health (relative to the general population in their origins) in order to migrate and work in a different city. However, in addition to these pre-conditions, they still have to confront health challenges in urban settings. For example, research conducted in Shanghai by Wong et al. (2018, p.483) found that most male migrant manual labourers’ mental health problems are caused by “financial and employment-related difficulties” and “interpersonal tensions and conflicts” (Wong et al., 2008). I found that the health perceptions presented by these male migrant workers (migrant fathers) are not only interpreted as how “invincible” they are. Migrant fathers have shown fewer complaints about their health problems compared to migrant mothers. However, their perceptions of health problems are interpreted as a consideration of family responsibilities rather than illness itself. For example, in Cases SHM5 and SHM11, the migrant fathers considered their health problems, including hyperlipidaemia and stomach problems, as inevitable since they have to drink and eat outside constantly with their business partners.

The complexities of the lay health perceptions expressed by migrant fathers’ is difficult to capture through a short interview since it requires internal processing and balancing of concepts, such as degree of resistance, gendered perceptions, survival strategies, and sense of family responsibilities. I will use my in-depth interview with Mr Pan in Case BJM1 to demonstrate this process.

Case BJM1 is the first migrant family I met in Beijing’s Slope village. The migrant

mother Ms Gu is a social worker who works in the NGO, and she was also my primary fieldwork gatekeeper in that village. Ms Gu, her husband Mr Pan, her eight-year-old son, and Mr Pan's older parents live together in a rented rural house in the village. They also have a 14-year-old daughter, but she was "left behind" at Shandong province for her high school education and the Gaokao. Mr Pan is a DIDI taxi driver,[28] and like many other migrant workers who do DIDI driving, Mr Pan is not recognised as an employee in Beijing (Qi and Li, 2019). Mr Pan and Ms Gu used to work in two computer accessory shops in Zhongguancun electronic market in Beijing for 16 years. The two computer accessory shops bankrupted in 2016, and Mr Pan started working as a DIDI driver, and Ms Gu was hired by the NGO as a social worker in the village. The eight-year-old son is enrolled in the local primary school and is also the client of the NGO.

Mr Pan is confident with his body resilience when talking about resisting cold or fever symptoms without medical intervention. As he explained, he used to practice martial arts in his childhood because his hometown village has a strong historical martial arts tradition. He told me that he could "kang" most of the cold or fever symptoms since he has good health and has never gotten infusions in his life. By his health account, he explained his experiences of "kang".

> 'When was the most recent time you have had the experience of "kang"?' [Researcher]
>
> 'About three years ago. My health is good in my family; I have never gotten any infusions in my life. About three years ago I had a high fever, I just drunk more water and covered myself and slept, just rested for two days, and it was gone.' [BJM2, Mr Pan]
>
> 'Did you take any other measures?' [Researcher]
>
> 'It's like my own methods, maybe only suitable for myself. When I had a high fever, I just crazily ate a lot of garlic and then drunk hot water, more hot water and more raw garlic, and then my body would feel super warm and sweaty. I would feel very relaxed afterwards. These were my methods.' [BJM2, Mr Pan]

Mr Pan explained that on most occasions, he would just ignore the symptoms and

[28] DIDI is the biggest online taxi platform in China. Similar to Uber, DIDI provides employment opportunities for drivers as subcontractors, and there is no formal employment relationship between the company and the subcontracted drivers. It can therefore be described as a precarious source of employment.

carry on with his job, he would only rest if he had a fever or other disturbing symptoms. In the interview, he explained that he would not ask other people, especially his children or wife, to do the same thing since he considered the methods were only suitable for himself. Similar health perceptions are common among many other migrant fathers in the Slope village. Migrant fathers perceived themselves as healthy and more resilient in terms of dealing with health problems. This masculine perception of themselves typically results in ignoring symptoms and carrying on work despite illness.

6.2.2 Lay definition of pain as a DIDI driver

As described by Mr Pan, many other migrant workers like him decided to become DIDI drivers in Beijing due to the decreasing employment opportunities for low-skilled migrant workers in the city. During my fieldwork period, he was always busy and did not have many opportunities to participate in my in-depth interviews, although we had short conversations many times. One time his car was heavily scratched by a bus when he drove his DIDI driving business in the city, and he had to stop his business while the car was being repaired. During the few days short break, Mr Pan participated in my in-depth interview multiple times and invited me to join his mountain climbing exercises together. He told me that he enjoys outdoor exercises like climbing mountains, hiking and running. However, since he became a DIDI driver, he could not find spare time to exercise, and he advised his wife told him that he had lost the muscles he had built from martial arts in the past two years.

Mr Pan realised that being a DIDI driver has caused some damage to his body. During the two years he has conducted his DIDI driving business, Mr Pan has experienced different kinds of health problems, including eye problems, neck pain and bladder problems due to long-time driving. In 2017, Mr Pan heard from his close friends, who are also DIDI drivers, of two DIDI drivers who suddenly died while working in Beijing. One died while taking a break on a park bench in the Shihaiqiao area of Beijing, and another died in his own car when he pulled over to have a short break in his car in the Wangjing area of Beijing. The first death was not reported by the local newspaper, the news only circulated among the DIDI drivers. The second death was reported by the Beijing Evening newspaper on 8 December 2017 (Li, 2017a). Mr Pan was shocked and was also scared by these sudden deaths, and he explained that as a DIDI driver himself, he could understand why some DIDI drivers would have sudden deaths. Mr Pan explained that every full-time DIDI driver wants to drive as long as they can, and they do not have an opportunity to move their bodies while driving. At the same time, it is very difficult to find parking places in the city, and DIDI drivers often face difficulties to find food to eat or a bathroom. To Mr Pan's understanding, all these factors are

related to sudden death, but the vital and final cause is the numbed sense of the resilience of the body.

Similar to lay understandings of “kang”, Mr Pan interprets bodily resilience as the two senses of pain and resistance, which can be evaluated by subjective feelings. However, these senses are easily disrupted by external desires, and the desire of earning more money is the strongest influence. Mr Pan described how his sense of pain is altered while driving for DIDI, and how easy DIDI drivers can fall into dangerous situations.

> ‘I think making money is a kind of addiction, people always want to earn more… if you work longer, you get more money, there are no limits on the driving time, no matter day or night. You would always think about this, about earning money, even if I am not the kind of person who values money over everything else. When you are driving with about five or six hundred Yuan displayed on the App, you would feel very tired, would say that it is not easy to make money on this job. But when you kept driving and kept earning about seven or eight hundred Yuan, you would feel that the tiredness is gone, the exhaustion could be resisted (“kang”), and you would feel like it is fine. When you are driving to 1 thousand Yuan, you would feel it is not exhausted at all and would probably feel a bit happy.’ [BJM2, Mr Pan]

> ‘When you say you don’t feel tired anymore, do you mean the tiredness is disappeared, or you just feel too joyful about the increasing money?’ [Researcher]

> ‘Both. You would feel it’s OK to keep driving, and you would be happy with the increased earnings. I used to drive DIDI until 3 am, I didn’t feel unwell during the night, but I couldn’t get up the following morning – too exhausted. However, during the time when you feel like the exhaustion has passed, and you see the increased money, you would just ignore the tiredness and carry on driving. You wouldn’t have noticed that you have worked over 10 hours without a break if you calculate it.’ [BJM2, Mr Pan]

Mr Pan described that, based on his own work experiences, it is very easy for a DIDI driver to exceed the bodily limit because of the numbed sense of exhaustion and the excitement of earning more money. From a biomedical perspective, pain is described as an unpleasant sensory and emotional experience, which is associated with actual or potential tissue damage or perceived harms (Merskey, 1986, Eccleston, 2013). Mr

Pan's description describes pain as subjective feelings among DIDI drivers that could be shaped and measured by their external drives. In accordance with Mr Pan's descriptions of pain arising from driving while exhausted, I have identified three levels of pain. As shown in **Table 11,** although the sense of pain is aggravated by excessive overtime driving, the sense of extreme exhaustion is veiled by numbed feelings and the excitement of increased earnings. Mr Pan believes that excessive overtime driving is the main reason for the sudden deaths of the DIDI drivers, and the third stage is most dangerous since people cannot sense and evaluate the damage anymore at this point. He used the same term "kang" to describe the stage at which he tries to fight back the extreme exhaustion and eventually becomes numb to body signals.

Table 10 Lay definitions of pain from a DIDI driver

Expression of pain	**Expression of Concerns**
Very tired	Earning 5-6 hundred Yuan
Exhaustion is controllable	Earning 7-8 hundred Yuan
Capable of driving with numbed extreme exhaustion (acceptance of endangering health)	Earning above 1 thousand Yuan

Mr Pan's health-related experiences as a DIDI driver shows that aggravated "health depletion" is a serious health issue among migrant workers in precarious employment in the city, and that health beliefs of "kang" can be very uncertain and difficult to balance. Mr Pan reflected on his situation after hearing of the sudden deaths of other DIDI drivers. He described that he used to drive DIDI every day from 6am to 10pm, and sometimes he kept driving until 3am. Mr Pan received the "City Hero" Medal from DIDI since he made the top one per cent of DIDI drivers who had worked for the longest hours in Beijing over 2017. After the sudden deaths of other DIDI drivers, he started to take one day off every week and take a break every four hours of driving. Mr Pan also changed the way he senses pain signals in his body. As he described, when the eyes are too dry, and the neck is uncomfortable, he would take a short break from driving.

Mr Pan has deep compassion for other DIDI drivers since he considered that he is still luckier than other migrant workers working at the same job. Mr Pan has his own private car registered with a Beijing number plate to run his DIDI business, in this way he only needs to pay for his own petrol expenditure and provide 30% of his DIDI business income to the DIDI company. Many other migrant workers cannot afford to buy a

private car to run a DIDI business, and they have to pay a large proportion of their income to rent a car. Meanwhile, Beijing has a strict car ownership control policy to limit the number of available car registration plates each year (Feng and Li, 2013), meaning it is particularly difficult for migrant workers to register their cars in Beijing even if they have their own private cars. For these DIDI drivers, they have to work harder and longer to make profits out of their investment.

It is also important to understand the underlying social constraints that underpin, as Mr Pan described it, the “numbed” feeling and the excitement of increased earnings. For many migrant workers who suffer from precarious employment, the desire of earning more money is not driven by their greediness, but the survival needs of their families. These drives sometimes outweigh the concerns of health and danger. For example, Mr Pan’s reasons for changing his unhealthy and risky work routine is not only a reflection upon other drivers’ deaths. He explained that it is important for him to avoid falling ill and spending his hard-earned income in a hospital as his family needs the money to survive in Beijing. All DIDI drivers are subcontractors of the DIDI company, and Mr Pan does not have any urban medical insurance in Beijing. He adjusted his work routine after he heard of the sudden deaths of other DIDI drives. However, the adjustment was not explained as a fear of death, and the things that worried him most were the expensive hospital bills and the possible damage to his family.

The perceived resilience of Mr Pan’s health experiences is marked by uncertainty, and the decisions are not made in accordance with any tangible lay health knowledge or beliefs. In recent research conducted that explores internal rural-to-urban migration and gendered compromises, the authors found that migrant fathers tend to compromise their perceptions of masculinity and put more energy into looking after family members (Choi, 2019). However, the authors did not inquire into the aspects of health arrangement, where the sense of masculinity is transferred into family responsibilities and compromised and sacrificed health needs among migrant fathers. In these cases, the term “kang” is interpreted as a symbol of either masculine fatherhood or responsible parenthood, and it refers to the individual and subjective evaluation of the health sacrifice that migrant workers can make for their families.

6.3 Bearing the pain: lay aetiology of “dampness” among female migrant workers

As explored in the previous sections, “kang” is interpreted by research participants as a form of “natural immunity” which can lead to self-recovery from illness. For the migrant fathers that I interviewed, this lay knowledge of “kang” strongly influenced pain

management practices, but they regarded it with a level of uncertainty. The health accounts of my research participants demonstrate that their understandings of health are shaped by their "sense" of being rural-to-urban migrant workers, which involves not only precarious living circumstances but also the experiences of migration, pragmatic living strategies, and future expectations. Among various explanations of "kang", I found that the lay aetiologic theories of "dampness" were specifically explained by the female migrant workers I interviewed. The term "dampness" is translated from a traditional Chinese medical term called "Shiqi",[29] and is believed to be one of the most popular causes of illness in traditional Chinese medicine (Wang et al., 2013). The relevant symptoms of "dampness" often include headaches, dizziness, diarrhoea, pallid, itchy skin or cold limbs (Min, 2012, Wu, 2014, Yun, 2016). I found this lay aetiology was only referenced and described by the female migrant workers I interviewed. The lay aetiology of the health accounts provided by both the migrant mothers and fathers I interviewed highlights the gendered nature of lay health beliefs and influence of masculinities and femininities. By analysing the health accounts provided by female migrant workers in Shanghai and Beijing, the following section explores the perception of "dampness". I will analyse Case SHM4 in particular to demonstrate the relationship between "dampness" and female migrant workers' sense of family responsibilities and subjective meanings.

6.3.1 Perceived "dampness" in female migrant workers' everyday lives: cold, wet and bad emotions

The lay aetiology of "dampness" is often related to unhappy family relationships. For example, the mother Ms Juan in Case SHM10 believes her "dampness" was accumulated during her childbirth in Shanghai. As a migrant worker who married a local Shanghai husband, Ms Juan complained that she did not receive proper care from her husband's family while experiencing childbirth in Shanghai. Ms Juan believes her experience of childbirth caused her several health problems, including becoming over-weight, darker skin colour, laziness and always feeling sleepy. She advised that the "dampness" accumulated after her childbirth when her husband always ignored her and left all the housework to her at home. Ms Juan believes that the relationship with her husband is the key to solving her accumulative health problems. She explained that she felt much better when she was in Guangdong province living with her own parents and having traditional food therapy.

The lay aetiology of "dampness" is also often related to specific physical suffering

[29] "Shiqi" refers to the Chinese word "湿气" – it is a popular folk health perception in traditional Chinese medicine to describe the cause of illness. The New-workers Club also promoted this folk medical term through its massage training program, as shown on the picture in **Appendix C2.2**.

experienced by female migrant workers, especially in terms of living in cold and wet conditions. For example, in Case BJM1 Ms Gu believes the “dampness” in her body accumulated throughout her living experiences in Beijing. She explained that before her husband purchased their car, she and her husband had to go to work from Slope village to the city centre by an electric bike, and the cold winter wind brought the “dampness” into her head and eyes. Consequently, she blamed the stomach problems she experienced to the cold wind and late dinners because she had to stay back at work late every day. According to Ms Gu, the “dampness” accumulated particularly because she had to live in a damp room in Slope village for two years.

> ‘My body was very bad for a while; I often had tinnitus, indigestion, stomach-aches, cold hands and feet. These symptoms are all caused by too much “dampness” in my body. For two years, we lived in a damp room in Slope village, there was no ventilation and no sunlight, and there were often drops of water on the wall. The quilt was always cold and moist, and our furniture went mouldy.’ [BJM1, Ms Gu]

Ms Gu believes these experiences, particularly the cold wind and damp living conditions, have accumulated in her body as “dampness”. She believes that this “dampness” has had a long-term negative effect on her health, and all of her other health problems she has experienced are caused by the accumulated “dampness”. Similar to Ms Gu, the mother Ms Mei in Case BJM15 believed that her long-term headaches and backpain is a result of her earlier experience as a sand mining manual labourer about 20 years ago that involved heavy lifting. As she explained, she did not feel unwell around that time since she was still young and strong, but she knew that her health was damaged after that time, and the “dampness” accumulated throughout her migration journey in Beijing as a factory canteen kitchenhand.

These two types of explanations of “dampness” are often used by female migrant workers to describe their illness. However, these explanations are often uncertain and are always different in individual living circumstances. The lay explanations of “dampness” provided by female migrant workers mainly refers to two lay theories. The first one is that “dampness” is a kind of long-term accumulative damage in female bodies, and it is often caused by cold or wet food, living environments and negative emotions. The second lay theory is that since “dampness” is a long-term chronic illness, it is not likely to be cured by any specific medicine. The second conclusion is based on the first lay health belief but often leads to female migrant workers’ negative and passive reactions to their health problems. Ms Hui’s story is a good example that illustrates the complexity of the lay aetiology of “dampness”.

6.3.2 Bearing the unbearable: a story of childbirth, raising children and future expectations

As I introduced previously in Case SHM4, Ms Hui is a migrant mother from Hubei province who works in a container making factory as an accountant. She believes that her cold or fever symptoms are rooted in her bodily nature of having too much “dampness”. She used this lay theory to explain her skinny body, pale face, headaches and long-term ill-health. Ms Hui believes that she has internalised “dampness” and this is reinforced by her unhappy relationship with her husband. Her husband lived in another city and was separated from her and her son (though not divorced, just living separately). Ms Hui complained that her husband did not meet her expectations as a father in her family, and their relationship was always intense. Therefore, Ms Hui has a very passive attitude towards receiving any medical treatment for her health problems since she believes these problems are caused by her unhappy relationship with her husband. She advises that she prefers “Kang” as her primary method to simply “wait and see” with respect to her illness in daily life. However, Ms Hui stressed that she would prefer to have a rest in her office and continue her work while suffering cold or fever symptoms every time as she can only get paid when she is in the office. By her account, the symptoms would eventually dissipate wherever she is, and the more important thing is to make sure her income will not be influenced by illness.

A similar lay logic can also be seen in her stories of giving birth to her son in 2006, although the severity and pain was much worse than usual. In 2006, Ms Hui and her husband ran a small business selling construction materials in Shanghai, but one of their clients ran away and left them a huge debt. Ms Hui was carrying her second child around that time, and her family was facing financial difficulties. Ms Hui delivered her first child at her hometown with help from her experienced aunt, but for the second one, she insisted on working in the city in construction drafting at a construction site to earn more money. Following suggestions given by her aunt, Ms Hui took ginseng soup and progesterone regularly to give comfort from pregnancy cramps. Even one time when she accidentally fell down the stairs at a construction site and suffered from acute cramps, she insisted on dealing with it herself and just took the same ginseng soup and progesterone as relief. Ms Hui eventually delivered her childbirth in an informal clinic next to her workplace. The way that she explained the experience was focused on how she managed to get through the pain by herself.

> ‘Life was bitter, and our economic conditions were not good. I gave birth at an informal clinic opposite to the railway station. Around that time many other migrant workers also went there for childbirth. When I felt like I was nearing the time of labour, I rushed to have a shower and went to that

> informal clinic. The doctor told me that the beds are full and let me wait outside on the street. So, I just walked around the square next to the railway station. When I felt too painful, I just held the wire pole to get a rest, and then walked around again to wait for the bed. I waited almost the whole night until about 7am in the morning, when they had a bed for me, and the doctor gave me an oxytocin injection. Around 9am my child was born. My husband went away in the morning to work and returned in the afternoon, and we went back home together from the clinic.' [SHM4, Ms Hui]

In Ms Hui's narrative, the whole purpose of bearing the pregnancy pain and childbirth risks was to minimise the expense of medical services and overcome economic hardship over that period. As she stressed before her childbirth story, "life was bitter, and our conditions are poor", and that "many other migrant workers also go there [informal clinic]". Ms Hui believes that the fundamental determinant of her pain is her identity as a regular migrant worker, and the sacrifice of health was interpreted as a kind of moral responsibility that she must make for her family. She told me many other similar examples to illustrate her sacrifice for her family, such as when she had to carry her baby while carrying two hot water bottles from the hot water station, so her son had to ride on her neck and grab her ears to stabilise himself. Compared with previous stories, her strategies of managing her cold or fever symptoms in her office is not something significant but a regular life habit. Although her family crisis has passed, her mindset of managing pain and unwellness continued into her new work environments.

Therefore, from Ms Hui's perspective, her current pain management strategy of staying in the office and resting for cold or fever symptoms is not interpreted as a habit accumulated in her life, but a new sacrifice that she made for ultimate family aspirations. In Ms Hui's lay aetiology, the economic constraints, the lack of social support including healthcare insurance, and related health sufferings are inevitable for low-income migrant workers like her and her husband, and the sacrifice of health needs is necessary to minimise medical expenses and work longer and earn more money for her family. She explained that the only way to end her suffering is to change her fate as a migrant worker, and the only available and relatively realistic way for her is to expect her children to have a better future, being outstanding and climbing up the social class ladder. She has great expectations for her children. Ms Hui explained that the pain of cold or fever symptoms is nothing compared with the pain and headache she had got from her children, especially when she heard that her daughter was unwilling to continue her education because of eye surgery and lack of attention from

her parents. In 2017 her daughter had eye surgery at the hometown, but Ms Hui was unable to return back to her hometown to look after her due to being busy at work. After that, Ms Hui's daughter was disappointed and decided to quit school. Ms Hui explained that she developed her headache and felt extremely painful when she heard the decision that was made by her daughter. She explained that the end of education in high school would make all of her sacrifices for her children meaningless, and it is more painful than any other psychical problems she has suffered previously.

Rural-to-urban migrant workers often have a higher prevalence of depressive symptoms compared to the general population in China (Qiu et al., 2011). According to the qualitative survey conducted among 17 migrant workers in Shenzhen, family-related stress is one of the most significant factors contributing to migrant workers' depression, and most of them are related to the guilt of being separated from their children or older parents (Zhong et al., 2016). Ms Hui's stories demonstrate that the influence of family separation can be more profound considering the meanings of family responsibility that many migrant workers have attached to their everyday efforts. In Ms Hui's lay aetiology, the factors associated with her illness include her bodily nature of "dampness", the economic hardship she experienced, and the mental distress related to her family separation and her daughter's education. The illness associated to her bodily nature is unalterable, and she has to bear it. The physical pain related to her economic hardship was considered as a kind of sacrifice and can be managed through the excuse of "kang", but the mental distress related to her children's education is more damaging and often unbearable since it touches the ultimate meanings that she has attached to her everyday efforts. In other words, family separation and its related risks for a child's education are the main life concerns of many migrant workers, and even their approaches to health problems are shaped by this overarching concern.

Cases SHM2 and SHM4 participated in a group interview together. I have found they have very different perceptions about their health needs as migrant workers in Shanghai. Ms Hui is unsatisfied with her current situation with her separated family and unhappy relationship with her husband. She has a strong will to change her life, including her efforts to pass the accountant qualification examination, to pay back their debt, and to bear the pain and health risks in her life. Ms Hui believes that the overall reason for her suffering is because she is a rural-to-urban migrant worker, and she wants to change this identity as soon as possible. The reason for her unhappy relationship with her husband is also explained in this way since she believes that her husband is not as determined as her. However, Ms Hui did not succeed although she has sacrificed her health in Shanghai, and she believes that is because she did not get a good education opportunity. Therefore, Ms Hui invests all her efforts and

expectations for her children's education. Ms Hui showed me the letters she wrote to her daughter in the past few years, and her high expectations are expressed clearly in her words. As Ms Hui explained, her daughter stopped talking to her after she underwent eye surgery, and she was also unhappy when Ms Hui made mean comments to persuade her daughter to stop the suspicious "romantic relationship" with a boy in the same class. Ms Hui's daughter was offended by the comments that were supposed to encourage her to do better at school. According to Ms Hui's narrative, all of her health sacrifices are made for the greater purpose of changing her fate as a migrant worker, and all the expectations are transferred to her children. Her daughter's decision to quit school is devastating for her, and it also caused her new health problems such as a long-term headache. From Ms Hui's perspective, these health problems are uncurable as long as things are not going as she expected, and it is not useless to seek medical treatment.

By contrast, Case SHM2 is a migrant family that lives in the same building with Case SHM4. The migrant mother Ms Fei, her husband and her daughter live together in one of the office rooms. Although Ms Fei also prefers self-medication and informal healthcare providers, she has more positive reactions to her and her family members' minor health problems. For example, Ms Fei showed me her preference of OTC drugs to treat flu-like symptoms, including Ganmaoling,[30] antipyretics, and anti-inflammatory drugs. Ms Fei explained that she discovered this combination of drugs from the informal migrant clinic in the migrant village, which was demolished in 2016 by the local government. Ms Fei explained that she trusted the informal clinic since it was cheap, convenient and efficient. It did not interrupt her and her husband's work. She explained that she can only have five days annual leave from her work and does not have sick leave rights at her current work. The informal clinic allowed them to have a short treatment after work, and they can carry on their work the second day. Although the informal clinic has been demolished, Ms Fei still keeps and trusts the combination of drugs from there. In contrast to Ms Hui, Ms Fei is not bothered by the identity of being a migrant worker, and she also did not show any interest in staying in Shanghai long-term. However, Ms Fei is still worried about her daughter's education and looming family separation that will occur shortly when her daughter has to go back to Shandong province to continue her education after primary school. The office building they are residing in will also be demolished soon, and they will have to find a new place to live. Ms Fei expressed that although she does not have high expectations, these challenges still affect her ability to plan the next year. However, Ms Fei separated these issues from her health concerns, and her methods were to lower her

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[30] A Chinese version of Fluidixine, a popular OTC drug for mild flu-like symptoms in China.

expectations.

As examined above, the concept of “dampness” is construed as a result of disappointment and dissatisfaction in the lives of the two migrant women, especially considering the gap between their expectations and the reality they live in. Ms Fei believes that the dampness, which does not bother her, is related to high and unrealistic expectations. From Ms Fei’s perspective, high and unrealistic expectations would often cause unhappiness and would eventually harm a person’s health.

The lay health knowledge of “kang” is often interpreted as a method to deal with physical health problems, and the majority of them can be ignored for the purpose of reducing medical expenses and carrying on working. However, the lay understandings of bearable and unbearable symptoms are often unclear, and this lack of clarity can be problematic and sometimes vital in terms of determining migrant workers’ health welfare. Similar lay aetiology patterns can also be seen in other health research in the Chinese context. For example, Lora-Wainwright (2013) identified the so-called “epistemic uncertainty” among rural residents in Yunnan province who dealt with heavy industrial pollution and the correlation between exposure to it and various health problems in the village. As Lora-Wainwright found, the complexity of illness causation had been embedded into various ways of explaining different health problems according to a villager’s own health beliefs (Lora-Wainwright, 2013). In my fieldwork conducted among the migrant workers in Shanghai and Beijing, a similar “epistemic uncertainty” can be identified from the health experiences. However, health and illness in these migrant workers’ health accounts are not expressed as observable bodily conditions, but an internal state of subjective feelings and these subjective feelings are closely related to their living status as rural-to-urban migrant workers.

As indicated by Van Hooft (1997, p.24), health is an “experience and a condition of that person’s subjectivity”, “the pre-intentional activity of constituting oneself as a self”, and “a sense of when things go well with us” (Van Hooft, 1997). Lay health beliefs like “kang” and “dampness” are interpreted as a kind of resilience in relation to their bodies and work tolerance, and this tolerance is negotiable with migrant workers’ other life concerns and priorities. Along with other lay explanations of “kang”, migrant workers’ lay health knowledge and lay health practices are not only related to the current urban healthcare environments, but are also associated with their migrant status, including their experiences of migration, family separation and family aspirations. These subjective experiences and subjective meanings are the keys to understanding why the folk term “kang” is widely believed among the Chinese rural-to-urban migrant workers, and why these beliefs are uncertain and are always changing according to different family concerns.

My argument is that the lay health beliefs of “kang” are constructed by migrant workers’ own experiences, and they are much more influential and convincing compared with the scientific and professional health suggestions made from experts. Therefore, migrant workers’ health-related decisions and practices are not easily changed by, as Baum described, the dominant public health discourses of behavioural messages (Baum et al., 2014). My fieldwork demonstrated that lay health knowledge is constructed as a result of an interrelation between constrained socioeconomic conditions on one hand, and on the other, policy factors and migrant workers’ health utilisation patterns and health-related behaviours. These lay health explanations can be identified through migrant workers’ health accounts, and they have presented a clearer social-cognitive approach to understanding migrant workers’ health-related behaviours and decisions in particular circumstances – a negotiating process that balances the body tolerance with the sense of family responsibility.

Chapter summary

This chapter explained how migrant workers use the lay health beliefs of “kang” to justify their negative reactions to illness. I demonstrated that “kang”, as one of the popular folk medical terms in China, is not believed or preferred by its scientific evidence but the “uncertain” emphasis on “natural immunity” and body resistance which can be used to justify migrant workers’ negative reactions to health problems.

The lay health explanations of “kang” and the related health practices vary in different individual contexts. Rather than a method of dealing with minor health problems, my fieldwork found that the lay knowledge of “kang” is widely accepted even with some serious and dangerous illness situations. Uncertain knowledge becomes a process of negotiating health and work tolerance in everyday life. There are also gender differences in this lay health knowledge system. The “masculine” interpretations placed emphasis on the migrant fathers’ resistance and tolerance of health problems, which sees health as a balance between health tolerance and family responsibilities. The “feminine” interpretations placed emphasis on the “dampness” they perceived as accumulating as a result of poor living and working conditions and negative emotions in the family lives of migrant mothers. The subjective meanings that migrant workers have attached to their ways of dealing with health problems, which need further exploration, are dominated by their life expectations and migration aspirations for family.

Chapter 7
Lay Health Beliefs related to Aspirations: Examining Migrant Workers' Perceptions of Health and Migration Aspirations

Chapter introduction

The previous chapter explained that migrant workers' lay health beliefs are uncertain knowledge systems which are interpreted as a balance between their body tolerance and family responsibilities. This chapter will continue discussing the relationship between migrant workers' lay health perceptions and their ultimate subjective meanings related to their life expectations and aspirations for family. I found that Chinese rural-to-urban migrant workers' definition of health and health-related behaviours appear to be associated with their changing perspectives on fulfilling family responsibilities and aspirations including children's education, housing and overall improvement of their family financially and socially. The qualitative narrative-based research I have collected indicates that heath is often seen among migrant workers as something that can be compromised and sacrificed to achieve their aspirations and expectations in different migration stages.

There are three sections in this chapter analysing the three migration stages and the related aspirations and health perceptions respectively. The first section focuses on the earliest stage of migration when migrant workers are driven to move out from their hometowns and to migrate to cities. As will be shown, most migrant workers were driven by poverty or relevant life pressures, and aspirations to change their lives often dominate their perceptions of health and related life arrangements. The second section will focus on the middle stage when migrant workers have to face the distress of children's education and inevitable family separation in most cases. These issues are widely considered by migrant workers as their primary concern and the origin of physical and mental health problems. Most of them have developed this strong lay logic of health and illness that aspirations are an unsolvable dilemma in terms of addressing health issues. It is widely believed that aspirations for family are essential for migrant workers to organise their family lives, including health-related activities. In addition, high aspirations or over-ambition are also considered as the main reasons for poor health or even death. The third section will focus on the late stage of migration when migrant workers have seen the outcomes of their sacrifices and have realised that these aspirations are "false hopes". It reveals a fact of migration aspirations, which is uncomfortable for many migrant workers – that although they are aware or have known that their aspirations are unrealistic and are not likely to be achieved, they still pin their hopes on the small possibility of success. In return, an unwavering belief in

uncertain – and ever-changing – practices to cure ill-health have shaped migrant workers' lay health knowledge systems. As will be shown, it is apparent that no matter how migrant workers' aspirations have changed over time, health has been constructed as something that can be compromised and sacrificed to deal with systematic social and personal sufferings.

7.1 Driven by poverty: migrant workers' stories of tuberculosis, hypertension and leukemia

Aspirations are considered one of the most important influential factors in terms of migration, especially for economic migrants (Carling, 2001). In recent years, more researchers have identified that migration expectations and aspirations are a key factor closely related with migrants' subjective wellbeing, especially migrants' happiness satisfaction, in their post-move lives (De Jong et al., 2002, Knight and Gunatilaka, 2012, Boccagni, 2017). For example, Knight and Gunatilaka (2012) demonstrated that the false high aspirations are raised by the new reference groups among Chinese rural-to-urban migrant workers in cities, and they often led to more unhappiness(Knight and Gunatilaka, 2012). Boccagni (2017) explained that the negative impact would occur when migrants face reality checks, which could systematically downsize or displace the initial migration aims. The concept of aspirations therefore is examined as "a conflation of different content, relational references and space-time horizons" (Boccagni, 2017). Although these research findings have identified migration aspirations as one of the key factors which affect migrants' total wellbeing, how migrants' health knowledge and health-related behaviours are shaped by their aspirations are still unclear.

Continuing the discussion of Chinese migrant workers' lay health knowledge, my fieldwork found that migration aspirations are not only related to migrants' unhappiness and subjective wellbeing, they are also perceived as the main cause of health problems. The negotiation of migration aspirations and health has become a central issue in some migrant workers' health knowledge systems, particularly during the early stage of migration when migrants are eager to break away from poverty and to improve their family conditions. In this section, I will use three migrant workers' illness stories to demonstrate how migration aspirations are perceived as the major concern in migrant workers' lay health knowledge systems, and how the idea of "not being too ambitious" is considered as key to keeping good health.

7.1.1 "Being too frugal": a migrant worker's explanation of tuberculosis and aspirations

Throughout the narratives of migrant workers depicted in this thesis, one of the

common characteristics is that many of the lay health beliefs are not developed based on tangible evidence but from their personal life experiences. As indicated by Parse, health should be considered as a synthesis of values, a personal commitment, and "a process of living or unfolding rather than the absence of disease or a dynamic state of physical, psychological, social and spiritual well-being" (Parse, 1981, Parse, 1990). Ms Su's story in Case BJM22 is a good example to show how health and illness events are perceived as meaningful life experiences rather than a health event in migrant workers' lives.

Ms Su is a 46-year-old migrant mother from Shandong province. Her husband, her 16-year-old daughter and her 10-year-old son live together in Slope village. Ms Su and her husband migrated to Beijing in 2006, and her memories of migration are unpleasant. As Ms Su described, her original family was discriminated against in her hometown village because she has four sisters, but does not have any male siblings. Ms Su explained that in her rural village in Shandong province, boys were much more valued than girls, and people considered that it was a kind of punishment for her family to not have sons because of presumed moral wrongs her family has committed. She felt relieved when she got married to her husband and left her own family. However, Ms Su soon realised that she had entered another kind of shame and humiliation – the shame of poverty in her new family.

In Ms Su's new family, her husband's parents were sick for a long time and spent a very large amount of money on treatment. Her father-in-law died a few years later after Ms Su's marriage. Since Ms Su's husband is the oldest brother in his family, he had to pay back all the debt they had incurred from paying medical bills. Ms Su's husband was also responsible for his younger brother's wedding costs after his father's death. The debt heavily accumulated in Ms Su's new family. The creditors, including relatives, friends and banks sought after them every day, and Ms Su and her husband were often threatened and humiliated by them in the village. In 2006, Ms Su and her husband decided to migrate to Beijing so they can avoid the humiliation from debt collectors and earn more money to pay back their debts. As she described, she had enough of the shame, from the shame of no boys in the family to the shame of poverty, and she was determined to change her family situation when she had the opportunity to work in Beijing.

Ms Su's first job in Beijing was a kitchen-hand in a small bakery. Only after about half a year, she had developed a serious cough and was soon diagnosed with tuberculosis in a hospital in Beijing. She had to quit her job and moved back to her hometown to receive a cheaper price treatment. However, rather than thinking of Tuberculosis as an infectious disease, Ms Su described her Tuberculosis as a result of her over-frugal

livelihood and diet in Beijing. In her health narratives, she believed that health problems accumulated throughout the first half-year of hard life in Beijing, which was caused by the economic pressures for her family.

> 'Around that time, the only thing in my mind was about saving more money and not spending on food, and my body was overdrawn. The bakery job was not hard, I just did not want to spend my earnings on anything. When I got the problem, I did not get surgery but only got some pills… I think my disease was caused by my diet. I wasn't eating well, and the conditions were very poor. Because around that time, I only wanted to save more money so my family can pay things when necessary, and I would rather have a bitter life for myself. I was too good at saving, too frugal.' [BJM22, Ms Su]

In Ms Su's lay aetiology, the Tuberculosis was caused by her poor diet without enough food. The "bitter life" was described as her sacrifice for prioritising saving money for her indebted family. The poverty and the relevant moral shame, including being accused as dishonest, was the strongest driver for migration for both Ms Su and her husband. When Ms Su had an opportunity to make money in Beijing, she valued this opportunity over her health concerns. From her personal health experience, the most meaningful thing she could take from her illness was not the disease of Tuberculosis itself, but that it was connected to her life priorities around that time. The lessons that she concluded were linked to her subjective feelings of her lifestyle, which she described as being "too frugal"[31] and being "reluctant to have more food".[32] In Ms Su's narratives, good health or the ways of maintaining good health were interpreted as eating well. She stressed that most health problems experienced by people are a result of insufficient food. In her first half-year in Beijing, she stated her health was not her priority in life because she aspired to earn her self-esteem back and to get away from the moral shame she had suffered since she was young.

However, Ms Su had to stop working for half a year to treat her Tuberculosis, and she still has some of the sequelae such as breathing difficulties and slow speaking pace. Ms Su reflected on the illness event and concluded that she should not risk her health too much for her migration aspirations. The key to balancing her health and her aspirations for family was summarised by Ms Su as not being too ambitious, not being too frugal, and most importantly, eating well. This philosophy continues to inform Ms Su's lay health beliefs when facing other challenges in her life. For example, when she

[31] Translated from Chinese "太会过了".
[32] Translated from Chinese "舍不得吃".

participated in my research in 2018, her family had paid off all their debts a long time ago, and her primary life concern is now her son's education since migrant children have to go back to their hometowns to continue their education. Ms Su explained that she is not worried about this issue very much since she can just return to her hometown with her son together[33]. As she described, she would be able to find a job in a garment factory, a job with a 4 thousand Yuan monthly salary, and the workers need to work 10 hours per day with no weekends. Ms Su calculated the income with her family household expenses and the estimated work tolerance, and she concluded this would be tolerable from a health perspective. And the key factor to make this conclusion is, as described by Ms Su, "I don't expect too much anymore, as long as it's enough for purchasing food when I return to my hometown".

Ms Su's lay health beliefs about aspirations and health problems show that it is important to explore the subjective meanings in migrant workers' health and illness events. From Ms Su's perspective, the lay aetiology is a simple conclusion from her illness experiences. The high expectations and aspirations for migration led to her constrained food expenses, and the "frugal" diet caused her Tuberculosis in the first year of work in Beijing. Although this conclusion is not scientific or evidential from a medical professional perspective, it has convinced Ms Su according to the illness-related events happened in her life. Ms Su developed this lay aetiology to explain all of her health problems and to guide her new living arrangement. I found that this lay logic of negotiating health and aspirations are shared by many other Chinese rural-to-urban migrant workers who seek to rise out of poverty and improve their family conditions by migrating to urban cities.

7.1.2 "Being too feisty": lay understandings of hypertension and leukaemia

Ms Su's migration experiences and illness understandings are shared by many other migrant workers in Slope village. For example, Case BJM19 Ms Jia, who is another migrant mother from Shandong province. Ms Jia and her husband work together in the factory next to Slope village, and her 12-year-old son is in the last year of his primary school and is waiting for a transfer back to a hometown school. Ms Jia's husband also has another part-time job as a carpenter in the village. Similar to Ms Su's background, Ms Jia and her husband were in extreme poverty when they got married since both Ms Jia and her husband are from very poor farming families. Ms Jia is determined to change her family conditions by working very hard in Beijing, and her husband takes two jobs and rarely has any breaks throughout the year. After about

[33] This is also the reason Ms Su does not care to fix the broken and leaking ceiling in one of the bedrooms in her residence in Beijing. As shown on the picture in Appendix C.2.4

15 years of hard work in Beijing, Ms Jia and her husband managed to purchase an apartment in her hometown county centre area and a private car in Beijing. As described by Ms Jia, she felt very satisfied and proud of her family when people who were dismissive of them before, particularly those close relatives at her hometown, started being friendly toward them. This change occurred after Ms Jia and her family returned to their hometown with their own car and after hearing the widespread news that they had bought a new apartment in the county centre.

However, Ms Jia also realised the health price she has paid for achieving her life expectations, as she expressed in the interview, *"it is a lie if I said I am not tired, pursuing more makes people tired".* Ms Jia also suffers from chronic hypertension, and she believes that her hypertension was caused by the fight between her and her colleagues in the factory, the time when she felt that her blood pressure suddenly elevated by the fight. Ms Jia also reflected on the link between her feisty personality and her hypertension sufferings, and she sees hypertension as an inevitable sacrifice for her achievement since she believes that her achievement is a result of her feisty personality. Ms Jia's reflections also include another story that happened to one of her colleagues Lin, who was, as described by Ms Jia, a "feistier" migrant mother who died from Leukemia at the same time that I was doing fieldwork in the village.

The deceased migrant mother Lin was also from Shandong province. Like many other migrant workers in Slope village, she used to work in the big factory next to the village. Her story was mentioned to me at the very beginning of my fieldwork when I met the NGO leader in Slope village and expressed my research topics. Around that time, Lin was terminally ill from her Leukemia in a hospital in Beijing. The NGO leader, who is also a labour rights activist, mentioned that Ms Lin's workplace contamination, particularly the product quality checking X-Ray machine, could be the main cause for her Leukemia. However, most of the other migrant workers working in the same factory did not accept this theory since Ms Lin's colleagues who worked with her did not have the same health problems. Instead of the contamination theory, most migrant workers tend to believe that Ms Lin's Leukemia and her death was caused by her personality of being too "feisty", which was described as too eager to succeed and outdo others, no matter whether it was in the workplace or family matters. One of the strong pieces of evidence referred to was the suicide of Ms Lin's mother in 2017. Ms Lin's mother lived together with Lin and Ms Lin's two children in Slope village. She suffered from long-term major depression and committed suicide in their rental room in 2017, the year before Ms Lin's Leukemia was diagnosed.

In a group discussion with migrant mothers Ms Gu and Ms Jia, they discussed Ms Lin's Leukaemia and death was used as an example to demonstrate the health

consequences of "being too feisty".[34] This was explained as the kind of people who are extremely hard working, too tough, and too eager to succeed and outdo others. Reflecting on this tragedy the conclusion was drawn in the group discussion that people should not be too ambitious or too eager to pursue their migration aspirations. Lin was seen as an extreme case of a migrant worker who sacrificed too much of her health. For example, Lin was described as a person who was always very harsh to herself as well as people around her. The stories about her at her workplace focused on how she always worked overtime, always defeated the male competitors to be a team leader in the factory. The stories about her at home focused on how she survived the domestic violence, fought with her ex-husband and divorced him, how she "strictly and violently" shouted at her second husband and her children at home.

As one of Ms Lin's factory colleagues, Ms Jia has a deep impression of Lin although they were not working in the same department. Ms Jia describes Lin as a woman who was very feisty but at the same time also very polite to her. However, Ms Jia believed that her feisty side was the main cause of Ms Lin's illness and death. In the group discussion, Ms Jia and Ms Gu repeatedly placed stress on "being too feisty" and expressed their shared lay health logic between personality and health outcomes.

> 'She was too tough, not the common tough but too tough. Otherwise, she wouldn't suffer that. She fainted one time at work, but she didn't take it seriously … She was too tough, like, if you earn 10,000 Kuai (Chinese Yuan), she wouldn't be satisfied with earning 10 times more, she would still work harder to earn more, she was that kind of person.' [BJM19, Ms Jia]

> 'In our hometown, we have a saying, people who have a feistier mind often have a shorter life.'[35] [BJM19, Ms Gu]

> 'Yes, my father used to say that to me as well. Your heart is higher than the sky and your life would be thinner than a paper.[36] We cannot be too ambitious, it's too tiring… Nowadays everyone has very high pressure, and you can't be too ambitious.' [BJM19, Ms Jia]

Unlike discussing health problems and personal feelings in a private setting, group discussions of other people's health and illness events can represent shared lay health understandings among people. There is a link between types of personality and health

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[34] Translated from Chinese "太要强".

[35] Translated from a Chinese saying "心强命不强".

[36] Translated from a Chinese saying "心比天高，命比纸薄".

outcomes shared among migrant workers. This lay knowledge was expressed when discussing the female migrant worker's death in the migrant village in Beijing. In their conversation, the personality traits of being "too tough" or "too ambitious" relates to their mindset of dealing with migration aspirations in everyday life.

In terms of migration, aspirations are not simply individual subjective desires or wishes, but also the observable migratory achievements in realistic perspectives (Carling and Collins, 2018). However, health and illness events cannot be neglected either as biographical disruptions (Bury, 1982) or becoming a central part of ones' biography (Williams, 2000). For example, Cornwell (1984, pp.151-200) found that elderly working-class people residing in the Eastend of London view having a stroke as a "normal crisis" which was "not that bad" although it in fact "shatters lives". This lay view was explained in the context of old age, patterns of co-morbidity, and the "hard-earned lives" which the people had experienced in their lives (Cornwell, 1984). The illness stories in these three cases show that most migrant workers are eager to improve their family conditions while working in a harmful environment in terms of health and wellbeing. Although they are working in the city, their life meanings are always attached to their original aspirations to change their living conditions, their reputations and their future in their hometown places. By talking about Ms Lin's illness and death, both Ms Gu and Ms Jia agreed that the illness was caused by the personality of being too tough and too ambitious and the working ethics of being overcommitted. These reflections on Ms Lin's death focused on how they could adjust to life pressures which are directly related to their aims and meanings of leaving their hometowns and bearing their health sacrifices in Beijing. In other words, to Ms Gu and Ms Jia, their understanding of "being too feisty" is not only a word to describe a certain kind of personality, but also a word used to describe a kind of person who sacrificed their health to pursue their migration aspirations. In their view, people like Lin suffer health problems because they have broken the fragile balance between their health tolerance and their aspirations for family.

7.2 Health and aspirations for family: how children's education and the separated households influence migrant workers' health

In the previous chapter, I found that migrant workers' lay health knowledge systems are shaped by their family concerns rather than personal bodily conditions. These concerns at the beginning of the migration stage are often interpreted as a balance between health and aspirations to work hard and earn money. With increasing age, one of the biggest struggles mentioned by many migrant workers is their children's education, which would inevitably cause the separation of migrant parents and their

children. In most cases this separation occurs when the migrant parents are around 35 to 50 years old and their children are around 12 to 15 years old. The “illness” brought by this concern has been interpreted as an unsolvable dilemma in migrant workers’ family arrangements: they cannot keep their children in the city since the children have to go back to their hometowns to continue their education, and most of them have to work in the city to keep working and support their children’s education. In contrast to the previously discussed migration aspirations of “being feisty”, this dilemma is directly shaped by the discriminatory urban hukou and education policies against rural-to-urban migrant workers in China. From the migrant parents’ perspectives, being separated from their children is stressful and sometimes traumatising. However, most migrant workers still decide to send their children back to their hometowns although they have to bear the “pain” of separation. Such an example is the migrant mother in Case SHM4. Her mental health was deeply influenced by the family separation. In Case SHM2 the migrant mother reflected on this issue and concluded that the way to prevent this issue from damaging health is to lower one’s expectations.

In this section, I will discuss the profound influence of education and split households among Chinese migrant workers in Shanghai and Beijing. My research found that the subjective meanings attached to children’s education are extremely important for migrant workers since it has been understood as the only way to achieve a “good life” for their family in the future, which is pursued from the first day of the migration journey.

7.2.1 Left-behind for education: the common struggles faced by Chinese rural-to-urban migrant workers and their children

To understand the profound meanings that migrant workers attach to their children’s education and family separation, we have to learn the policy background and the position of these issues in migrant workers’ lives. The divided households that are split between hometowns and migration destinations is one of the common struggles faced by many Chinese rural-to-urban migrant workers (Fan and Li, 2020). Most of these family separations are a direct consequence of the discriminatory education policy restrictions that urban cities have placed on rural-to-urban migrant children (Wang and Sciences, 2019). According to the hukou restrictions on current education policy in China, migrant children are only entitled to have nine years of compulsory education outside of their hukou registration places, and Chinese students can only participate in the College Entrance Examination (“Gaokao”) at their hukou registration places (Zhichao, 2009). Even after nine-years compulsory education, many migrant children are not able to enrol in the public schools in cities since there are always strict conditions to limit numbers of migrant children in cities (Chen et al., 2014, Donzuso,

2015). In 2017, there are around 61 million migrant children that are "left-behind" in rural China without the company of their parents (Wang and Yao, 2020). The lack of supervision and parenting has led to many family tragedies among Chinese rural-to-urban migrant workers (Tao, 2008, Chang et al., 2011, Jingzhong and Lu, 2011, Pong, 2014, Fan and Chen, 2020).

Along with low-income, work pressures and poor living conditions, family separation is one of the biggest causes that account for mental health issues experienced by Chinese migrant workers (Fan et al., 2011, Li, 2014a, Zhong et al., 2016, Zhong et al., 2018). The practice of dividing households between migration destinations (often, urban cities) and a migrant's rural hometown is confirmed in recent research carried out by Tsinghua University (Beijing) on the coping strategies of migrant workers. Researchers have tracked the living arrangements of migrant workers and found that divided households within one family widely exists among Chinese rural-to-urban migrant workers. This study found that the elderly and young children are often left behind in their rural hometowns; migrant workers themselves work in big cities where the employment opportunities are abundant, but hukou restrictions are strict; and in recent years, more migrant workers prefer to purchase new accommodation in a small city close to their work cities so that their children can be enrolled in urban schools, since hukou restrictions in small cities are more flexible (Shen, 2006, Fan, 2016, Jin, 2018).

Migrant children were not allowed to enrol in public schools in Shanghai and Beijing before 2006. In 2006, the Chinese State Council issued the first migration-related education policy which encourages big cities to accept migrant children enrolling in local public schools (Council, 2006). In the first few years, there are many informal, low-quality and unregulated private primary schools in Shanghai and Beijing specifically for migrant children. In Shanghai, the Municipal Government started to accept migrant children enrolling in local public schools for primary education since 2008, and the informal private schools were removed or reconstructed as part of public education in Shanghai. This new education policy, which is well known as the "accepting policy",[37] helped many migrant children receive proper primary education in a safe environment in Shanghai (Chen and Feng, 2013, Qian and Walker, 2015, Han, 2017).

In Beijing, the Municipal Government began accepting migrant children into local public schools for primary education in 2011, but with many conditions and requirements for migrant parents. To this day, unregulated informal primary schools for migrant children in Beijing are excluded from the public education system and are

[37] Translated from Chinese "纳民".

facing crackdowns constantly (Goodburn, 2009, Chen et al., 2014). In recent years, both Shanghai and Beijing have placed more regulations and requirements upon the enrolment of migrant children in local public schools, which has been described as a part of overall population control methods (Wang and Aleph, 2019). For example, the population control and exclusion of migrant workers has become the dominant policy in Beijing. The policy was summarised by a Chinese scholar Li (2017, p.4) as *"changing industrial types to evacuate the population, controlling school admission to limit population, demolishing houses to control population, and using certificates to regulate population"*[38] *(Li, 2017b).* For many migrant parents, being apart from their children is the only way to deal with this restriction. The only difference is when to be separated from them: some of them leave their children at hometowns from the beginning of their primary education, some of them send their children back to their hometowns at a point during the compulsory education period from year one to year nine. All migrant parents expect that their children can be well prepared for the "Gaokao" so that they can get into universities and have a better future – this aspiration for children's education is as strong as the initial drive which encouraged migrant workers to migrate from their rural hometowns to urban cities and to suffer from the health sacrifices.

7.2.2 The unsolvable health dilemma and aspirations for children's education

As demonstrated in Case SHM4, many migrant parents have similar concerns like Ms Hui's story about her left-behind daughter, and they tend to consider that the mental depression of being separated from their children as an inevitable health sacrifice that they have to make for their children's education. Many migrant workers have expressed the same idea that the whole purpose of their migration and their sufferings in cities is to make a better future for their children so that they do not need to be migrant workers anymore. This purpose is not easy to achieve, and education is considered as the most reliable way to achieve this goal.

For example, in Case BJM13, the migrant mother Ms Ming is from Henan province. Ms Ming's family is relatively poorer compared to other migrant workers in Slope village. Ms Ming is a supermarket wine seller, and her husband is a home appliance waste recycler. Since both of them are not formally employed in Beijing, their two sons are not allowed to enrol in the local public primary school. The 13-year-old son is left behind at the hometown for his middle school, and the 10-year-old son is enrolled in a private primary school next to Slope village, which is recognised as a low-quality primary school built specifically for migrant children. The younger son is considered a

[38] Translated from Chinese "以产疏人、以学控人、以房管人、以证管人".

troublemaker by the NGO workers since he often gets involved in fights with other students in the NGO classes. According to Ms Ming's narratives, her husband is very inpatient with the second son and often beats him at home because of his bad exam results and bad behaviours at school and in the village. However, Ms Ming and her husband are very satisfied with their older son – although he has been "left behind" at their hometown without his parents, he has performed well at school, and his good exam results are often delivered to Ms Ming and her husband from their relatives back at their hometown.

Ms Ming has diabetes. She believes that she contracted this health problem due to the lack of care she received during the period when she gave birth to her second son. Due to her diabetes, Ms Ming is very cautious with her diet, and this is extremely troublesome for her as a supermarket worker. As she described, she often only has one steamed stuffed bun as her breakfast. She has to have her lunch at her workplace, so she often only has two cucumbers and boiled corn as lunch. She said she has always ignored her diabetes because it is too expensive to stop her work and completely treat her diabetes. From her perspectives, diabetes is not curable in her current situation as she has to work hard to support both her sons' education, especially the first son's education. The only way to treat her diabetes is to slowly control her diet over time.

> 'My first [son] was not very outstanding in the first year of his middle school, but recently he is very good, always the top 10 in his class. I always say to him, our family is poor, no money, no property, what else can you do except studying harder? He is always very comforting; the good score is more important than everything we did here in Beijing.' [BJM13, Ms Ming]

Life is bitter for Ms Ming in Beijing. As a supermarket worker, she has to ride her electric bike to work early morning in the cold wind. Her accommodation is a small temporary shack assembled with colour steel tile composited boards. It is built in a corner of the village which is enclosed by surrounding rural houses, and it is very difficult to locate the place unless you enter the enclosed space completely. The place does not have tap water or a heating system, and it is extremely cold in the winter. Ms Ming also has a very bad relationship with her husband. The fights between them often escalate to very serious consequences. As described by the NGO workers, Ms Ming attempted to kill herself by stabbing herself in the head with a chopping knife during a fight with her husband. She was sent to the hospital with a cut on her head. However, in Ms Ming's health narratives, all of her suffering becomes more meaningful when talking about her older son's good school performance and his potential future to

change their family's fate.

Similar to Ms Ming, in Case BJM1, Ms Gu's 15-year-old daughter is also "left behind" at their hometown in Shandong province, and the 10-year-old son is enrolled in the local public primary school in Slope village. It was very difficult for Ms Gu's son to enrol in the local public primary school due to the various restrictions and requirements for migrant children. It was very difficult for Ms Gu's son to get enrolled in the local public primary school in 2015. Based on the education policy issued in 2015 by the Beijing Municipal Government (BMEC, 2015), migrant children in Beijing can only enrol in the primary school if their parents can submit 28 of the required certificates to the school. Ms Gu had to queue up for the certificates in front of the District Government building at midnight since the numbers are limited and there were too many people lined up for them. The NGO leader who has personal connections to a member of the Chinese People's Political Consultative Conference (CPPCC) helped Ms Gu to publish Ms Gu's story on the CPPCC's official newspaper. This media exposure ultimately helped Ms Gu's son to enrol in the local public primary school in Slope village. Appreciation for the NGO leader's help is the main reason that Ms Gu decided to work as a social worker at the NGO in 2016, the year after her son's admission.

As Ms Gu described, every year during the primary school admission period, many migrant parents who have school-age children feel "tortured" by the various restrictions and requirements that they have to address, otherwise they would have to bear the pain of being separated from their children at a very young age. Ms Gu believes that similar to the damp living environment, the anxiety and depression of children's education could lead to many health problems, such as endocrine disorder, digestion problems and insomnia. Similar to Ms Ming's explanation of her sufferings in the city, Ms Gu believes that although these health problems are caused by bad emotions and anxiety, they can be seen as meaningful health sacrifices in terms of supporting her children's education. For example, Ms Gu has very high expectations for her daughter, and she always believes that her daughter should strive to enter Tsinghua University, which is the 2nd top university in China.

Education is one of the most significant factors in understanding rural-to-urban migration in China. By analysing a survey of migrants from Guangdong province, Fan (1996, p.28) points out that in China the educated adolescents of a relatively younger age are more likely to migrate to urban cities from rural areas, and economic opportunities are not the only reasons fuelling internal migration in China, with other factors such as traditional culture and values leading young migrants to stay in the city (Fan, 1996). As indicated by Wang et al. (2019, p.240), the high educational expectation on children's education has emerged as a dominant ideology among

Chinese rural-to-urban migrant workers without examining the various social barriers. The authors (2019, p.244) found that migrant parents' great aspirations for their children's educational futures have worked as a response to their difficulties in cities, and the educational attainment has been regarded as a shortcut to achieve their aspirations for family, including "getting a good job", "having a nice marriage", and "providing old-age support" for parents (Wang et al., 2019). However, research shows that in China rural students are 11 times less likely to access any top 100 universities than urban students (Li et al., 2015). The unrealistic high educational expectations among these rural-to-urban migrant workers mostly ends up with huge disappointment.

In summary, migrant workers' understandings of suffering, including the negative ways of dealing with health problems are often associated and are interpreted as a kind of health sacrifice for their great expectations on children's education. These unrealistic educational ambitions often lead to more anxiety and depression in migrant workers' health and wellbeing, especially when facing the reality check of unequal education policies and social barriers. Therefore, the educational aspirations and health suffering becomes an unsolvable health dilemma among Chinese rural-to-urban migrant workers. The urban life difficulties encourage migrant workers to have high and unrealistic ambitions for their children's education, and the great educational aspirations encourage them to sacrifice more in urban lives. Among these sacrifices, uncertain health needs and body tolerance becomes the first thing to be negotiated, compromised and eventually sacrificed.

7.3 Migrant workers' health and false hopes: a way of living

> 'I expect things to improve next year, although I know I will still wear the same torn cotton-padded jacket.'[39]

This is a popular Chinese saying frequently mentioned by the migrant workers in Slope village to express their feelings of being migrant workers in Beijing. While different from the high expectations I discussed previously, this proverb is more pessimistic, and more popular among the relatively older migrant workers. I found that, although many migrant workers expressed their high expectations, most of their lifestyles are defined by strict and tough self-imposed constraints. In this section, I will focus on the late (and final) stage of migration, when migrant workers become older and can see the outcome of the health sacrifices that they have made throughout the migration journey. I found that although most migrant workers are aware or have known that their aspirations are "false hopes" and are not likely to be achieved, they still pin their

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[39] Translated from the Chinese saying "今年盼着明年好，明年还穿破棉袄".

hopes on small chances. In return, the unclear and uncertain hopes has shaped migrant workers' lay health knowledge systems – no matter how migrant workers' aspirations have changed over time, health has been constructed as something that can be compromised and sacrificed to deal with systematic social and personal sufferings.

7.3.1 Lay perceptions of improving living conditions as migrant workers

There are many migrant workers who have expressed that their living conditions in the city are compromised compared with the way they live in their hometowns. I found that although many migrant workers have improved their economic conditions, their living conditions in cities remain the same. It is very common for migrant workers to see their living circumstances as temporary, although some of them have been living in the same way for over 20 years. How migrant workers perceive their living conditions in cities is another key to addressing migrant workers' health challenges in urban China.

Literature shows that rural migrants are more likely to be exposed to industrial pollution, especially air and water pollution, due to their geographical locations and the lack of protection (Ma, 2010, Schoolman and Ma, 2012, Chen et al., 2013). Liu (2010) describes these urban villages, where migrant workers usually find low-cost residences, as a "transitional neighbourhood" without stable land rights and proper state regulations (Liu et al., 2010). Chen (2013) analysed the Chinese national household survey conducted in 2009 and found that exposure to environmental hazards has significantly influenced migrant workers' self-perceived physical and mental health conditions (Chen et al., 2013). Many migrant workers tend to attribute the diseases to unsafe drinking water and food rather than other popular factors perceived in Western countries, such as smoking and alcohol. This Chinese folk health belief is also elucidated in other health research conducted in overseas Chinese communities, which was captured by Gervais and Jovchelovitch (1998, p.34) as "you are what you eat" when describing the health beliefs of the Chinese community in England (Gervais and Jovchelovitch, 1998).

In Beijing, the most concerning health hazards are its contaminated water and air as well as unsafe food. Researchers have delivered warnings about the groundwater pollution in Beijing, since all the rivers and groundwater systems are heavily polluted (Beach, 2001, Jing et al., 2013). The report shows that in 2017, 39.9% of the groundwater in Beijing is too polluted to use (Tingting, 2017). As concluded by different research studies, the tap water in Beijing is not drinkable (Tian et al., 2012). Although migrant workers do consider it a health threat, they rarely take actions to solve this problem. Case BJM3 is an example to show migrant workers' lay perceptions of healthy living conditions.

Case BJM3 is a migrant family from Hubei province. The mother Ms Jian and her husband migrated to Beijing in 1996. Ms Jian's husband is an upholstery materials businessman who used to have an informal shop running in Beijing. In 2017, after the deadly Daxing fire, Ms Jian's husband had to close down his business and move his shop to Tianjin, which is another mega-city next to Beijing. As described by Ms Jian, her family economic conditions have improved by her husband's business and they also purchased an apartment in Tianjin. Their children have been enrolled in the local public primary school in Slope village, and they cannot be transferred to Tianjin since their hukou is still in Hubei province. Ms Jian's husband has to travel between Beijing and Tianjin, and Ms Jian looks after her two children in Slope village.

Ms Jian and her children live in a small room, which is part of a two-floor rural house but isolated from the main structure where the landlord's family live. The room has a temporary wooden board shelter attached in front of the entrance as a kitchen. Ms Jian described that she was very disappointed when she moved to Beijing, as the living conditions are too poor compared with her own hometown place. One of her major family health concerns is the drinking water in Beijing. She used to live in another village in Beijing and could only use the groundwater from a ground well drilled by the landlord. She used to think the tap water is better than the well water, and she always took water from elsewhere to avoid using the well water at her place. When she moved to Slope village in 2009, she has the tap water at her place. However, she is still worried about the tap water since she heard that the tap water in this village is also from the well water. She could not confirm the truth about the tap water, but she realised that the tap water is not safe due to the abnormal smell and taste she detected from it.

However, although she does not trust the tap water, Ms Jian does not want to take any further action for her health concerns over the water pollution. She explained that she does not think that her economic conditions are good enough to solve this problem, and the health risks are uncertain since many other migrant workers, or even local residents are using the same tap water. Another important reason she placed emphasis on is the instability she has experienced in Beijing with respect to renting. Ms Jian advised that she and her husband have been required to move six times in Beijing due to increasing rent levels, and they have had to move further and further away from the city centre to find an affordable place. As she explained:

> 'You know, the first reason, we are just renting a place to live, we have limited income, and our residence is always changing. Today we live here, tomorrow we may be somewhere else. Moving from one place to another is troublesome, but we have to. I feel like our economic conditions are not

> good enough for me to spend money on improving things here. You know, we are just migrant workers – the good things, like water purifiers, are not very common for migrant workers.' [BJM3, Ms Jian]

Many other migrant workers have expressed similar feelings in relation to living in Beijing. It appears that the feeling of being "temporary" does not only concern incomplete citizenship rights but is also related to geographic changes to migrant workers' residential areas in Beijing. Many self-employed migrant worker's small businesses, vegetable markets, and entrepreneurial spaces have been demolished throughout redevelopment transformations in Beijing's urban spaces. In the book "Spatial Mobility of Migrant Workers in Beijing, China", the author documented how since the late 2000s, the buildings where low-wage migrants' reside have been demolished and the migrants are required to find an affordable residence further away from the city centre (Liu, 2015). Unstable and unpredictable accommodation often overlaps with different forms of vulnerabilities in metropolitan areas, such as social isolation and poverty (Pendall et al., 2012). In Slope village, many migrant workers are worried that their current residence would be demolished soon. The changes are unpredictable, and this has encouraged them to keep a small and simple number of belongings.

Housing conditions and neighbourhood environments are very important factors for people's health (Stafford and McCarthy, 2006). The living conditions for migrant workers in Shanghai and Beijing are similar in terms of being, for the most part, informal and temporary housing conditions, and the process of continually moving to different informal houses has created significant mental stress for many migrant workers (Liu and Wong, 2018, Li and Liu, 2018).

In Ms Jian's narrative, her passive reaction to the polluted water was expressed as simply a way of living and surviving in unstable and unpredictable conditions. These constraints were more influential than health concerns, especially when that particular "problem" is shared by many other people. A similar reaction is also described in "Resigned Activism: Living with Pollution in Rural China". The author Lora-Wainwright (2017, pp.125-156) found that many rural residents living in the "cancer village" used the expression "there is no way" to respond to the question about the link between a polluted environment and prevalent cancer in that village due to the lack of knowledge and "tangible evidence" (Lora-Wainwright, 2017). My fieldwork in Shanghai and Beijing found that this pervasive failure to improve their living conditions in cities is related to both internal and external factors. It appears that the unstable and unpredictable renting situation has created further social barriers for migrant workers, and, at the same time, they perceive life in urban cities as temporary and able to be

sacrificed to serve a greater purpose – the expected "good life" at another place. In other words, the aspirations for a "good life" are used to justify the reality of a "bad life" for migrant workers, although it appears the "bad life" would often last for a long time, and sometimes their whole lives.

7.3.2 The end of false hope: a story of sharing a cigarette in a detention centre

According to the health accounts of migrant workers in Shanghai and Beijing, the migration aspirations for family dominate perceptions of health and illness events. The lay understandings of health and illness are often interpreted by migrant workers as an uncertain balance between their body tolerance and their aspirations. However, with their increasing age, migrant workers eventually are forced to confront reality and the weight of the sacrifices they have made in the pursuit of their aspirations, and their health perceptions also change accordingly. As stated by Bircher (2005, p.336), health is a dynamic state of wellbeing because "the demands of life vary with the life cycle, are culture-specific, and need to be met in personal responsibility" (Bircher, 2005). Case BJM14 is an example of a migrant family whose journey demonstrates this change in perception of health once the reality of the sacrifices they have made throughout their migration journeys is finally understood.

As introduced previously, Case BJM14 is a migrant family from Henan province. The father Mr Wan is 55 years old and operates a small garbage recycling business on his tricycle in Slope village. His left leg was injured from an accident when he was 17 years old – it becomes limp every time he stands on it for too long or walks too fast. His son graduated from a college in Henan province a few years ago and joined the NGO as a social worker in Slope village. His wife Ms Mei is a kitchen hand working in the factory canteen next to the village. Mr Wan's family live in the small bungalow built by the landlord in the middle of vegetable farmland. His landlord is also the head of the village, meaning his informal residence is protected from demolition. Mr Wan's parents used to live in Beijing with them, but both of them died a few years ago.

Mr Wan has multiple health problems. In addition to his injured left leg and low-back pain, Mr Wan has lost some of his teeth, and he was also diagnosed with liver and intestinal problems. However, Mr Wan expressed that he does not want to quit smoking or drinking although he knows that they are dangerous for him. He is aware of his health conditions and repeatedly stressed that "people like us do not have a long life". He explained he finally feels relief now: his parents have lived to a long age and have passed away; his son has graduated from a college; and he cannot see any other contributions he could make for his family given his age. From his point of view, talking or caring about health is meaningless for him. Mr Wan is a heavy smoker. He

explained that although he can physically feel that smoking is destroying his lungs, he still enjoys smoking since it brings him great comfort and relief.

Mr Wan migrated to Beijing around the year of 1996. He and his wife did garbage recycling together to generate income in a small village originally located next to the Beijing Capital Airport. Around that time, the Custody and Repatriation System in Beijing was still very strict, and migrant workers would be arrested and then sent back to their hometown province if discovered by the police in Beijing. Mr Wan tried his best to avoid encountering the police when he was outdoors. In 1997, Mr Wan and his relatives were doing garbage recycling together, and Mr Wan was arrested when he was on his way back home. His relatives were also arrested in another place. He met his relatives who were arrested in different locations in the same detention centre, while awaiting deportation back to Henan province. They were detained in a detention centre in Changping District in Beijing. Mr Wan did not have any way to communicate with his wife and two years old son, and he was very anxious that his wife and son were not aware of what happened to him.

Mr Wan and his relatives were detained in the detention centre for a long time, and they did not know when they would be deported. They were searched by the security guards, and all of their personal belongings were impounded. Mr Wan secretly hid some money and cigarettes in the interlayer of his broken coat. When some of Mr Wan's relatives were beaten by the security guards in the detention centre, Mr Wan used his hidden money to bribe the guards so they would avoid getting beaten again. About one week later, Mr Wan and all the migrant workers from Henan province in the same detention centre were sent back to Henan by train. They were first sent to a city in Henan called Anyang, and from there they were sent separately to their hometown cities from the dentition centre. The transfer in Anyang detention centre was another difficult time for Mr Wan and his relatives. He became more anxious about his family in Beijing, and he struggled internally as to whether he should escape from the detention centre or jump off from the train so that he could return to Beijing as early as he could. The days he spent in Anyang detention centre were extremely difficult for everyone in there. They did not have any money and could not obtain anything from outside except the rough corn flour food provided by the detention centre. Mr Wan's cigarettes became the most popular items in the detention centre among the migrant workers, who were wrecked by anxiety. Mr Wan recalls the memories clearly even though it was 20 years ago. He remembers every detail of the events – when he was arrested from his tricycle, when he was sent away on the train, and when everyone was jealous that he had cigarettes in the detention centre.

> 'In Anyang detention centre, people were so jealous that I had cigarettes –

> my last ten cigarettes saved us. When I lighted up one cigarette, three people would immediately come to share it, one by one, it was too tempting. At that time, a single cigarette was only 0.1 Yuan outside, but it was sold for 1 Yuan per cigarette among us, and nobody would sell it to others even at that price because they were so valued. People were so jealous of me and the others who had cigarettes … it was really miserable when I think about it, and the cigarettes saved me.' [BJM14, Mr Wan]

Mr Wan's detention experience is shared by many other migrant workers in Slope village. Before the Custody and Repatriation System was banned in 2003, many migrant workers have experienced being arrested, being treated violently, being forced to do heavy manual work without payment, and being deported back to their hometown without notifying any family members (Yi, 2003, Hand, 2006). For example, in Case BJM2, Mr Pan described that to avoid being arrested, he had to stay in a night club since the police would not check the night club for migrant workers. But he still got arrested and deported the second year after he came to Beijing. Mr Pan jumped off from the train and walked back to Beijing because he worried about his wife too much. Mr Pan described his feelings about the experience "there are too many things I want to say, but I'd rather keep silent because it is useless to say anything". These same feelings of being powerless and voiceless could be seen to also be embedded in the relief that Mr Wan derived from smoking. This traumatic memory in Mr Wan's narrative was connected to his "addiction" to cigarettes. Mr Wan considers that this feeling of relief that he derives from smoking is far more important than other health concerns at his age.

Research shows that meanings of health and illness are often constructed by previous disruptive events rather than health challenges they currently face (Carricaburu and Pierret, 1995, Ciambrone, 2001). Mr Wan's story is a good example to illustrate how biographical disruption has shaped his perception of "being healthy". From Mr Wan's perspectives, he has accomplished his family duties, and his migration aspirations have come to an end. His family is still stuck between Beijing and his hometown, and he could not see any possibilities to change this. Mr Wan accepted his damaged physical health which he described as "would not live very long". The new meanings of health for Mr Wan is the sense of being relieved from family responsibilities and pressure of aspirations. As he described, smoking cigarettes and drinking beer is the "healthiest" thing that he deserves to have. However, this kind of "relief" is considered unhealthy behaviour from a biomedical perspective.

As a result of the massive rural-to-urban migration throughout China in the recent three decades, many migrant workers have eventually come to recognise that their

aspirations for family are unlikely to be achieved. However, as the popular Chinese saying that I cited at the beginning of this section shows, many migrant workers still pin their hopes on the opportunities they would not have if they were still at their hometowns. As explained by many migrant workers in Shanghai and Beijing, they know that their aspirations for family sometimes are just “false hopes”, but they need these “false hopes” to support them to overcome the difficulties they are facing in cities, and their sufferings become meaningful when they are connected with these “false hopes”. For these rural-to-urban migrant workers, the certain and tangible health knowledge is not only too expensive but also too unpleasant and unsettling for them to share, and the uncertain health beliefs would always give them a space to negotiate with harsh social injustice and inequalities.

Chapter summary

As the last analytical chapter, I continued the discussion of migrant workers’ lay health beliefs about their health balance and work tolerance. In addition to the lay health beliefs of “kang” and the lay aetiology of “dampness” – these health knowledge and beliefs closely related to their living and working conditions in cities – I demonstrated that migrant workers have developed lay health perceptions which directly link their health outcomes to their migration aspirations.

The migration aspirations for family can be divided into three main stages. By analysing the health-related stories from these three migration stages, I found that migrant workers’ health perceptions change over time. At the beginning of the migration, migrant workers are often driven by poverty and are eager to change their family economic situations, and they often blame their health problems on their frugal lifestyles and personalities (for example, “feisty”, “hard-working”). During the second stage when migrant workers face their children’s education challenges, they connect their health problems with the unsolvable dilemma between their migration realities and their children’s educational aspirations. These challenges often lead to migrant workers experiencing depressive symptoms, and the negative emotions are believed as the reason for other physical health problems. During the late stage of migration, migrant workers often need to face unpleasant reality checks. For some migrant workers, the situation they found themselves in, and the social limitations placed on them, have led them to realise the impossibility of ever achieving the level of wealth and change in family status that had driven them to migrate in the first place. They often became complacent and accept that their situation would not improve, including their health. Others, however, appear to have remained determined to pursue their migration aspirations enduring whatever cost to their health. However, as my research

illustrates, both often meet the same destination.

Chapter 8
Conclusion and Discussion: Understanding the Lay Health Knowledge Systems Shared by Chinese Rural-to-urban Migrant Workers in Shanghai and Beijing

Chapter introduction

In this chapter, I will summarise my research findings and address the potential implications for addressing the health challenges faced by Chinese rural-to-urban migrant workers in contemporary China. In this study, I systematically analysed the lay health knowledge systems shared by Chinese rural-to-urban migrant workers selected from two "urban villages" in Shanghai and Beijing. These lay health knowledge systems illustrate how migration-related social factors have influenced the health outcomes of Chinese rural-to-urban migrant workers by shaping their subjective meanings attached to health and illness events in everyday life. These analyses lead to my final conclusion: a person's health is often considered as the only thing that can be negotiated and sacrificed in terms of pursuing migration aspirations in the context of social adversity. Although these "migration aspirations" are easily revealed as "false hopes" in reality, they have dominated the ways of thinking in relation to health and illness and methods for dealing with health problems among the Chinese rural-to-urban migrant workers in contemporary China.

There are three sections in this chapter. The first section will summarise how I identified and addressed the challenges of researching health issues faced by Chinese rural-to-urban migrant workers in China. The second section will introduce the findings of migrant workers' health-seeking patterns. I will discuss the significance of "informality" in migrant workers' health lives in urban settings. The third section will summarise the ultimate conceptual framework of my research findings, which has illustrated how social structural factors and migrants' subjective factors interplay together to create migrants' health challenges. The lay health beliefs of "kang" include three central knowledge systems: the lay understandings of "natural immunity" and self-recovery; the lay aetiology of "dampness"; and the lay aetiology of aspirations. I will explain why it is important to address the relationship between "migration aspirations" and "health sacrifices" in terms of researching the health challenges of migrants.

8.1 Addressing the health challenges shared by Chinese rural-to-urban migrant workers in urban China

There are challenges in terms of identifying Chinese rural-to-urban migrant workers'

health problems in contemporary urban China. My first research finding is to identify these significant challenges. As I indicated in the second chapter, although rural-to-urban migrant workers have become the primary labour force behind the curtain of "Made in China", their health challenges, especially the health problems associated with rural-to-urban migration-related social inequalities remains unclear in the literature. As indicated in the second section of the second chapter, attempts to monitor the health outcomes of the migrant population is limited by "health selection" and "Salmon Bias" effects, which has been the subject of research of many scholars in China. Based on these studies, it is clear that the migrant population with compromised health have been excluded from health monitoring surveys (Chen, 2011, Qi and Niu, 2013, Lu and Qin, 2014). As indicated in my preliminary analysis of Chinese migrant workers' health characteristics based on the *"China Migrants Health and Family Planning Dynamic Monitoring Survey 2017"*, Chinese migrant workers have different health characteristics compared with general health trends in China (CMDS, 2018). First, due to the younger population structure, Chinese rural-to-urban migrants have less non-communicable chronic diseases, such as hypertension and diabetes. Second, the majority of Chinese rural-to-urban migrants experience minor health problems, such as cold or flu symptoms, without seeking medical treatment in their daily lives. Third, many rural-to-urban migrant workers choose self-medication or do not seek professional help when they experience health problems. These results indicate that the health challenges faced by Chinese rural-to-urban migrant workers are embedded in their everyday lives.

As the concept of "health depletion" demonstrates that Chinese migrant workers experience a more rapid rate of suffering from health problems compared to urban counterparts (Zhou and Lu, 2016), I suggested that we should inspect the health struggles and health inequalities experienced by Chinese migrant workers in their everyday lives. As indicated in the third and fourth sections of the second chapter, health insurance inequalities and the discriminatory living circumstances faced by Chinese migrant workers are primary concerns that have been widely discussed in literature. However, these discussions also often contradict each other, especially in explaining the inconsistent results between social inequalities and health outcomes of migrant populations in Shanghai and Beijing. There is an absence of research that addresses the mechanisms in which migration-related social inequalities are embedded in the ways of thinking and dealing with health problems in everyday life, which this thesis sought to address. Qualitative studies are necessary in terms of addressing the everyday health challenges and struggles among Chinese rural-to-urban migrant workers.

As I outlined in the third chapter, both international literature and the research in China

suggests that there is a lack of qualitative research focusing on migration-related social determinants of health in China. Literature has emphasised that lay health knowledge and beliefs are embedded in health experiences and health narratives. At an individual level, Champion and Skinner (2008) suggest that people's health-related behaviours are often explained by their lay health beliefs (Champion and Skinner, 2008). However, as suggested by Popay, Williams, and other health researchers in the UK, people do not have the freedom to make healthy choices in their daily lives since lay health knowledge and beliefs are embedded in people's material and environmental conditions (Dines, 1994, Furnham, 1994, Popay and Williams, 1996, Popay et al., 1998b, Prior, 2003, Williams and Popay, 2013, Williams, 2013b). I summarised the theoretical framework in **Figure 16** to show how to bridge social inequalities with health outcomes through examining people's lay health beliefs through their respective health narratives. I also identified that health subjectivities and migration aspirations shared by migrants are underestimated in terms of addressing how migrants construct their lay health beliefs in everyday life.

Based on the literature I reviewed in the third chapter, I developed my research outline in the fourth chapter which focuses on both individual and social factors which have shaped people's lay health knowledge systems. Adapted from the types of research questions presented in **Table 3**, **Table 4** and **Table 5**, which are explored by other researchers who focused on lay health beliefs, I designed my own interview outline. My interview outline focuses on the interrelated relationships between people's lay health knowledge, the subjective meanings people attach to health, and related social contexts. I selected two migrant villages in Shanghai and Beijing as my fieldwork sites to research the ways that health problems are addressed, and the lay health beliefs shared by Chinese rural-to-urban migrant workers in different social contexts. As illustrated by Horton (2016, p.2071), migrant populations contain their own diversities of age, gender, ethnicities, family status and reasons for migrating (Horton, 2016). The research sites are two migrant villages that I selected in Shanghai and Beijing respectively, and my research participants are all married migrant couples (although some are separated) who have children in their families. Most of my research participants are ethnic Han Chinese, and only one of them has a minority ethnicity background. In this way, my analysis does not address the experiences of relatively younger single migrant workers and older migrant workers who have returned to their hometowns. I also recognise that migrants from different ethnic backgrounds may also have different lay health perceptions compared with the Han ethnicity.

The scope of my research extends to the lay health experiences and understandings related to rural-to-urban migration in urban living circumstances shared by migrant workers, particularly migrant parents who have experienced health problems of their

own or of their family members. Based on this selection, I recognise that my research does not present an inclusive, or complete, picture of the migrant population, but it does focus on typical social inequalities faced by most migrant workers in urban settings, particularly felt acutely by migrants with children separated by provincial policies.

I recognise also that my position as a researcher in the research sites necessarily means that I bring a different perspective in terms of viewing these health challenges. As a male health researcher, I encountered some problems in my fieldwork when interviewing female migrant mothers. For example, I found that some of them appeared to be embarrassed to discuss any reproductive health problems they faced with me and challenges they faced in urban settings. I addressed these topics by inviting more female interviewers such as the NGO staff to organise group interviews. At the same time, as a male researcher I had more opportunities to interview male migrant fathers, who are often neglected in literature since mothers are always presumed as responsible for family health issues. Through examination of the health narratives of migrant fathers and mothers, I discovered that there are gender differences in the lay health knowledge systems shared by migrant workers despite similar health-seeking patterns.

The second issue relating to my positionality is my identity as a returning Chinese student from overseas. As I addressed in the fourth chapter, conducting fieldwork in China is presently more difficult if the researcher does not have the backing of a government-granted project or background. Accessing channels through local NGOs helped me to avoid these barriers and risks. This “isolation” from a government-related background, however, helped me to observe and empathise with everyday life in migrant communities from the bottom-up. I believe that this strategy was also effective in terms of facilitating migrant workers to share their stories more “freely” because they were not doing so for the purpose of seeking potential intervention from higher authorities, and there were no potential repercussions for speaking their mind.

8.2 Dealing with health challenges: health-seeking patterns among Chinese rural-to-urban migrant workers

One of my research objectives addressed in this section was to identify the health-seeking patterns shared by migrant workers in urban settings. As identified through the national survey data in the first chapter, one of the significant health characteristics of Chinese rural-to-urban migrant workers is the prevalence of self-medication or not seeking professional help when they experience health problems. My fieldwork in two rural-to-urban migrant workers’ communities in Shanghai and Beijing demonstrated

that there are two significant factors which have caused the health-seeking patterns of avoiding urban healthcare systems. My first finding was there were many migrant workers who mistrust formal urban healthcare systems, especially among lower-income groups. A second finding was that most of those I interviewed preferred self-care or using informal healthcare providers to deal with everyday health problems regardless of their different living circumstances in Shanghai and Beijing.

As demonstrated in Cases SHM2, SHM7 and SHM10 in the fifth chapter, migrant workers often perceive urban healthcare systems as “careless” and untrustworthy due to over-crowded environments, the short and confusing communications and high prices, which cannot meet migrant workers’ medical needs and healthcare expectations. As showed in **Figure 17**, self-medication and informal healthcare providers are much more popular in the migrant village in Beijing. The health narratives collected from Cases BJM5, BJM7 and BJM11 in the fifth chapter also demonstrated that the demand for convenient and cost-effective healthcare services among migrant workers is shaped by their low-income status, lack of social protection, harsh work conditions and precarious living circumstances in urban cities. Further, informal healthcare providers and various self-care methods are considered more affordable and much easier to access. The health narrative from Mr Tang (BJM27) also indicated that there is a historical continuity of informal rural medical service providers, and they are more familiar and affordable for migrant workers. More importantly, they are accessible from the point of view of a migrant worker whose harsh work conditions and long working hours constrain them from attending formal urban healthcare services.

By analysing the perceived barriers and benefits of migrant workers’ health-seeking activities in the third section of the fifth chapter, I argued that the “informality” is reinforced by social and policy factors in the two migrant communities in Shanghai and Beijing. The exclusive and discriminatory health insurance policies in Shanghai and Beijing work as a barrier for migrant workers in accessing urban healthcare service systems. The informal urban spaces in migrant communities have provided them alternative channels to deal with their health problems. The “informality” in migrant workers’ health lives includes informal self-medication methods, health-seeking providers as well as lay health knowledge systems.

As I demonstrated in the fifth chapter, urban healthcare systems have failed to meet migrant workers’ medical needs and expectations. Both Shanghai and Beijing have exclusive and discriminatory health insurance policies aimed towards rural-to-urban migrant workers despite their lower-income and harsh working conditions. Reducing the inequalities in urban healthcare insurance policies could lower the economic

barriers for migrant workers to be able to seek formal urban healthcare providers.

My research also recommends placing greater value on informal healthcare channels. Many rural migrant workers reside in urban/urbanising villages located in the peripheral areas of megacities, which can provide low rent housing and some network benefits (Zhu, 2016). The exclusion of state-provided entitlements in these migrant urban villages have created a space of informality and "autonomy" for rural migrants to live in. Mackenzie (2002, p.314) suggests that Chinese rural-to-urban migrants are able to 'enjoy great autonomy from state control than any other group within Chinese society'. This "autonomy" refers to the village not being recognised by any Governmental documents – that it 'does not exist in most official senses'. Instead, unlicensed doctors and teachers reside there and provide community services for the residents who are without a local hukou (Mackenzie, 2002). However, these informal spaces are often described as rural-like and underdeveloped "threats" by many urban authorities, and have been increasingly targeted and subjected to demolition (Yue et al., 2014). My research recommends further consideration of the role of informal healthcare providers and the value of their contributions in assisting lower-income groups in urban cities.

8.3 Conceptual framework of the lay health knowledge systems shared by Chinese rural-to-urban migrant workers

This section included my findings concerning the lay health knowledge systems shared by Chinese rural-to-urban migrant workers. I found that the aspirations of the migrant workers I interviewed are interpreted as the central concerns and life meanings they have attached to their health and illness-related events. As conveyed in the sixth chapter, I identified the mechanisms between rural-to-urban migration and health-related behaviours and lay health beliefs by investigating a folk medical term "kang" which was commonly emphasised by many of my research participants in Shanghai and Beijing. My research illustrated that health is easily sacrificed by migrant workers to deal with social injustice and social disadvantages and to pursue other life priorities in urban settings. The lay health knowledge of "kang" is drawn upon to describe more passive-like attempts to resist illness and to justify avoidance of professional treatment among the migrant workers. As I summarised in **Figure 20,** social structural factors, lay health beliefs and lay aetiologies, and patterns of health and illness activities are interwoven together in the lay health knowledge systems shared by migrant workers.

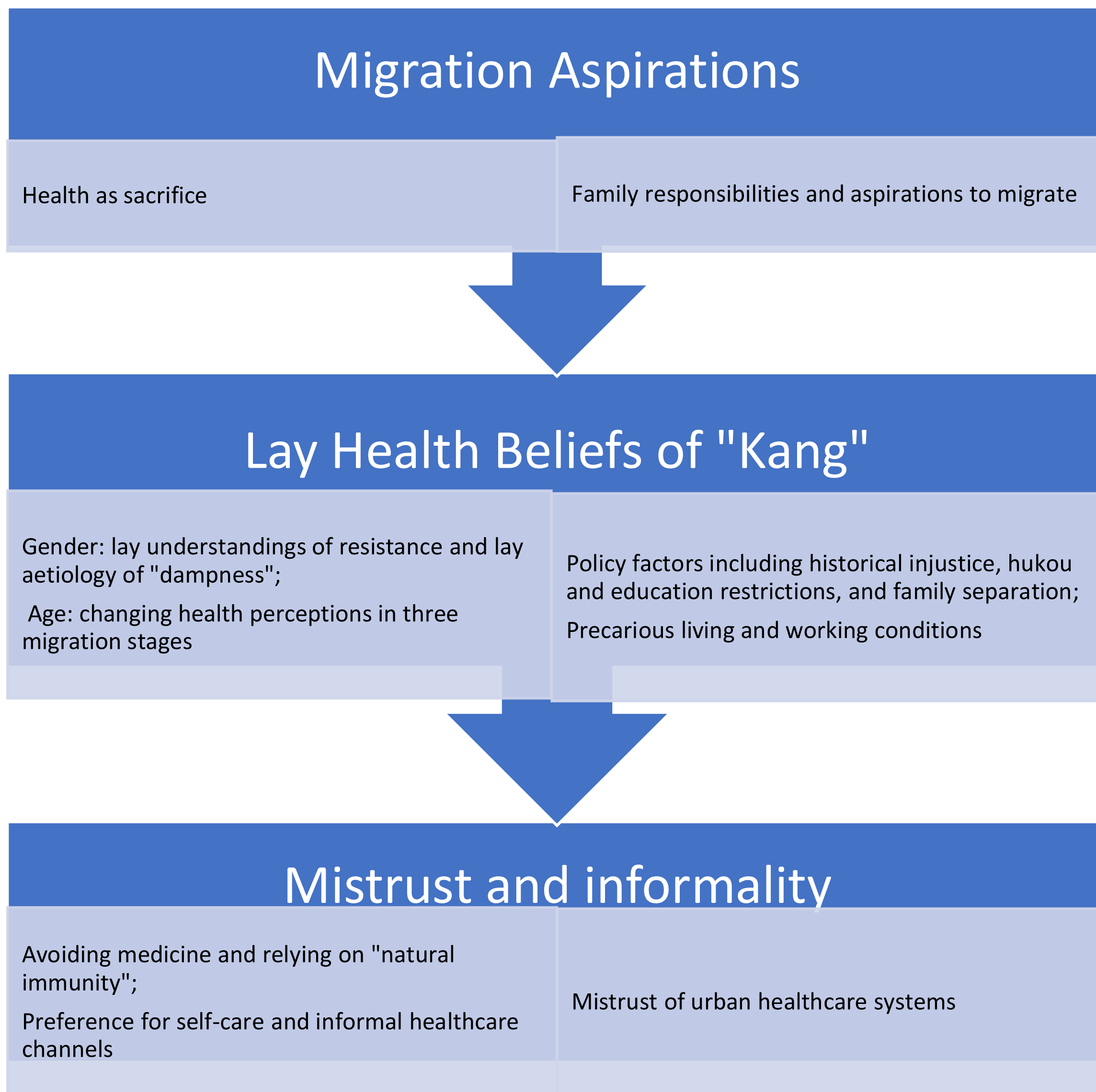

Figure 19 Conceptual framework of the lay health knowledge systems shared by Chinese rural-to-urban migrant workers

As shown in **Figure 20**, there are three levels to the negotiating process of lay health knowledge systems. Lay health beliefs of “kang” form a central component of the lay health knowledge systems that link meanings of migration with health-seeking patterns experienced by Chinese rural-to-urban migrant workers.

As I analysed in the sixth chapter, although some of the lay health knowledge terms used by Chinese rural-to-urban migrant workers are borrowed from traditional Chinese medicine or modern biological medicine, such as “immunity” and “dampness”, migrant workers have developed their own different understandings around these terms. First, the lay understandings of “immunity” are interpreted as the ability to resist disease and recover from illness without, or with minimal, external medical interventions. It is often used as an excuse for migrant workers to avoid visiting hospitals or using medicine from the hospital and instead relying on their own alternative medical practices, including food therapy or other informal healthcare practices. Second, there are also gendered interpretations of “kang” among migrant workers.

As Case BJM1 showed in the sixth chapter, migrant fathers tend to place emphasis on the capacity to “tolerate” and “resist” health problems in everyday life, and the perceived severity is often balanced with their sense of family responsibilities. In contrast, the migrant mothers placed more emphasis on the lay aetiology of “dampness”. “Dampness” is another folk medical term relating to cold and wet living conditions. In female migrant workers’ interpretations, unhappy family relationships and emotions associated with disappointment and dissatisfaction facilitate the accumulation of “dampness” in their bodies, and this “dampness” could then lead to various symptoms including headaches, insomnia, or depression. As showed in Cases BJM1 and SHM4 examined in the sixth chapter, the migrant mothers I interviewed appeared to believe that disease is caused by living in damp environments and experiencing negative emotions. Further, they considered that this “dampness” is not curable by any medicine, but only through the improvement of living conditions or emotions. By this lay aetiology, illness is interpreted as causative of life expectations since higher expectations ultimately ends with more significant disappointment. This, in turn, could lead to a greater accumulation of “dampness”.

Negative emotions, including strained family relationships and feelings of disappointment in family members, are interpreted as one of the leading causes of “dampness” related illness by many female migrant workers. Similar explanations can also be found in Lora-Wainwright’s research (2010, p.79) on the lay aetiology of cancer among rural villagers from the “cancer villages” in Sichuan province of China. Negative emotions, particularly repressed anger, is seen as one of the most common causes of cancer (Lora-Wainwright, 2010). Herzlich (1973) suggested that cultural factors often

influence the perception, labelling and explanation of illness, and people in the West tend to seek out an explanation for disease through environmental factors, stress and so forth, to a greater extent than people in non-Western societies (Herzlich, 1973).

In my research, “dampness” is a translation from the folk medical term “Shiqi”, which is one of the fundamental concepts of “qi” in traditional Chinese medical systems (Ellis and Wiseman, 1995). However, interpretations from migrant workers demonstrated that lay understandings of “dampness” are attributed to environmental factors and emotional wellbeing issues that go beyond cultural beliefs. It appears that these lay understandings are caused by the adversity and inequalities experienced by migrant workers when pursuing migration aspirations in urban settings. As I indicated in the first chapter, the citizen rights of rural-to-urban migrant workers have been compromised due to the discriminatory hukou policy in China. My research has also illustrated that the unequal education rights in urban cities for children of migrant parents has significantly influenced the mental and physical health of migrant workers. It is the main reason for family separation and split households among Chinese rural-to-urban migrant workers. As displayed in many migrant workers’ health accounts, children’s education is considered the highest priority of all migration aspirations for families. Allowing migrant children to have equal education rights in cities could significantly reduce the health risks of migrant parents and their left-behind children considering their split households.

Notably, these lay health knowledge systems and interpretations are always changing according to social policy factors and living and working conditions faced by Chinese rural-to-urban migrant workers. My research found that the nature of “uncertainty” in lay health knowledge systems is very important for migrant workers’ resilience in urban settings. They have to keep negotiating their health tolerance and needs with their aspirations for migration, their family responsibilities, the discriminatory policies in urban cities, and their living circumstances. As I argued in the seventh chapter, the meanings that Chinese rural-to-urban migrant workers attach to their health and illness depends on the changing perspective of aspirations for their families throughout their migration journeys.

My research in Chapter 7 illustrates that migrant workers prioritise migration aspirations in their health-related decisions. “Aspiration” and “desire” are widely used to conceptualise migration possibilities and to justify that ‘leaving would be better than staying’ (Creighton, 2013, Carling and Collins, 2018, Alpes, 2014). The high expectations often lead to heightened frustrations when migrants realise that the reality of life in a new country is more difficult than imagined (Van Heelsum, 2017). As I discussed in dividing migration aspirations into three stages in the seventh chapter,

Chinese rural-to-urban migrant workers have directly linked their changing aspirations with their health problems. As showed in Case BJM22, Ms Su believed that her tuberculosis is caused by her lifestyle of being “too frugal” although it is an infectious disease. In Case BJM19, Ms Jia also blamed her colleague Ms Lin’s Leukaemia and death to the personality of being “too feisty”. Both of them believed that these characters are associated with the excessive ambition to rise out of poverty and improve their family conditions in the early stage of migration journeys. At this stage, migrant workers tend to take more health risks by overworking, and they often end up with more severe health problems.

In the second section of the seventh chapter, I also identified the second migration stage when migrant workers link their health problems with their children’s education and family separation problems. As showed in Case BJM13, Ms Ming considered her physical and mental health problems as sacrifices to support their high and sometimes unrealistic expectations for their children’s future educational achievement. At this stage, illness is often interpreted as an unsolvable dilemma by migrant workers since they cannot change the hukou and education policy, and the health sacrifices become “necessary” to pursue their aspirations for their families.

As I discussed in the first chapter of this thesis, Chinese rural-to-urban migrant workers have to confront many exclusive and discriminatory urban policies in urban settings. These social injustice and disadvantages have inevitably influenced the ways that migrant workers perceive health and migration aspirations. As showed in Case BJM3, Ms Jian had to put aside her expected “good life” in another city since her family could not afford a stable residence in Beijing. At the same time, her family could not leave Beijing because of their education and work arrangements. The life in Beijing, including health, was considered by Ms Jian as unstable, temporary, and able to be sacrificed for her expected “good life” in another place. However, as I observed in most migrant families, the expected “good life” is not likely to be achieved, and many migrant workers also accept that most of the aspirations are just “false hopes”. As showed in Case BJM14 in the seventh chapter, the unpleasant reality checks made “health” more meaningless in Mr Wan’s health accounts because the purpose of maintaining good health does not exist anymore. At this stage of migration, Mr Wan’s health perceptions are influenced by his previous disruptive events, especially helpless moments of dealing with social injustice and social disadvantages as migrant workers in urban settings. He realised the impossibility of ever achieving the level of wealth and change in family status that had driven him to migrate in the first place, and he became complacent and accepted that the situation would not improve, including his health.

As indicated by Backett (1992, p.505), the concern for good health is only one

behavioural motivator amongst other priorities of everyday life, and people would always find ways to legitimate their behaviours under the pressure of work, social, and domestic obligations (Backett, 1992). My research demonstrated that many migrant workers did not consider valuing their health due to their unstable residence in cities, and the feelings of being “temporary” significantly held back any initiative of the migrant workers I interviewed to look after their health. The conceptual framework of lay health knowledge systems shared by Chinese rural-to-urban migrant workers bridged the theoretical gap between research on migration and the construction of migrants’ health subjectivities. As I identified in the third chapter, there is an absence of subjective explanations of the lay health beliefs of migrants and lay health practices, including in particular the social context in which their migration journeys have taken place. My thesis addressed this gap by exploring the aspirations of migrants with respect to undertaking migration and their associated meanings of health in their everyday lives. Lay health beliefs shared by migrant workers are the product of a negotiating process with social inequalities, and they will not change if the hukou restrictions, discriminatory education policies, and exclusive urban healthcare systems remain the same.

Conclusion and Discussion

> Policies made in all sectors can have a profound effect on population health and health equity.
>
> The Helsinki Statement on Health in All Policies declared by the World Health Organisation during the 8th Global Conference on Health Promotion (2013, p.1).

The Helsinki Statement emphasised that health inequalities are profoundly impacted by policies throughout all sectors and are politically, socially and economically unacceptable, as well as avoidable (WHO, 2014). As this thesis has illustrated, the health and wellbeing of Chinese rural-to-urban migrant workers is largely shaped by the social inequalities and challenges they experience in urban settings. Throughout the narratives I collected from the Chinese rural-to-urban migrant workers in Shanghai and Beijing, it appears that health concerns are always associated with the very specific policy constraints which they feel powerless to change. Fundamentally, their social identities, including general civil rights and health entitlements as "second-class citizens" in urban cities, are primarily shaped by the hukou policy and rural-urban barriers in China. As my research has shown, their health-seeking patterns and habits can be directly related to their perception of urban healthcare systems, their working conditions, and unequal labour protection policies in urban cities. Further, their family health arrangements and the mental health challenges they experience are closely related to the exclusive health insurance policies and education policies in urban China. The World Health Organisation's Framework of Health in All Policies, which was delivered at on 10-14 June 2013, can provide important insight to China – as one of the major participants of the World Health Organisation – in their efforts to reduce health inequalities and evaluate the health consequences of these health, education and internal migration policies at a national level.

Importantly, my research suggests a new perspective in which to examine the relationship between health and migration, by focusing on the changing dynamic of the aspirations shared by migrant groups over time. Many researchers focusing on migration and health, especially in relation to transnational migrant groups, have largely prioritised cultural differences in terms of interpreting lay health beliefs and knowledge systems (Salant et al., 2003, Thurston and Vissandjée, 2005). However, the focus on internal migrants in my research enables us to examine how lay health beliefs develop in different contexts although with similar cultural backgrounds. As

demonstrated in my research, the definitions of health and health-related behaviours shared by Chinese rural-to-urban migrant workers are associated with their changing perspectives on fulfilling family responsibilities and aspirations, including children's education, housing, and overall improvement of their family financially and socially. The lay health beliefs of "kang" are commonly used by migrant workers to describe more passive-like attempts to resist illness and to justify avoidance of professional treatment. These lay health beliefs, including the lay health belief of "immunity" and "self-recovery", the lay aetiology of "dampness", and the lay aetiology of aspirations, are shaped by personal experiences confronting the social inequalities and barriers faced by Chinese rural-to-urban migrant workers. These beliefs, regardless of their cultural foundations, are selectively used to justify the taking of health risks to continue working towards one's migration aspirations.

Based on my research, it appears that health is seen as a necessary sacrifice for migrant workers. This has become a dominating ideology interwoven throughout their health accounts. Today, the forces behind the "curtain" of "Made in China" – Chinese rural-to-urban migrant workers – continue to be a major labour force deeply involved in the expanding global capitalism. Placing a spotlight on their health sacrifices is not only a scholarly contribution to the research on migration and health, but also a timely reminder to help us understand the price of human suffering paid behind the "curtain" of expanding global capitalism.

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List of Abbreviations

AIDS	Acquired immune deficiency syndrome
BJCHFP	Beijing Commission of Health and Family Planning
BMBC	Beijing Municipal Bureau of Commerce
BMBS	Beijing Municipal Bureau of Statistics
BMI	Body Mass Index
BJ	Coding for cases from Beijing
CCDC	Chinese Centre for Disease and Prevention.
CCP	Chinese Communist Party
CGSS	China General Social Survey
CMDS	China Migrants Health and Family Planning Dynamic Monitoring Survey
COPD	Chronic obstructive pulmonary disease
COVID -19	Coronavirus Disease of 2019
CPPCC	Chinese People's Political Consultative Conference
DIDI	Didi Chuxing Technology Co.
GBP	British pound sterling
GDP	Gross domestic product
IMR	Infant mortality rate
MMR	Maternal mortality ratio
MPSC	Migrant Population Service Centre
MOTRIN	Pain Reliever & Fever Reducer for Adults & Kids | MOTRIN®
NBS	National Bureau of Statistics of P.R.China
NGO	Non-Governmental Organisation
NHS	United Kingdom National Health Service
NRCMI	New Rural Cooperative Medical Insurance System
OTC	Over the counter
SARS	Severe Acute Respiratory Syndrome
SH	Coding for cases from Shanghai

SLI	Salience of Lifestyle Index
SMBS	Shanghai Municipal Bureau of Statistics
SMG	Shanghai Municipal Government
TCM	Traditional Chinese Medicine
UCL	University College London
UEBMI	Urban Employees Basic Medical Insurance
UNICEF	United Nations Children's Fund
URBMI	Urban Resident Basic Medical Insurance
URRMI	Urban and Rural Residents Medical Insurance Scheme
WHO	World Health Organisation
XF	Name of the failed access village in Shanghai
XT	Name of the NGO in Shanghai
YLLs	Years of life lost

Appendix A
Research Recruitment Information Forms

A.1 Information sheet

A.1.1 Information sheet in English

Project:

Narratives of Chinese migrant workers negotiating health in Shanghai / Beijing

Invitation:

You are being invited to take part in the research project: the fieldwork of narratives of Chinese migrant workers negotiating health care in Shanghai / Beijing. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Purpose:

This project is to collect data for my PhD thesis "Narratives of Chinese migrant workers negotiating health care in Shanghai / Beijing", and the thesis is to explore how Chinese migrant workers deal with health problems in urban settings of China. The duration of the fieldwork is from January 2018 to March 2019.

Why have I been chosen?

Participants are recruited based on their age, hometown, employment, and health situations. You would be selected if you are:

Chinese rural-to-urban migrant workers;

currently working in Shanghai / Beijing without local household registrations;

30 – 55 years old;

have or have had children or parents living together in the city;

have health and illness experiences in the city.

You might also be selected if you are NGO workers who currently provide services to Chinese rural-to-urban migrant workers who participated in my research.

People who are younger than 18 years old will be excluded.

What do I have to do?

Participants will be interviewed about their health experiences throughout their

migration journeys. Some participants will be observed of their health-related activities. All interview questions are open ended, participants will be able to suspend, stop all withdraw during the interview. During the time, participants will be interviewed weekly, and each time of the interview will be around1 hour. Some participants will also be involved in observation, and each time of observation will be up to 3 hours. The time for each participant taking part in the research will be up to 30 hours in total.

All participants should have agreed with the information sheet and the consent form (or verbal consent) before participating in this project.
All participants are voluntary to take part in this project; it does not involve any rewards or reimbursement.

What are the possible disadvantages and risks of taking part?

Interviews and observation of health problems may be sensitive or uncomfortable for some people. However, participants have full rights to decide what they want to talk about.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will help participants develop the depth of understanding of their health situations.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form (or verbal consent), and you can still withdraw at any time up until March 30, 2019. You do not have to give a reason.

Will my taking part in this project be kept confidential?

Yes.

All participants' names will be anonymised so that they cannot be identified by the details from the data. All personal information will not be shared with any third party. The data, including fieldwork notes, audio or video documents will be stored in the university approved cloud computing services (Microsoft OneDrive for Business, student account). All voice or video recording files will not be kept after transcription. The fieldwork data (without personal information) will be retained 2 years after publication.

However, sometimes it is not possible to keep everything confidential. There are two situations that researchers cannot keep data confidentially. First, if the participant discloses an intention to harm themselves or others. Second, in focus group interviews, while the researcher will maintain confidentiality, we cannot promise this

on behalf of other participants, although it will be requested.

As the result, the collected data will be analysed and be published as my PhD thesis. Participants will not obtain a copy of the published work automatically but can request a copy from me after publication. All participants will not be identified in any document that result from the research.

Withdrawing

Participants can withdraw from the research at any time during the fieldwork. However, it will not be possible to withdraw once the data has been processed anonymously after March 30, 2019.

Who is organising the research?

Juntao Lyu, School of Sociology and Social Policy, University of Leeds

Contact for further information

Juntao Lyu

ssjly@leeds.ac.uk

A.1.2 Original information sheet in Chinese

研究项目说明书

项目名称：上海和北京农民工的医疗叙事研究项目

邀请：

您被邀请参加上海和北京市农民工的医疗叙事研究访谈项目。在您参加之前，请您了解一下这个项目是什么，涉及什么内容。请您仔细阅读以下信息，并可以随时与他人询问和讨论。您也可以向我询问更多相关信息。您可以在阅读后再决定是否参与这个项目。

研究目的：

该项目是为我的博士论文“农民工的医疗叙事研究”搜集社会调查资料。我的博士论文主要研究的问题是，面对城市环境，上海和北京市的来自外省市的务工人员是如何处理疾病和医疗问题的。本项目持续时间 2018 年 1 月 15 日至 2019 年 3 月 30 日。

为什么您会被选择？

这项调查是根据参与者的年龄，户籍，职业和健康与疾病经历进行选择的。一般条件是：

从农村到城市务工的人并且只有农村户口；

目前正在上海/北京工作的，来自外省市；

年龄为 30 岁到 55 岁之间；

有孩子或者年迈父母在城市一起生活的经历；

有处理健康和疾病相关问题的经历；

有些服务农民工的 NGO 工作人员也可能被选入参加研究。

未满 18 周岁的人无法参与研究。

参与者需要做什么？

研究者会对参与者进行访谈，访谈内容主要是您生活中面临的健康与医疗问题。在得到参与者允许的情况下，研究者会对一些参与者的健康活动进行观察。所有的采访问题都是开放式的，你可以随时要求中断或退出访谈或者观察。参与者每周至少被

访谈一次，每次访谈大约 1 小时左右。对于需要观察的参与者，每次观察不超过 3 个小时。

请您在参与之阅读研究信息表并同意《知情同意书》（或口头同意）。

所有参与者都是志愿参与本访谈项目，本访谈项目不提供任何奖品或花费报销。

参与会有哪些可能的风险？

研究涉及一些健康与疾病相关的问题，可能会激发不开心的回忆，或引起尴尬的情绪。不过作为参与者您可以自主决定讨论的内容。

参与会有哪些可能的好处？

尽管这项研究不提供任何直接的物质利益，研究者希望您能通过访谈增进对自己健康状况的理解和认知，更好的处理健康问题。

是必须参与的吗？

您可以自行决定是否参与本研究项目。如果您决定参与，您可以保留这一张《研究信息表》，并同意《知情同意书》。您在签署知情同意书（或口头同意）之后，依然可以在项目结束之前（2019 年 3 月 30 日）无理由退出这项研究。

您的参与会被保密吗？

是的。所有参与者的信息都会经过匿名化处理，以保证其身份无法通过资料中的细节识别出来。所有访谈笔记，录音或者视频会被储存到经过利兹大学认证的微软公司在线网盘（Microsoft OneDrive for Business, student account）上。所有录音录像文件在文字化处理之后即被删除。所有匿名数据保存期限为博士论文发表的 2 年之内。

但在一些特殊情况下，研究者无法保证参与者信息的保密性。第一种情况是当参与者表示出要伤害自己或伤害其他人的意图时。第二种情况是小组访谈，尽管研究者本人会保证小组访谈资料的保密性，并要求其他参与者保密，但研究者无法确保每位小组成员都能为其他成员保密。

访谈和观察的资料会被研究者分析并应用到博士论文中。研究结果发表后，参与者可以向研究者提出索取博士论文的复件。研究者确保您的个人身份不会通过论文或任何分析报告识别出来。

取消参与

参与者可以在参与研究期间的任何时间取消参与。项目结束之后，因为所有数据都已进行匿名化处理，不再受理取消参与的要求。研究项目结束日期为 2019 年 3 月 30 日。

研究组织者是谁?

吕俊涛， 社会学与社会政策学院，利兹大学(The University of Leeds)

获取更多信息，请联系

吕俊涛

电子邮件：ssjly@leeds.ac.uk

感谢您的阅读!

A.2 Research consent forms

A.2.1 Research consent form in English

Consent to take part in the 'Narratives of Chinese Migrant Workers Negotiating Health Care in Shanghai /Beijing'	Add your initials next to the statement if you agree
I confirm that I have read and understand the information sheet dated [/ /] explaining the above research project and I have had the opportunity to ask questions about the project.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline. (For withdrawing the research please contact ssjly@leeds.ac.uk, Juntao Lyu. However, you may not be able to withdraw the anonymous data once the fieldwork data is processed around 30/03/201).	
I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research. I understand that my responses will be kept strictly confidential.	
I agree for the data collected from me to be stored and used in relevant future research in an anonymised form.	
I understand that other genuine researchers will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form.	
I understand that other researchers may use my words in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	
I understand that relevant sections of the data collected during the study, may be looked at by auditors from the University of Leeds where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	
I agree to take part in the above research project and will inform the lead researcher should my contact details change during the project and, if necessary, afterwards.	

Name of participant	
Participant's signature	
Date	
Name of lead researcher	

Signature	
Date*	

*To be signed and dated in the presence of the participant.

Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form, the letter/ pre-written script/ information sheet and any other written information provided to the participants. A copy of the signed and dated consent form should be kept with the project’s main documents which must be kept in a secure location.

A.2.2 Original research consent form in Chinese

参与 “上海和北京外来务工人员医疗健康叙事研究”的知情同意表格

我已阅读并理解研究说明书中对研究项目的解释，并有机会对不清楚的部分进行询问。	
我同意研究人员对访谈资料进行匿名化处理。我明白我的名字不会出现在任何材料中，而且我的身份也不会通过任何材料被识别出来。我明白我的回答将会被严格保密，研究者不会向任何第三人或者第三方透露我的访谈。	
我知道我的参与是志愿的，并且能够随时的，无理由的， 没有任何不良后果的停止和退出访谈。如果有任何我不愿意回答的问题，我可以不予回答。（如果在参与之后希望退出，请联系 吕俊涛 的电子邮箱 ssjly@leeds.ac.uk 进行告知。但是在田野调查结束后，即 2019 年 3 月 30 日后，你可能无法退回已经经过匿名处理的数据。）	
我同意我的匿名访谈资料被储存并被用于将来的进一步研究。	
我明白别的研究人员只有在适用本表的保密性要求的情况下，才能使用我的访谈资料。	
我明白别的研究人员只有在适用本表的保密性要求的情况下，才能使用含有访谈资料的论文、报告、网页或其他研究成果。	
我明白含有匿名访谈资料的论文会被利兹大学研究者审阅。我同意研究者对匿名访谈资料的审阅。	
我同意参加此访谈项目，如果在访谈过程中我的联系方式发生变化，我会通知研究者以便取得联系。	

参与者姓名	
参与者签名	
日期	
研究者姓名	
研究者签名	
日期	

A.2.3 Original verbal consent in Chinese

您好，

很高兴能够邀请到您参与利兹大学(The University of Leeds)博士候选人吕俊涛的上海市农民工的医疗叙事研究项目。

本项目是为我的博士论文“上海和北京农民工的医疗叙事研究”搜集社会调查资料，持续时间2018年1月至2019年3月。

研究者将会对您在上海/北京面临的健康困扰，包括医疗疾病和医疗问题进行访谈和观察。访谈和观察至少每周一次，时间不超过3个小时。为了研究需要，我可能会对访谈进行录音，您可以决定是否接受录音。录音文件会在文字砖路之后删除，您的访谈资料将会被匿名化处理，您的个人信息将会被保密，您的身份也不会通过任何研究资料被识别出来。

需要说明的是，如果您在访谈过程中有伤害自己或者他人的意图，您的资料将不会被保密。在小组访谈中，研究者会为您的资料保密，也会要求参与人员保密，但无法确保他们会保密。

参与研究项目是完全自愿的，不涉及任何物质利益。您可以在访谈和观察期间随时中断，停止或者退出这项研究，不需要提供理由也不需要承担任何不良后果。

您可以参考研究信息表了解更多内容。如果您有任何疑问，或者想了解更多信息，可以随时向我咨询。

如果您同意以上条款，并决定参与本研究项目，请重复下面这句话：

“我明白并同意以上条款和解释，参与这个项目”

（以下由研究者记录）

访谈人员：

参与人：

通知日期：

A.2.4 Verbal consent (translated from the original Chinese version)

Dear Participants,

I am very delighted to have you participating in the research project “Narratives of Chinese Migrant Workers Negotiating Health Care in Shanghai / Beijing”. It is a PhD project conducted by Juntao Lyu, a PhD candidate of the University of Leeds.

The purpose of this project is to collect data for my PhD thesis, and the duration of this project is from January 2018 to March 2019.

Researcher will interview or observe the health problems you have had in Shanghai /Beijing. You will be interviewed or observed at least one time per week, and each time will be up to 3 hours. For the purpose of research, I might need to record the interview. However, you can decide if you want to be recorded. All voice or video recording files will be deleted after the transcription. All research data will be anonymised, your personal information will be confidential and will not be identified from any document that result from the research.

But if you disclose an intention to harm yourself or others, your information will not be confidential. In group interviews, research will maintain confidentiality, we cannot promise this on behalf of other participants, although it will be requested.

Participating this project will be voluntary, it does not involve any rewards or reimbursement. You will be able to suspend, stop of withdraw from the interview or observation during the research without giving any reason and without there being any negative consequences.

Please have a look at the information sheet if you would like to learn more about this research. If you have any further questions about this project, you can ask me, and I will explain them to you.

If you agree with the statement above, and have decided to take part in this project, please repeat the words below:

“I understand and agree with the consent and explanations, and I have decided to participant in this project”.

(Filled up by researchers below)

Interviewers:

Name of participant:

Date:

Appendix B
Semi-structured Interview Questions in Chinese

访谈主题	主要使用的访谈问题
入场介绍	我们可以先互相介绍一下，我主要想了解的就是您和您的家庭的健康和就医经历，比如说您来上海/北京之后第一次看病是什么时候，或者是有哪些生病的经历您觉得特别难忘，哪些预防措施，哪些日常成就等等。
个人背景	您老家是哪里的？什么时候来的上海/北京？当时为什么想来这儿？从事过哪些工作？感觉工作怎么样？现在在做什么工作？
家庭生活	目前您一家几口人住在一起？在这里有比较亲近经常往来的亲戚朋友之类的吗？周末或者下班休息的时候您和家人亲戚朋友都做些什么？
生育健康	您的孩子都多大了？他/他在哪里出生的（老家还是工作地）？生孩子期间有哪些健康或者生活困扰吗？
对医疗服务的体验和评价	您感觉老家和这里的医疗服务欧哪里更好一些，更方便一些？为什么？
个人或家庭的健康与疾病经历	来上海/北京之后有没有生病的经历？ 有没有哪些印象特别深刻的，比如说特别困难不知道怎么处理的健康或疾病问题？最终是如何解决的？您和家人最近一次生病是什么时候？是怎么处理的？
日常熟知并使用的医疗知识，比如“抗”	您有没有“抗”病的经历？一般是怎么“抗”的？您了解哪些特别好用的方法处理疾病问题吗？在您个人经历中有没有哪些方法您觉得特别有效的？您的亲戚朋友有没有给你介绍一些特别有效的医生，医疗方法？
对健康的自我评价	您对自己和家人的健康状况是怎么评价的？ 如果说从 1 分到 10 分进行打分的话，你一般会给您和家人分别打几分？为什么这么打分？在家庭生活中，您有没有一些觉得特别好的健康习惯或者方法？是什么？
对外出务工的生活期待	您觉得目前最担忧的事情是什么？对未来的主要期待是什么？您觉得您理想的生活是什么样的？
理想的健康状态	您觉得理想的健康状态应该是什么样的？您觉得您可以实现这种理想的健康状态吗？如果可以的话如何实现？如果难以实现的话是为什么？

Appendix C
Fieldwork Materials

C.1 Case coding

C.1.1 Research participants in Shanghai

Case ID	Participants	Forms of data	Consent forms
SHN1	Ms li	Fieldwork notes	Verbal consent
SHN2	Ms Ying	Fieldwork notes	
SHM1	Ms Ling	2 recordings, 55 min	Verbal consent
SHM2	Ms Fei	2 recordings, 1h 45 min	Verbal consent
SHM3	Mr Jia	2 recordings, 1h 45 min	Verbal consent
SHM4	Ms Hui	2 recordings, 1h; Letters to her daughter	
SHM5	Ms Weng	1 recording, 1h	Verbal consent
SHM6	Mr He	Fieldwork notes	Verbal consent
SHM7	Ms Liu	1 recording, 23 min	Verbal consent
SHM8	Ms Fang	1 recording, 23 min	Verbal consent
SHM9	Ms Lan	2 recordings, 1h15 min	Verbal consent
SHM10	Ms Juan	1 recording, 48 min	Verbal consent
SHM11	Ms Fu	1 recording, 37 min	Verbal consent
SHM12	Ms Ping	1 recording, 47 min	Verbal consent

C.1.2 Research participants in Beijing

Case ID	Participants	Forms of data	Consent forms
BJN1	Mr Hua	Fieldwork notes	Verbal consent
BJN2	Mr Miao	Fieldwork notes	Verbal consent
BJN3	Ms Yao	Fieldwork notes	Verbal consent
BJN4	Mr Deng	Fieldwork notes	Verbal consent
BJM1	Ms Gu	3 recordings, 3h 20 min	Signed consent
BJM2	Mr Pan	1 video recording, 1h	Signed consent
BJM3	Ms Jian	2 recordings, 1h 20 min	Verbal consent
BJM4	Mr Wen	2 recordings, 1h 20 min	Verbal consent
BJM5	Ms Tan	2 recordings, 1h 20 min	Verbal consent
BJM6	Mr He	Fieldwork notes	Verbal consent
BJM7	Mr Yao	1 recording, 2h 6 min	Verbal consent
BJM8	Ms Shu	1 recording, 2h 6 min	Verbal consent
BJM9	Ms Wei	1 recording, 1h 3 min	Signed consent
BJM10	Ms Nan	1 recording, 2h 3 min	Signed consent
BJM11	Mr Li	1 recording, 1h 13 min	Verbal consent
BJM12	Ms Yi	1 recording, 1h 13 min	Verbal consent
BJM13	Ms Ming	1 video recording, 50 min	Verbal consent
BJM14	Mr Wan	2 recordings, 4 h 40 min	Verbal consent
BJM15	Ms Mei	2 recordings, 4 h 40 min	Verbal consent
BJM16	Xiao Wan	2 recordings, 4 h 40 min	Verbal consent
BJM17	Ms Ye	2 recordings, 2h 20 min	Verbal consent
BJM18	Mr Chen	2 recordings, 2h 20 min	Verbal consent
BJM19	Ms Jia	1 recording, 1h 45 min	Verbal consent
BJM20	Ms Kun	1 recording, 1h 5 min	Verbal consent
BJM21	Mr Yuan	1 recording, 1h 5 min	Verbal consent
BJM22	Ms Su	1 recording, 1 h 10 min	Verbal consent
BJM23	Ms Zi	1 recording, 1h 40 min	Verbal consent

BJM24	Ms Zong	Fieldwork notes, photos	Verbal consent
BJM25	Mr Qi	Fieldwork notes	Verbal consent
BJM26	Ms Xian	Fieldwork notes	Verbal consent
BJM27	Mr Tang	Fieldwork notes	Verbal consent
BJM28	Ms Hao	Fieldwork notes	Verbal consent
BJM29	Ms Guo	Fieldwork notes	Verbal consent
BJM30	Ms Tao	Fieldwork notes	Verbal consent
BJM31	Ms Xin	Fieldwork notes	Verbal consent
BJM32	Mr Da	Fieldwork notes	Verbal consent
BJM33	Ms Jun	Fieldwork notes	Verbal consent

C.2 Fieldwork Photographs

C.2.1 The health service provided by the NGO in Shanghai

* The left poster explains what “dampness” is and how to get rid of it by soaking foot in hot water. The right side is the price for massage services provided by the NGO.

C.2.2 The broken and leaking ceiling in Ms Su’s bedroom in Beijing

* This is the bedroom of Ms Su’s accommodation in Beijing. The ceiling was broken and leaking, she had to use a wooden pole to support it temporarily. However, Ms Su did not complain about this accommodation. She was satisfied with her recovery from tuberculosis as well as the life without debts, and she was preparing to leave Beijing when her son has to go back to hometown for education.