

Everyday Health Challenges of Liberian International Students in Hangzhou, China: A Qualitative Descriptive Study

Tarweh P. Surkula, Kamara Sedeke Mohammed, Yunxian Zhou*

School of Nursing, Zhejiang Chinese Medical University, Hangzhou, China

Email: *tarwehsurkula8@gmail.com

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Abstract

Background: Few published empirical studies have examined the intersection of everyday health, healthcare navigation, academic demands, and social support among Liberian international students in Hangzhou. This study explored how students understood and managed health while studying in this setting.

Methods: A qualitative descriptive design was used. Twenty Liberian undergraduate, master's, and doctoral students were recruited purposively by direct approach across five universities in Hangzhou. Data were collected from 2 April to 15 June 2026. Semi-structured interviews were conducted in English and in person by Kamara and Tarweh, two Liberian members of the research team who shared the participants' national background. Interviews lasted approximately 45 - 60 minutes. Interviews were audio-recorded with oral permission; detailed contemporaneous notes were used when recording was declined. Tarweh transcribed the recorded interviews. Coding was conducted manually using Microsoft Word and Excel for Microsoft 365 and was supported by a working codebook, analytic memos, and a dated audit trail. Ethical approval was obtained from the Ethics Committee of Zhejiang Chinese Medical University (ZCMU), and oral informed consent was obtained from all participants.

Results: Within this sample, eight themes were developed: health as the ability to continue studying; adaptation to climate, food, and daily life; academic pressure and emotional well-being; reliance on self-care, pharmacies, and delayed formal treatment; language and communication barriers; cost and uncertainty about student health insurance; trust, respect, and perceived differential treatment; and peer, community, and transnational support. Participants described cold-weather discomfort, unfamiliar food, irregular sleep, fatigue, academic pressure, loneliness, and homesickness. Many described postponing formal care because of language difficulties, cost uncertainty, limited insurance knowledge, time constraints, or unfamiliar hospital procedures. Friends, African student net-

works, family members in Liberia, religious communities, pharmacies, and online resources were prominent sources of practical and emotional support. **Conclusion:** The accounts in this one-city sample show how academic continuity, environmental adjustment, social well-being, and healthcare navigation can intersect in students' everyday health experiences. Participant-informed priorities included clearer multilingual healthcare and insurance guidance, confidential interpretation, accessible counseling, peer navigation, and flexible academic support during illness. These approaches may address identified barriers, but their feasibility, acceptability, and effects require evaluation.

Keywords

Liberian Students, International Students, Health Challenges, Healthcare Access, Coping Strategies, Qualitative Research, Hangzhou, China

1. Background and Rationale

Research on African migrants in China provides useful context for understanding healthcare navigation in an unfamiliar health system. A nationwide study described uneven formal health-service use shaped by enabling resources and perceived need (Xiong et al., 2021). Qualitative work in Guangzhou identified affordability, language, legal concerns, cultural differences, and limited knowledge of services as barriers (Lin et al., 2015), while related research documented strategies such as informal networks, interpreters, delayed care, and care outside formal systems (Lin et al., 2016). Healthcare-seeking practices have also been linked to migrants' urban social position and the organization of local services (Bork-Hüffer, 2015). Trust may be weakened by poor communication, perceived discrimination, and payment concerns (McLaughlin et al., 2015). Community mutual aid has been emphasized as an important coping resource (Bodomo et al., 2020). Reproductive-health research among African women in Beijing identified language, information, discrimination, and policy-related barriers (Asuamah & Agyenim-Boateng, 2023). Work among Nigerians in Guangdong highlighted circulation and transnational health-maintenance practices (Adebayo, 2023), and a health-diplomacy perspective called for stronger policy coordination and service responsiveness (McLaughlin et al., 2014). However, this evidence base includes heterogeneous groups such as traders, workers, long-term residents, women seeking reproductive healthcare, and migrants with different legal and economic circumstances. It should therefore not be treated as directly interchangeable with evidence about enrolled international students, who generally have legal student status, university affiliation, and some form of student health insurance. Its relevance to the present study lies mainly in shared encounters with host-country healthcare structures, while differences in entitlement, livelihood, and institutional support limit transferability.

Evidence focused on international students is more directly applicable to the

educational context. A systematic review of mental-health care in China identified depression, loneliness, acculturative stress, and social support as recurring concerns (Wu et al., 2021). Research in China also linked social support, attachment closeness, and self-esteem with depression among international students (Li et al., 2021). Among African international students in China, alcohol-related risks have been reported (Ng'uni et al., 2023), while research on online health-information seeking highlights the importance of health literacy and digital navigation (Dong et al., 2018). Studies of African students' mobility in China emphasize the active negotiation of study, belonging, and future plans (Xu, 2025), and research on West African students describes stepwise and transnational migration trajectories (Garvik & Valenta, 2024). Work in other destinations has identified sexual-health literacy and service access as relevant to sub-Saharan African international students (Okeke, 2021). Travel-health research shows that risk perception and pre-travel help-seeking influence how students prepare for health challenges abroad (Sohail et al., 2023). Recent research also suggests that international students may combine host-country care with advice, medicines, and other resources obtained through home-country ties (Jang & Yi, 2024).

Social and institutional support are central to understanding international students' health and adjustment. Social support may buffer acculturative stress (Kristiana et al., 2022), and sociocultural adjustment and support are associated with mental-health outcomes (Razgulin et al., 2023). A meta-analysis likewise found an overall benefit of social support for psychological adjustment, while noting that the type and source of support matter (Bender et al., 2019). Universities' academic and social support services therefore form an important part of the institutional context (Martirosyan et al., 2019). Research on help-seeking among international students has emphasized the need for culturally adapted support (De Moissac et al., 2020). Recent reviews describe layered mental-health challenges during life transitions, including isolation, stigma, limited mental-health literacy, and cultural barriers to service use (Ansari Lari et al., 2025). Mixed-methods evidence also identifies stigma, service availability, cost, and waiting times as influences on treatment experience and care needs (Moghimini et al., 2023). A broader higher-education review identifies academic pressure, isolation, discrimination, and financial stress as recurring concerns (Hyseni Duraku et al., 2024), while graduate-school literature highlights separation from family, uncertainty, racism, and isolation (Murguía Burton & Cao, 2022). Perceived discrimination has been associated with poorer mental health among international students (Zhao et al., 2022). Social support may also improve college adjustment (Lee et al., 2020), whereas family communication and cultural beliefs can shape disclosure and coping (Jin & Acharya, 2021). Narrative-review evidence further shows that symptom interpretation, stigma, cultural meaning, and service use vary across settings (Magnusdottir & Thornicroft, 2022). Together, this literature suggests that students' health experiences are embedded in academic life, social relationships, cultural adjustment, and the practical organization of university and healthcare services.

It also leaves unresolved how these influences intersect in the everyday experiences of Liberian students in Hangzhou.

Few published empirical studies have specifically examined Liberian international students in Hangzhou, and fewer still have considered everyday physical and emotional health, healthcare navigation, coping, and support within a single qualitative account. This study therefore explored how Liberian students living and studying in Hangzhou understood health, experienced everyday health difficulties, decided when and where to seek help, used formal and informal sources of care, and described priorities for university and healthcare support. The study did not assume that national-level conditions in Liberia determined individual participants' experiences; interpretations were grounded in the accounts provided in this sample.

2. Methods

2.1. Study Design

This study used a qualitative descriptive design to produce a practical, context-sensitive account of everyday health experiences among Liberian students in Hangzhou. Purposive recruitment sought Liberian degree students with direct experience of the topic (Campbell et al., 2020). Twenty participants from five universities completed interviews; five of 25 eligible students approached declined because of busy schedules. The focused aim, a specific national student group in one city, 45 - 60-minute interviews, and a descriptive analytic approach together support the information power of 20 interviews. This is a retrospective rationale: information power and thematic saturation were not formally assessed as stopping criteria during recruitment.

2.2. Setting and Population

The study was conducted across five university campuses in Hangzhou, Zhejiang Province, China, from 2 April to 15 June 2026. Tarweh and Kamara approached students directly in person. The recruitment record establishes eligibility, 25 approaches, 20 interviews, and five refusals due to busy schedules. The researcher identified potential participants through available Liberian student networks and direct contacts with eligible students. Students who were identified as potentially eligible were approached and given information about the study, including its purpose, the interview process, confidentiality, voluntary participation, and their right to withdraw at any time. All interviews took place in private or quiet locations on university campuses.

2.3. Sample Size and Participant Characteristics

Eligible participants were Liberian nationals aged 18 years or older who were living and studying in Hangzhou at the time of data collection. Eligibility was limited to students enrolled in undergraduate, master's, or doctoral degree programs, matching the final sample. Language-program and professional-program catego-

ries were removed from the eligibility criteria and study records because no participants from those categories were recruited.

The sample included 12 men and eight women aged 22 - 37 years. Four participants were undergraduates, 11 were master's students, and five were doctoral students. Length of residence in Hangzhou ranged from eight months to six years. Ten lived in university dormitories, seven in privately rented apartments, and three with family members or in shared off-campus accommodation. Eleven were fully funded, five were partially funded, and four were self-funded. All participants reported some form of student health insurance (**Table 1**).

Table 1. Participant characteristics.

ID	Participants	Study level	Length of stay	Chinese ability	Previous healthcare use
P01	Female, 24	Master's	1 year	Basic	Pharmacy and campus clinic
P02	Male, 31	Doctoral	4 years	Intermediate	Public hospital
P03	Male, 27	Master's	2 years	Basic	Pharmacy
P04	Female, 22	Undergraduate	8 months	None	No formal care
P05	Male, 29	Master's	3 years	Basic	Campus clinic and hospital
P06	Female, 34	Doctoral	5 years	Intermediate	Hospital and online consultation
P07	Male, 23	Undergraduate	18 months	Basic	Pharmacy
P08	Male, 28	Master's	1 year	None	Pharmacy and online consultation
P09	Female, 26	Master's	2 years	Basic	Campus clinic
P10	Male, 32	Doctoral	6 years	Advanced	Hospital and pharmacy
P11	Female, 25	Master's	20 months	Basic	Pharmacy and hospital
P12	Male, 30	Master's	3 years	Intermediate	Campus clinic and hospital
P13	Male, 24	Undergraduate	1 year	None	Peer advice and pharmacy
P14	Female, 29	Doctoral	4 years	Intermediate	Hospital and online consultation
P15	Male, 27	Master's	2 years	Basic	Pharmacy
P16	Female, 23	Undergraduate	10 months	Basic	Campus clinic
P17	Male, 35	Doctoral	5 years	Intermediate	Hospital
P18	Male, 28	Master's	3 years	Basic	Pharmacy and hospital
P19	Female, 26	Master's	2 years	Basic	Online consultation and pharmacy
P20	Male, 37	Master's	4 years	None	Hospital with interpreter

2.4. Data Collection

Semi-structured individual interviews lasted approximately 45 - 60 minutes. Tarweh and Kamara conducted all interviews in English and in person on university campuses. Both interviewers were Liberian and shared the participants' na-

tional background. Open-ended questions and reflexive notes were used to examine assumptions of shared experience. Interviews were audio-recorded with separate oral permission; when recording was declined, contemporaneous notes were expanded immediately afterward.

Tarweh transcribed recordings in English. Note-only accounts were quoted verbatim only when exact wording was documented contemporaneously.

The interview guide was pilot-tested with two Liberian students who met the eligibility criteria, and both pilot participants were included in the final sample of 20. Following the pilot interviews, several questions were simplified for clarity, the sequence was adjusted to improve conversational flow, overlapping prompts were combined, and sensitive topics such as sexual and reproductive health and alcohol use were retained as optional probes rather than compulsory questions. These revisions did not change the study objectives or core topic domains. Primary questions remained open-ended, and optional probes were used only after participants had first described their experiences in their own terms.

The guide covered participants' meanings of health; physical and emotional experiences; climate, food, sleep, activity, and daily routines; decisions about self-care and professional care; experiences with pharmacies, clinics, hospitals, online services, and transnational advice; communication, cost, insurance, privacy, and trust; sources of social support; and participant suggestions. Sexual and reproductive health and alcohol use were approached as optional sensitive domains rather than assumed concerns. Participants could decline these topics without explanation.

2.5. Data Analysis

The analysis used a descriptive thematic approach with both deductive and inductive components. Interview-guide domains served as sensitizing starting points, but codes were not limited to those domains. Analysts also coded unanticipated meanings, relationships, contradictions, and contextual explanations emerging from participants' accounts. The unit of coding was a meaningful segment ranging from a phrase to several sentences. Coding was primarily semantic staying close to what participants said while interpretation considered how academic, social, and healthcare contexts shaped those accounts.

Tarweh conducted the initial reading and coding of the transcripts and expanded notes, while Kamara participated in the review and interpretation of the coding framework and candidate themes. Coding was completed manually using Microsoft Word and Excel for Microsoft 365. A working codebook recorded each code name, operational definition, inclusion and exclusion criteria, and an illustrative extract. Analytic memos documented emerging interpretations, relationships among codes, divergent accounts, and decisions to merge, divide, rename, or remove codes. Dated versions of the codebook, coding matrices, theme maps, and decision memos formed an audit trail. Interpretive differences were discussed by Kamara and Tarweh and resolved through rereading the relevant transcript or note, comparing the account with the code definition and wider dataset, and

reaching consensus; no statistical inter-coder agreement coefficient was calculated. Candidate themes were reviewed by both researchers against the full dataset, and ambiguous or divergent accounts were retained rather than forced into dominant themes. Formal participant feedback or member checking was not undertaken.

The analysis did not treat study level, residence duration, language ability, or funding status as formal comparative subgroups. These characteristics were used only as contextual descriptors when interpreting individual accounts. Accordingly, subgroup differences are presented cautiously and are not claimed as systematic findings (Table 2).

Table 2. Illustrative movement from extract to theme.

Illustrative extract	Initial code	Category	Theme
“Sometimes you use the translation application and hope they understand.”	Reliance on translation app; uncertainty about symptom communication	Communication during care	Language barriers and healthcare communication
“We are told that we have insurance, but many students do not know exactly how it works.”	Unclear coverage and reimbursement procedures	Financial and administrative uncertainty	Cost and uncertainty about student health insurance

2.6. Use of Descriptive Counts

Descriptive counts indicate how widely an explicitly coded experience appeared among the 20 interviews, with each participant counted once per category; overlapping categories are non-additive. Ambiguous accounts were excluded. Note-only accounts contributed only to categories explicitly documented in contemporaneous or expanded notes. Counts are neither prevalence estimates nor population estimates. First-person care experiences were distinguished in coding from observations, stories about other students, and broader community perceptions; the latter do not establish that the speaker personally encountered the event.

2.7. Ethical Considerations

Ethical approval was obtained from the Ethics Committee of Zhejiang Chinese Medical University (ZCMU) before data collection. Participants provided oral informed consent before each interview and separate oral permission for recording. Participation was voluntary, and participants could decline a question, pause, or withdraw without penalty.

Interviews involving sensitive topics were conducted in private or quiet locations on university campuses. Because all interviews were conducted in person, online-platform privacy procedures were not applicable. Sensitive domains were introduced as optional topics, and participants were reminded that they could decline to answer. When discomfort was observed or reported, the planned response was to pause or stop the interview, acknowledge the participant’s concern, and

provide information about available university or local support services when appropriate. The interviews were research interviews and did not include clinical assessment or treatment.

Direct identifiers were removed from transcripts, notes, coding files, and reports. No signed consent forms were created because consent was oral. To reduce deductive disclosure within a small national community, participant characteristics are reported in aggregate and quotation labels are not linked to detailed demographic profiles. Audio, transcripts, notes, codebooks, and memos were stored in password-protected files accessible only to the research team.

3. Results

Eight themes were developed: 1) health as the capacity to continue studying; 2) adaptation to climate, food, and daily life; 3) academic pressure and emotional well-being; 4) self-care, pharmacy use, and delayed formal treatment; 5) language barriers and healthcare communication; 6) cost and uncertainty about student health insurance; 7) trust, respect, and perceived differential treatment; and 8) peer, community, and transnational support. Visa concerns are presented as a cross-cutting negative case rather than a ninth theme. Responses to directed questions about sensitive domains and service improvements are reported separately and are not treated as additional themes. Counts refer only to this sample and categories may overlap.

3.1. Health as the Capacity to Continue Studying

Seventeen participants described health mainly in terms of being able to attend classes, conduct research, complete assignments, and manage daily activities independently. They did not necessarily define health as the complete absence of symptoms. Instead, minor symptoms were sometimes tolerated while academic work continued. Several participants explicitly linked academic obligations with postponing rest or deciding that professional care was not yet necessary. The accounts show an academic-continuity orientation, but the analysis does not label studying while ill as resilience or infer a causal pathway beyond participants' descriptions.

“For me, being healthy means I can wake up, go to class, do my assignment, and take care of myself. Sometimes I may have a headache, but once I can still study, I do not consider myself seriously sick.”

Participant P03

“When you are doing a PhD, even when your body is tired, your mind is telling you that you have work to complete. You may not rest because you are thinking about your proposal, publication, or supervisor.”

Participant P14

3.2. Adapting to Climate, Food, and Daily Life

3.2.1. Weather and Seasonal Changes

Thirteen participants discussed difficulty adjusting to Hangzhou's climate. Cold

weather was the most frequently described challenge, with reports of cough, dry skin, body discomfort, weakness, or recurrent cold-like symptoms. Some also described hot and humid summers. Participants who had lived in Hangzhou longer often described practical strategies such as obtaining suitable clothing or heating devices, but the interviews did not support a systematic residence-duration comparison. Recall may also have been influenced by the season in which interviews occurred.

“The first winter was very difficult for me. I was not used to that level of cold. I had a cough almost every month, and sometimes my whole body felt weak.”

Participant P04

3.2.2. Food and Nutrition

Fourteen participants described changes in eating after moving to Hangzhou. Accounts included difficulty finding familiar Liberian food, the cost of African ingredients, limited time to cook, irregular meals, and uncertainty about unfamiliar dishes. Nine described frequent reliance on instant noodles, takeaway meals, snacks, or other convenience foods during demanding academic periods. Seven participants associated these patterns with digestive discomfort, appetite or weight changes, tiredness, or a sense that their diet was “not balanced.” These were participant-attributed associations, not clinically verified effects. Shared cooking with Liberian or African peers reduced costs and also provided social contact.

“Sometimes you leave the laboratory late and you do not have the strength to cook. You just buy something nearby or eat noodles. When it continues for many days, you can feel that your body is not balanced.” Participant P12

3.2.3. Sleep and Physical Activity

Fifteen participants described irregular sleep. Contributing circumstances included late-night study, research deadlines, worry about academic performance, social-media use, and communication with family in Liberia across time zones. Twelve described frequent fatigue, and eight reported less physical activity after arriving in China. Academic schedules, weather, tiredness, and low motivation were cited as reasons for not using available sports facilities regularly.

3.3. Academic Pressure and Emotional Well-Being

Sixteen participants described academic pressure as relevant to their health. They discussed examinations, research deadlines, publication expectations, communication with supervisors, scholarship time limits, language difficulties, and uncertainty about graduation. During demanding periods, participants reported headaches, appetite changes, sleep disruption, reduced motivation, or persistent worry.

Eleven participants described periods of loneliness, especially during early adjustment, and 12 discussed homesickness during illness, holidays, family emergencies, or important events in Liberia. Participants often used everyday expressions such as “thinking too much,” “being tired in the mind,” “losing interest,” or wanting to remain alone. These expressions indicate how distress was de-

scribed in this sample but do not establish a psychiatric diagnosis. Four participants had considered professional counseling; others reported limited information, concerns about confidentiality, stigma, or the belief that the difficulty would pass.

“The pressure is not only from the school. Your family is expecting you to succeed, and you also know the scholarship has a time limit. When your research is not moving well, you begin to think too much.”

Participant P18

“Sometimes you are sick, and that is when you miss home the most. At home, somebody will prepare food for you and stay with you. Here, everybody has their own classes and responsibilities.”

Participant P09

3.4. Self-Care, Pharmacy Use, and Delayed Formal Treatment

Eighteen participants described self-care as their first response to minor illness. Practices included rest, warm water, medicines brought from Liberia, previously prescribed medicines, advice from friends, online searches, and pharmacy visits. Fifteen used pharmacies and described them as faster or more convenient than hospitals, although communication about symptoms and medication instructions could be difficult. Thirteen used online information or contacted health professionals or family members in Liberia, while also noting that online advice could be confusing or contradictory.

Twelve participants described at least one occasion when they postponed professional care. Reasons included expecting symptoms to resolve, uncertainty about cost or insurance, concern about missing academic work, language difficulty, and unfamiliar hospital procedures. Participants generally described seeking formal care when symptoms persisted, worsened, interfered with study, or did not improve after self-care.

“The pharmacy is easier because you do not need to go through many steps. But the problem is explaining exactly what you are feeling. Sometimes you use the translation application and hope they understand.”

Participant P08

3.5. Language Barriers and Healthcare Communication

Fourteen participants described language as a significant barrier across registration, symptom explanation, consultation, testing, payment, medicine collection, and follow-up. Basic conversational Chinese was often described as insufficient for medical terminology, detailed pain descriptions, previous health history, emotional symptoms, or private concerns. Nine participants had asked Chinese-speaking friends or classmates to accompany them, which could improve navigation but reduce privacy. Eleven used translation applications; these were considered useful for simple instructions but less reliable for complex explanations. Positive encounters were associated with providers speaking slowly, using simple language, writing instructions, and allowing time for translation.

“When it is an ordinary cold, I can ask my Chinese friend to follow me. But when the problem is private, you do not want your friend to hear everything between you and the doctor.”

Participant P11

3.6. Cost and Uncertainty about Student Health Insurance

Thirteen participants described costs influencing care decisions, including consultation, testing, medicines, transportation, advance payment, and uncertainty about the final amount. All reported some form of student insurance. Some described uncertainty about eligible facilities, covered services, documentation, advance payment, or reimbursement. The source summaries do not support a reconciled count for insurance understanding, so no frequency is assigned to it. Participants' accounts of their own payment or claims are treated as direct experiences; statements about what other students knew or encountered are identified as community perceptions and are not counted as the speaker's personal insurance experience. Some preferred clinics or pharmacies because costs seemed more predictable.

“We are told that we have insurance, but many students do not know exactly how it works. You may pay the money first, and later they tell you that a certain document is missing.”

Participant P05

3.7. Trust, Respect, and Perceived Differential Treatment

Nine participants described at least one positive healthcare encounter in which providers were patient, respectful, and professional. Trust was strengthened when providers listened, explained test results, answered questions, and allowed time for communication.

Some participants described or discussed perceived differential treatment, but the summary coding does not reliably separate first-person encounters from observation and secondhand accounts for all such reports. Accordingly, no count is presented as a count of participants personally treated differently. In contrast, P20's quotation below describes the speaker's own encounter and uncertainty about its cause. Participants considered Black or African identity, foreign status, language difficulty, and pressure in crowded clinical settings as possible explanations. Reports about other students and general perceptions are contextual accounts, not independently verified healthcare encounters or evidence of a particular provider's motive.

“I cannot say whether it was because I am African or because they were busy, but I felt the attitude changed when they realized I could not speak Chinese. They were talking quickly and wanted to finish.”

Participant P20

3.8. Peer, Community, and Transnational Support

All 20 participants described friends as a source of health support. Friends pro-

vided food, medicines, transport, translation, hospital accompaniment, financial assistance, and emotional encouragement. More experienced Liberian and African students shared practical knowledge about hospitals, pharmacies, grocery stores, and online services. Fifteen participants contacted family members in Liberia for advice, reassurance, money, or information about previous treatment. Eight described support from religious communities, and seven reported direct assistance from university staff. Participants nevertheless varied in their knowledge of formal university services.

“The first person I normally call is my mother because she knows my health history. After speaking with her, I may contact a friend here who knows which hospital to use.”

Participant P01

3.9. Cross-Cutting Negative Case: Visa Concerns Were Not a Direct Barrier

Most participants did not describe visa or residence-permit status as a direct barrier to seeking healthcare. Three participants instead connected prolonged illness with possible interruption of study, scholarship conditions, absence from class, or residence-permit renewal. Thus, where legal status entered the accounts, it was mediated through concern about academic continuity rather than fear of direct immigration enforcement. This negative case is reported to distinguish the present student sample from other migrant contexts without importing that comparison into the findings themselves.

3.10. Directed Sensitive Domains That Did Not Form Separate Themes

Questions about sexual and reproductive health and alcohol use were included as optional domains. The available accounts were not sufficiently detailed or recurrent to support separate themes in the present analysis. Limited disclosure should not be interpreted as evidence that such concerns were absent, particularly because these are sensitive topics within a small student community.

3.11. Participant-Informed Suggestions for Support

Suggestions were elicited directly from participants and are reported separately from author-derived implications. The most consistently endorsed suggestions were clearer English-language insurance information (17 participants), lists of recommended hospitals, pharmacies, emergency contacts, and registration steps (16 participants), trained international-student health navigators (14 participants), and more accessible, confidential, culturally responsive counseling (13 participants). Additional suggestions raised less consistently included confidential interpretation, peer-support groups, nutrition and climate-adaptation education, emergency assistance for serious illness, stronger university-hospital referral arrangements, regular health-promotion activities, and flexible academic arrangements during

illness. The study did not evaluate feasibility, provider acceptability, implementation, or effectiveness.

“Students do not only need insurance. They need somebody to explain where to go, what to carry, how to register, and what to do after treatment.”

Participant P17

4. Discussion

This study contributes four main interpretations. First, academic continuity organized how many participants defined health and judged the seriousness of symptoms. Second, formal student status and insurance did not eliminate practical barriers to healthcare navigation. Third, peer and transnational networks functioned as an informal care and navigation infrastructure, while also creating limits related to privacy and reliability. Fourth, climate, food, sleep, loneliness, and everyday language for distress show that adaptation was experienced through intertwined bodily, emotional, and social processes. These interpretations confirm some findings from broader migrant and international-student research, extend them to a rarely studied Liberian student group, and complicate assumptions that legal status or insurance alone ensure usable access.

4.1. Academic Continuity as an Organizing Logic

Participants frequently judged health by whether they could continue studying, conducting research, and managing daily tasks. This finding extends literature on international-student mental health, life transitions, and graduate-school well-being by showing how academic obligations can enter everyday decisions about rest and care, not only mental-health outcomes. The data do not establish that a productivity-oriented definition of health caused delayed care. Rather, several participants explicitly linked deadlines, scholarship conditions, or fear of missing work with postponing rest or professional assessment. This distinction avoids valorizing illness-related presenteeism while retaining the importance of academic context.

The finding also suggests that visible attendance or research productivity should not be treated as evidence of good health. Participant suggestions for flexibility during illness are therefore best understood as a request to reduce the perceived academic cost of seeking care. Whether particular arrangements are feasible or improve timely care requires institutional evaluation.

4.2. Formal Status, Insurance, and the Usability of Healthcare Access

The healthcare barriers described here overlap with research on African migrants in China, including language difficulty, unfamiliar procedures, cost uncertainty, communication, and trust. Transferability remains partial: these participants were enrolled students with university affiliation and reported insurance. Direct accounts of navigating or paying for care show that coverage did not always make

procedures clear. Participants also voiced broader perceptions about other students' insurance knowledge; these perceptions illuminate the community context but do not establish those students' actual coverage or reimbursement experiences.

Language affected the entire pathway rather than only the clinical consultation. Friends and translation applications helped with navigation, but friends could compromise privacy and applications were less trusted for complex explanations. The finding aligns with research showing that communication and patient-provider trust influence African migrants' healthcare experiences. First-person accounts of care and reports about other students are distinct forms of evidence. Participants' accounts also distinguish possible racialization, African identity, foreign status, and language proficiency as separate sometimes overlapping interpretive possibilities. The study cannot determine providers' motives, but it demonstrates that uncertainty about the meaning of an encounter can itself affect trust and willingness to return.

4.3. Peer and Transnational Networks as Informal Health Infrastructure

Friends, African student networks, family members in Liberia, religious communities, pharmacies, and online resources were not peripheral supports; they were central to how participants interpreted symptoms, selected services, obtained transport or money, and communicated with providers. This pattern is consistent with studies of informal coping and transnational health practices among African migrants and international students. It also aligns with evidence that social support is associated with international students' adjustment and mental health.

At the same time, informal systems have limits. Advice may be inaccurate, sensitive concerns may be withheld, and translation or emergency assistance may repeatedly burden a small number of experienced students. Participant support for trained health navigators can therefore be interpreted as a preference for combining the accessibility of peer networks with clearer institutional responsibility, confidentiality, and referral pathways. The present study identifies that preference but does not establish that a navigator program would be effective.

4.4. Embodied Adaptation and Non-Clinical Language for Distress

Participants associated cold weather, humid summers, unfamiliar food, irregular meals, limited sleep, and reduced activity with discomfort, fatigue, digestive symptoms, appetite changes, or weight changes. These are self-reported associations rather than clinically verified effects. The findings nevertheless show that adaptation was experienced through routine conditions such as laboratory schedules, food availability, time-zone communication, and shared cooking, not only through abstract "culture shock." Travel-health and international-student research similarly indicates that preparation, sociocultural adjustment, and daily living conditions

matter for health.

Participants often described emotional strain through everyday phrases rather than diagnostic labels. Such language may communicate distress that is not captured by clinical terminology, but it cannot be used to infer an unrecognized disorder. Reviews and empirical research on international-student mental health show that symptom interpretation, stigma, confidentiality, cultural meanings, and service knowledge influence disclosure and help-seeking. The finding supports presenting counseling in accessible, non-stigmatizing language while avoiding assumptions that every expression of pressure requires clinical treatment.

4.5. The Limited Role of Visa Concerns

Visa concerns were less prominent than language, insurance, cost, and academic continuity. This differs from research in migrant populations where precarious legal or economic status may directly shape healthcare decisions. The difference reinforces the need not to treat African migrants and international students as interchangeable. Yet legal status was not entirely absent: a small number of participants connected prolonged illness with interruption of study, scholarship requirements, or residence-permit renewal. In this sample, legal concern therefore appeared indirectly through academic status.

4.6. Participant-Informed Implications and Priorities for Evaluation

The strongest participant-informed priorities were clear multilingual insurance and hospital-navigation information, identifiable health navigators, and confidential, culturally responsive counseling. These requests are directly grounded in the reported barriers and can be considered first-order service needs. Other suggestions peer groups, interpretation, nutrition and climate education, emergency assistance, referral partnerships, health promotion, and academic flexibility were less consistently endorsed or emerged from smaller numbers and should be treated as secondary options requiring consultation.

Author-derived policy implications should remain cautious. Universities and local services could co-design and pilot navigation materials, confidential interpretation pathways, and counseling outreach with international students. Such approaches may address the barriers identified in this study, but feasibility, acceptability, equity, cost, implementation, and outcomes were not assessed. Academic support should not depend only on prior medical documentation, because obtaining documentation may itself be difficult for students facing access barriers. Literature on international-student support favors accessible and culturally adapted services, but local implementation requires evaluation.

5. Strengths and Limitations

A strength of this study is its focused attention to Liberian students, a group rarely examined separately within research on African migrants and international stu-

dents in China. The sample included undergraduate, master's, and doctoral students with varied lengths of residence, living arrangements, funding situations, language abilities, and prior healthcare experiences. This variation broadened the range of accounts, but the study did not conduct a systematic subgroup analysis and does not claim comparative findings by these characteristics.

The qualitative design connected physical symptoms, emotional well-being, climate, food, sleep, academic demands, healthcare access, trust, and social support within participants' everyday narratives. Participant quotations and an illustrative coding example improve transparency. Methodological rigor was supported through a structured codebook, reflexive and analytic memos, a dated audit trail, attention to divergent cases, and team review of codes and candidate themes. Interpretive differences were resolved by consensus after returning to the source data. Formal participant feedback or member checking was not undertaken, which may have limited opportunities to confirm the researchers' interpretations with participants.

Several limitations should be considered. First, the purposive sample of 20 students from five universities in one city was designed for depth and cannot estimate prevalence or represent all Liberian students in China. Second, self-reported accounts may be affected by recall, social desirability, and reluctance to discuss sensitive physical, sexual, reproductive, alcohol-related, or emotional concerns. Direct recruitment may also have underrepresented students who were difficult to approach or unable to participate; five eligible students declined because of busy schedules. Third, the cross-sectional interviews did not follow changes across academic stages or repeated healthcare encounters. Data were collected from April to June, during spring and early summer, so accounts of winter conditions were retrospective and the findings do not capture experiences across a full annual cycle. Fourth, the study did not include healthcare providers, university administrators, insurers, or family members and therefore cannot determine institutional motives or independently verify service experiences.

Fifth, the number of note-only interviews and their contribution by theme remain to be verified against the interview inventory and coding matrix. Notes may contain less detail than transcripts; note-only material was counted only when an experience was explicitly documented and was quoted verbatim only if exact wording had been recorded contemporaneously. Sixth, shared Liberian background may have supported trust while also shaping responses or assumptions of shared meaning. Any pre-existing interviewer relationships require verification and disclosure. Seventh, optional prompts could have influenced responses, so themes close to guide domains require caution. Finally, reported health concerns and perceptions of differential treatment were not independently verified; secondhand accounts must not be read as personal clinical encounters.

6. Conclusion

Within this sample of 20 Liberian students in Hangzhou, commonly reported ex-

periences included climate and food adjustment, irregular sleep, fatigue, academic pressure, loneliness, language barriers, cost uncertainty, incomplete understanding of insurance, and postponement of formal care. Participants often evaluated health in relation to their ability to continue studying, and some explicitly connected academic obligations with delayed rest or care. These findings are sample-bound and do not establish population prevalence or causal effects.

Participants relied heavily on self-care, pharmacies, friends, African student networks, online information, family members in Liberia, religious communities, and selected university staff. These networks provided essential support but did not replace understandable insurance procedures, confidential communication, and accessible formal services. Participant-informed priorities included multilingual navigation and insurance guidance, trained health navigators, confidential interpretation, accessible counseling, and academic support during illness. In Hangzhou and similar settings, these approaches may address identified barriers, but broader relevance and effectiveness should be tested through co-designed implementation and outcome evaluation.

Declarations

Ethics approval and consent to participate.

Ethical approval was obtained from the Ethics Committee of Zhejiang Chinese Medical University (ZCMU) before data collection. Oral informed consent and separate oral recording permission were obtained as described in Methods. Participation was voluntary, and participants could decline questions or withdraw without penalty.

Consent for Publication

The manuscript reports only de-identified quotations and aggregate findings. No information that directly identifies an individual participant is included.

Availability of Data and Materials

Because the interviews concern a small national student community, the full transcripts and interview notes are not publicly available due to confidentiality and deductive-disclosure risks. Reasonable requests for appropriately de-identified materials may be considered by the corresponding author, subject to ethical requirements and protection of participant privacy.

Competing Interests

The authors declare that they have no competing interests.

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Author Contributions

Conceptualization of the Study: **Surkula Tarweh P.** Methodology: **Surkula Tarweh P.** Data Collection: **Surkula Tarweh P. and Kamara Sedeke Mohammed.** Transcribed the Recorded Interviews: **Surkula Tarweh P.** Conducted the Initial Coding: **Surkula Tarweh P. and Kamara Sedeke Mohammed.** Formal Analysis and Wrote the Original Manuscript Draft: **Surkula Tarweh P.**

Review and Editing: **Yunxian Zhou.**

Supervision: **Yunxian Zhou.**

All authors have read and approved the published version of the manuscript.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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Appendix A. Semi-Structured Interview Guide

The guide began with open primary questions. Optional probes were used only after participants had answered in their own terms, when clarification or elaboration was needed. Probes were not read as a checklist, and the interviewer did not assume that a listed experience applied.

Can you tell me about your everyday experience of staying healthy while studying in Hangzhou?

What changes, difficulties, or positive experiences have affected your health since coming to Hangzhou?

When you feel unwell, how do you decide what to do?

Can you describe a time when you sought—or decided not to seek—help for a health concern?

What has your experience been with healthcare services or other sources of health advice in Hangzhou?

How have your studies and daily routines affected your physical or emotional well-being?

Who supports you when you have a health concern, and how?

Are there health topics that are difficult to discuss or seek help for? You do not need to share anything you prefer to keep private.

What kinds of health support would be most useful from your university, healthcare services, or student community?

Is there anything important about your health experience in Hangzhou that I have not asked about?

Optional follow-up probes

Meaning and examples: “What does being healthy mean to you?” “Can you tell me more about that experience?”

Daily living: weather, food, sleep, exercise, housing, academic schedules, and communication across time zones.

Care pathways: self-care, pharmacy, campus clinic, hospital, online consultation, advice from family or professionals in Liberia, and traditional or familiar remedies.

Navigation: registration, communication, interpretation, privacy, payment, insurance, documentation, follow-up, and time away from study.

Emotional well-being: pressure, loneliness, homesickness, worry, loss of motivation, coping, and awareness of counseling.

Sensitive domains, only with permission: sexual or reproductive health information and services; alcohol use or other lifestyle concerns. Remind the participant that they may decline.

Support: friends, Liberian or African student groups, family, religious communities, Chinese friends, university staff, embassy/community organizations, and healthcare workers.

Improvement: what should change first, who should provide it, and what might make the proposed support acceptable or difficult to us.