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"I have a divine call to heal my people": Motivations and strategies of Nigerian medicine traders in Guangzhou, China

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Abstract

This case study explored the motivations and strategies of Nigerian medicine traders in responding to the health-care demands of co-migrants in China using observations and interview data from two Nigerian medicine traders in Guangzhou. The medicine traders initially responded to a 'divine call' but they shared similar economic motivations to survive, served predominantly African clientele and relied on 'flyers' and family networks to source for medicinal commodities between Nigeria and China. They were similar and different in certain respects and their undocumented statuses affected them in Guangzhou. The case study showed how survival pressures produced African health entrepreneurs in China.

Keywords: *China-Africa relations; health accessibility; health entrepreneurship; traditional African medicine; undocumented migrants.*

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Introduction

The role of migration as a social determinant of health has gained currency in research and global policy fields (Arnold et al., 2014; Fleischman et al., 2015; Zimmerman et al., 2011). Globally, people on the move experience health barriers at departure, during migration, and upon arrival at their destinations, and access to health services sometimes functions as a mechanism for distinguishing between citizens and aliens (Quesada, 2012). At their destinations especially, studies have documented the dimensions of the barriers that migrants experience (Biswas et al., 2011; Boateng et al., 2012; Czapka & Sagbakken, 2016; Ransford et al., 2010) and how the barriers expose them to vulnerabilities (Derose et al., 2007; Quesada, 2012), deportation fears (Fleischman et al., 2015) and poor integration into the host society (Czapka & Sagbakken, 2016).

In China, where more African migrants have congregated in the last two decades, access to health-care has remained a major challenge (Hall et al., 2014; Lin et al., 2015). For instance, while acknowledging that the growing presence of Africans in Chinese cities creates new health service needs, a widely distributed commentary reveals that racism, visa challenge and limited health-care accessibility impact on the quality of life of Africans in China (Hall et al., 2014). In accessing health-care, they experience affordability, legal, language and cultural challenges while documentation problems, discrimination and racist views towards Africans as disease carriers also impact negatively on their experiences in the Chinese health institutions (Davis et al., 2016; Lin et al., 2015; McLaughlin et al., 2014; McLaughlin, Simonson, Zou, Ling, & Tucker, 2015). In

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addition, problems at the interpersonal, health system, and sociocultural levels undermine the trust between African migrants and Chinese doctors (McLaughlin et al., 2015). A study probing the commonalities and differences in health conditions and health-seeking practices of African and Chinese internal migrants finds out that, apart from reporting language as a barrier to accessing health provisions, more Africans than Chinese-internal migrants complain about long waiting time, high cost, low knowledge about doctors' location and poor treatment, low comfortability with health-care professionals, and non-availability of the preferred care (Bork-Hüffer, 2016).

In response to these health barriers in China, African migrants explore alternative strategies such as engaging in self-medication, seeking out in-training African doctors for help and; recruiting friends, Chinese partners or other networks to serve as interpreters in hospitals (Lin et al., 2015). There are also African migrants who return to their countries of origin or travel from Guangzhou to nearby Chinese cities, such as Hong Kong, to access health-care (Bork-Hüffer, 2016). However, how the migrants themselves fill in the health needs and inaccessibility gaps, through the establishment of a medicine trade, is largely missing.

Using observation method and data obtained from face-to-face interviews with two Nigerian men, this study shows how African migrants constitute themselves into health entrepreneurs through their medicine trade in China. Our case study profiles them and describes their motivations and strategies, their commonalities and differences, and how the prevailing circumstances in Guangzhou shape their business. Our contribution transcends the 'migrants as health-seekers' theme as it brings to the fore the entrepreneurial drive of the African migrants in China. The contribution emphasises how international migrants fix themselves in the health service provision corridor by catering to the unmet health needs of migrants in Guangzhou City.

Methodology

Study design

This exploratory case study drew from the more extensive research on the settlement experiences of Nigerians in Guangzhou, China. As one of the earliest Africans to move into mainland China, Nigerians are the most populous African group in Guangzhou (Bodomo and Pajancic, 2015). Consequently, some Nigerians have established many micro-economies, including the medicine trade, to meet the varied needs of this populous migrant community.

The first author conducted the fieldwork over two separate visits to Guangzhou (January to February and September to October 2017). He observed a total of six medicine shops in addition to the several informal conversations with medicine traders targeting the African migrants. The first author carried out participant observation in medicine trade spaces (or shops) in some sections of the city. However, he purposively selected two Nigerian men, Fredrick and Buchi, and engaged them in in-depth interviews. In a city dominated by trade in clothes, bags, shoes, small and large machinery, as well as other associated services like shipping and cargo businesses, medicine trade is unique. Our participants are from the Igbo ethnic extraction of South-eastern Nigeria, and there are more Igbo people in China than the other Nigerian ethnicities (Adebayo & Omololu, 2020; Haugen, 2012).

As at the time of the fieldwork, the first author who conducted the interviews was a doctoral student in a Nigerian university. His attention was drawn to the medicine traders after a short encounter with one of them at an apparel store where the first author was serving as an apprentice

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– a type of job known to many Nigerians as *sampa*. The selected participants were from the Igbo ethnic extraction of South-eastern Nigeria but the two authors are from the Yoruba group which is found predominantly in South-western Nigeria.

Data collection

The first author probed the participants to share their motivations and medicine trade strategies based on prompts that emerged from the pre-determined questions. They were encouraged to reflect on the meaning that the trade had for them as Nigerian migrants in a Chinese city. As shown in Table 1, the participants had, between them, more than 15 years of continuous presence in Guangzhou and had engaged in other types of work before venturing into the medicine trade.

Table 1. Background information on the Nigerian medicine traders

	Age	State of origin/ Ethnicity	Marital status	Previous travels	Years in China	Previous occupations	Migration status
Buchi	**50**	Anambra/ Igbo	Married	Yes (India and Cote d'Ivoire)	10	International trade, Motorcycle rider, food vending,	Undocumented
Fredrick	**42**	Anambra/ Igbo	Single	No	5	Medicine trade, Apparel trade	Undocumented

Face-to-face interactions with the participants took place where they conducted their trade although minor exchanges occurred with one of them over a social media platform to collect multimedia files and documents or fact-check some assertions. The participants were duly informed about the purpose of the research and they gave their verbal consents. The researcher conducted the interviews both in the English language and Pidgin English (a language which is widely spoken in Nigeria).

Data analysis

We developed the observational notes into detailed field notes and processed them along with the transcribed interviews using NVivo 11. The authors read the texts repeatedly to identify general patterns. The authors initially organised the data into themes such as 'participant profile,' 'motivations,' 'similarities and differences in medicine trade strategies,' and 'challenges experienced' in conducting the trade. A focused reading of the themes was used to develop narratives about how the participants construct their involvement in the medicine trade. The authors presented the data through ethnographic summaries and direct quotes.

We obtained ethical clearance from the Social Science and Humanities Ethics Review Committee (SSHE) of the University of Ibadan, Nigeria (UI/SSHEC/2015/0029). Since the participants were undocumented and did not register to sell medicinal products, they initially expressed some fear for their safety. The authors applied core ethical principles before, during and after the data collection and in the reporting process. We adopted further risk mitigation measures such as the anonymisation and vague descriptions of all the personal identifying information,

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including the names and locations of the participants. The narrow scope of the case study was a limitation. For instance, because the authors focused on the medicine men alone, we excluded the perspectives of their clients. Hence, the nature of client-medicine men relations could not be determined. Despite this, our research provides valuable insights for designing further and potentially generalisable studies on the topic.

Motivations for medicine trade: 'Divine call' and survival in Guangzhou

Before starting the medicine trade, both participants experienced business failures which they attributed to the shady dealings of their family members and friends. Fredrick previously sent goods between Nigeria and China for survival but lost his investments to relatives and friends who collected goods but refused to deliver the proceeds. 'They can't give an account of the money, and I can't institute a case against them,' explained Fredrick. Similarly, Buchi attributed his past failures to the occult people of his village in Nigeria.

However, both participants foregrounded their decision to engage in medicine trade as a 'divine call' that was passed down supernaturally and communicated to them by a 'Man of God.' The 'Man of God' at the centre of this narrative is a Nigerian Catholic Reverend Father who visited Guangzhou twice on a religious mission. Many times, Fredrick and Buchi alluded to how God inspired them to take on the medicine trade.

On his part, Fredrick was attending a 'special service' when he received his call. As he said, the Reverend prophesied that 'there is somebody here [in the congregation] that can heal people; that the person cannot be favoured doing any other business' (Fredrick/IDI/42 yrs./2017). Similarly, Buchi, who attributed his past failures to the occult people of his village in Nigeria, also traced his medicine trade to a divine call. He recalled that, before the prophecy:

> anything I put hand fails... …So, when that man came, he began to tell me things [i.e. prophesy]. After he delivered me…I stopped my food business [and took up the medicine trade]. (Buchi/IDI/50 yrs.)

However, their repeated reference to 'divine call' as a motivation concealed two other significant motivating factors for engaging in the medicine trade. First, in China, both of them were experiencing structural and legal barriers which made the exploration of an alternative livelihood expedient. On the one hand, finding legal employment as a foreigner was difficult. With over a billion people in China, Buchi asked, 'where is the work?' The unemployment situation is particularly worse among the low-skilled Africans who are mostly over-stayers and without the right to work legally in the city (Haugen, 2015, Lan, 2017). This situation constituted a state of 'undocumentedness' for Fredrick and Buchi as their visas had expired long ago.

Without any employment and with a low prospect of finding a paid job, Fredrick and Buchi tried their hands on transnational trade between China and Nigeria. However, they were not successful transnational traders because the business was seasonal and highly sensitive to the global currency fluctuation. Besides, Fredrick and Buchi lost a large chunk of their investments to their Nigerian relatives who mismanaged the returns on the goods sent to them. It, therefore, became necessary for these Nigerian migrants to find another means of livelihood in Guangzhou.

Second, the participants recognised a gap in the health-care access of their co-migrants in the city and felt that they could leverage it for profit. On the one hand, Buchi perceived that Africans in China lacked access to 'quality medicine,' that 'whatever drug they manufacture in China, they

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do it according to their blood [that is, manufactured specifically for Chinese people]; and our [Nigeria/African] blood is thicker than Chinese blood.' As such, he felt that culturally appropriate medicine should be made available to Africans in China. On the other hand, they perceived that their co-migrants were suffering from poor health and dying. In Fredrick's view, many Nigerians were dying; 'as at early 2008, 2009, 2010, 2011, 2012, people were dying.' Both of them agreed that some of the deaths resulted from the spread of sexually transmitted infections and the proliferation of 'fake' and sugary foods and drinks in the African-dominated areas. Moreover, the medicine traders believed that the high cost of care in Guangzhou and, lack of work and income resulted in the migrants not being able to access prompt, appropriate, and adequate medical care. That reason, for them, made access to cheaper alternative care urgent.

Modalities of medicine trade

The Nigerian medicine traders employ various practices and strategies in conducting their trade and those strategies differ from one trader to the other. On similarities, both have the same national and ethnic origin, and ground their motivations in a divine call or prophesy. Also, Fredrick and Buchi are operating close to each other within the same 'safe zone.' Along with many other undocumented Nigerians in the city, they have established a base outside Guangyuan Xi Lu where police crackdown on undocumented foreigners is minimal. Unless there is a concern from the very top provincial or national authorities, the authors learnt that the police authority seldom conduct visa raids on undocumented Africans in areas that fall under the safe zone. Buchi, in particular, mentioned that they do not run from the regular Chinese police in the safe zone '…because they are not coming for [immigration] papers.'

Another similarity is that they rely commonly on people known as 'flyers,' the freely moving Nigerian migrants who transport goods between Nigeria and China. While family and friends in Nigeria source for roots, fruits, and leaves for traditional mixtures and shop for various Over-the-Counter (OTC) drugs, the flyers function as 'people as infrastructure' (Simone, 2004, pp. 407, 419) to facilitate the safe arrival of medicinal products in Guangzhou. Being 'people as infrastructure,' flyers and medicine traders engage in a socio-collaborative act which modulates and moderates the flows and exchanges among groups that are ordinarily spatially segregated. That the participants are undocumented, and therefore, unable to return home freely, makes the flyers even more central to their operations. Explaining how he came to rely on flyers, therefore, Buchi asked: 'How can I bring it [i.e. medicine] when I don't have money and visa in China? My movement is restricted. I don't have a valid document.'

Besides their mutual dependence on flyers, 'client selectivity' is also a standard feature of their practice. Client selectivity implies the exclusion of non-Africans, especially Chinese, from the clientele pool. According to them, withholding services from the Chinese people is necessary because (1) their medicine business is technically an 'illegal' operation; (2) both of them entered China on a business visa which does not permit them to work; and (3) their visas had expired and this means that their continued presence in China is 'illegal.' Beyond the legal grounds, however, the exclusion of the Chinese helps the medicine traders to avoid potential troubles with the government. As Fredrick insisted, 'when I treat Chinese, it means that I am looking for trouble.' Similarly, Buchi said 'I don't give Chinese my medicine because it may bring a problem that can affect my stay in China.'

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Having described their similarities, some differences between Fredrick and Buchi are worth highlighting. Their trajectories reveal some differences in business models, experience and practices of disease diagnosis. While Fredrick trades in Traditional African Medicine (TAM) only (a single item model), Buchi combines TAM and Western medicines and sells them alongside Nigeria-made and imported provisions and daily need items (a plural item model). The differences show the variation in their level of medicine trade specialisation. The distinct models allow them to attract unique and diverse clientele. It also enables them to provide services that meet the varied needs of the African migrants.

Second, Fredrick and Buchi have different background experiences. Much like his family members who now work as doctors and nurses, Fredrick learnt about herbal roots from childhood. He also sold TAM in Nigeria before departing for China. On the contrary, medicine trade for Buchi was something he 'saw in the dreams; something he needed to start.' The dissimilarity of experience between the two medicine traders has influenced their understanding of illness too. Whereas Fredrick gives reasons for administering alcohol or water-based medicine to his customers and explains drug interactions to them, Buchi does not make an effort in these areas.

However, the authors observed the most significant difference between the participants in the areas of disease diagnosis and modality of health service provision. While the medical diagnosis is a significant part of Fredrick's trade, Buchi shows little interest in this. From the observations at their shops, Fredrick probes to know the details about the client's health history before prescribing medicines. When Fredrick wants to be sure that his client has a 'sugar problem', he may direct them to self-test by tasting their early morning urine. If the client reports that his urine is salty, Fredrick could direct him/her to the '…hospital, [to] conduct the test and return to tell [him] the result.' When a client delivers the test result, Fredrick transfers it to his Chinese girlfriend for due interpretation because of his language limitation. He once refused service to a prospective client who was unwilling to talk about his condition.

Also, Fredrick, unlike Buchi, does not merely sell medicines to the other migrants for cash; he combines some healing modalities to restore the clients' full health. For example, in medicine preparation, he organises private prayer sessions in a 'chapel' at his apartment. In one photo that he shared, a tiny space with the appearance of a private shrine was visible. There were also alligator pepper, kola, rosary, bottle of holy water, olive oil, bible, medical laboratory test report and self-branded bottles of herbal mixtures on the table. He said, 'I must pray very well with candles and olive [oil].' In another photo, Fredrick kneels before sealed bottles of herbal mixtures by a row of seats in the auditorium of a famous cathedral in Guangzhou. He would later explain that specially ordered herbal mixtures undergo a 'purify-sanctify-fortify' process to improve their potency. Fredrick's multimodal approach aligns with the practice in Africa where healing occurs on a spectrum with different combinations of healing forms deployed according to the needs of the clients.

Discussion

Fredrick and Buchi have constituted themselves into health entrepreneurs to fill the gaps in the health service provision of the Guangzhou City. Such health entrepreneurship is mostly hidden from the literature on African migrant experiences, particularly in the Asian context. The fact that such business activity is unsanctioned and informal may have contributed to this (see Stoller, 2002). The

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authors observed, however, that in a bid to get by, our participants have established a livelihood that enables them to survive and bridge the health gaps for their co-migrants.

Unsurprisingly, TAM predominates the services that are offered by the Nigerian medicine traders. Given the high prevalence of the use of complementary and alternative medicine in Nigeria, with up to 84.7% of the adult population using biological products and spiritual therapies (Okoronkwo et al., 2014), the medicine traders are leveraging the familiarity of migrants with TAM. In Nigeria, people in need of health-care rely on spiritually grounded traditional medicine to cure mild and chronic ailments (Agunbiade, 2014; Akanle et al., 2017). Regardless of the differences in class, age, ethnicity and religious affiliation, many subscribe to a worldview in which God, ancestors, gods and other spiritual realms collapse into one to determine people's health and illness statuses (Ganyi & Ogar, 2012; Omonzejele & Maduka, 2011). In particular, members of the Igbo ethnic group, which most of the participants' clients likely belong to, are brought up knowing about diviners (*Dibia Afa*) and traditional medicine men (*Dibia Ogwu*) who invoke the personal, natural, social and spiritual worlds to explain and treat illnesses (Nwankwo, 2014). Hence, familiarity plays a vital role in that it provides the impetus for venturing into a trade that the traders know has a ready market.

Moreover, the legitimation of medicine trade as 'divine calling' and, combining African and non-African medicinal commodities reveal the ingenuity of the health entrepreneurs. In diagnosis, for instance, one medicine trader mimics known procedures in biomedicine and utilises the paraphernalia and symbols of healing that invoke an African healing outlook and practice. He also incorporates mainstream religious practices by subjecting his herbal preparations to an elaborate ceremony of prayers, in public and private spaces. With a private chapel at home and the transcultural materiality of healing and spirituality, he has constituted himself into a diviner, a traditional doctor and a faith healer wrapped into one person to deal with '…the complete person, and provides treatment for physical, psychological, spiritual and social symptoms. …[N]ot separate[ing] the natural from the spiritual, or the physical from the supernatural' (Truter, 2007, p. 57). Although their medicine business is partly a product of situational and occupational contingencies, their entrepreneurship is useful for thinking about the notion of therapeutic syncretism (Upvall, 1993) on the move, whereby migrants offer a mix-and-match of health-care provisioning to other migrants in response to opportunities and constraints in destination societies.

The involvement of Nigerians in medicine trade calls attention to an emergent but under-reported pattern in contemporary Africa-China interaction in the area of health. Much like Chinese entrepreneurs exported the Chinese ways of healing to East Africa (Hsu, 2002, 2007), African healing practice is flowing into China through the entrepreneurship of the Nigerian migrants. The authors argue that the bidirectional flow presents opportunities to explore Africa-China interaction through comparative and transnational lenses. It also allows us to probe the in-built inequalities and hierarchies in the structure of the global flow of health practices in the Global South. For instance, whereas Chinese entrepreneurs establish health clinics that target and serve the citizens of their host countries (see Hsu, 2007), Nigerian medicine traders are unable to do the same. Instead, Nigerian medicine traders withhold their services from the Chinese people and draw their clientele mainly from the pool of African migrants. Compared to their Chinese counterparts in Africa, therefore, Nigerians are serving other migrants who are, perhaps, equally undocumented and living at the margin of the host society as themselves.

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The authors must emphasise that the health entrepreneurship of Fredrick and Buchi is not a new phenomenon among African migrants. In global cities like London, Paris and New York where Africans from diverse nationalities reside in millions, African medicine traders set up shops and sell to African migrants, sometimes, clandestinely (Kane, 2012; Stoller, 2002; Thomas, 2010). Like our participants, they also maintain a back and forth over health-related exchange through what is called 'medicine remittance' (Kane, 2012), a phenomenon that is exemplary of the dual circulation of healing practices (Carvalho, 2012).

However, the practices of Fredrick and Buchi in Guangzhou are unique in certain respects. First, the complex mix-and-match of healing by Fredrick, which runs from the traditional to the Western and covers the physical and spiritual with additional performativity that relies on culturally-produced symbols, has not been reported in other settings. Second, our participants operate in a setting with a strong tradition of traditional medicine patronage (Chung et al., 2014). This context differs remarkably from the Western societies where African migrants are known to also circulate as medicine traders. Third, this case study has allowed us to ascertain the critical role of differently positioned actors such as flyers in the organisation of African medicine trade and circulation of medicinal commodities between the origin and the destination countries. The flyers are not just family members who circulate medicines in the other settings (Kane, 2012), but human infrastructures that remediate the healing potentialities in the age of borders and 'illegalisation' of people. Finally, with the withholding of medicinal commodities from Chinese, our case study further shows how 'undocumentedness' and operational illegality limit the cross-cultural exchange of medicinal commodities between migrants and citizens.

Conclusion

Despite the structural and legal impediments in Guangzhou, including lack of job opportunities and valid immigration papers, Nigerian medicine men have demonstrated a willingness to integrate themselves into China through health entrepreneurship. In a Chinese city where Africans typically move in to take advantage of the commodity economy, Fredrick and Buchi have been constrained to build a livelihood in a trade they did not anticipate. Survival pressures and entrepreneurship created 'accidental' medicine men. More in-depth studies should explore the connections of health entrepreneurship and syncretic healing in migrant communities. Mainly, how 'medicine men' are creating a business around unmet health needs is worthy of further exploration on a larger scale than the current attempt. Exploring this will enrich our understanding of the dynamics of health maintenance among African migrants in emerging migration destinations. Policy efforts should also be directed at expanding the access of African migrants to health services given their intensifying presence and settlement in China.

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