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Health Communication with Chinese Migrant Workers: Dialogue as an Analytical Framework

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Abstract

Invoking Kent & Taylor's model of dialogic public relations as an analytical framework, this study attempts to explore if communication between Chinese government health officials and migrant workers on sexually-transmitted diseases (STDs) could be dialogic in practice, and if so, how. The results out of a survey, focus-group meetings and interviews indicate that, first, the socially-marginalized migrant workers' need for dialogic communication, and the government health officials' willingness to apply dialogic approaches, prove to be the *potentials* to initiate dialogue between the two; second, the potentials seem *insufficient* to warrant genuine dialogue due to the functioning of several constraints. Furthermore, this study suggests possible remedies of these constraints, including growing a dialogic culture in society, reducing governmental control or interference, providing training based on dialogic principles and/or practices, and finding innovative ways of using social media to facilitate the dialogue.

Keywords: Dialogue, dialogic communication, organization-public relationships, health communication, Chinese migrant workers, Chinese health officials

1. Introduction

While recognized as a viable field of academic and public concerns in western world, health communication has recently begun to gain attention in China (Yu & Lu, 2011). Health communication in China has a unique community to tackle: *nongmingong* or migrant workers, referring to young-middle aged farmers and residents from impoverished areas relocating themselves to urban areas for better-paid jobs. With its number reaching 277.5 million at the end of 2015 (National Bureau of Statistics, 2016), communication focusing on the prevention of sexually-transmitted diseases (STDs) with this humongous group became one of the toughest challenges (Xue, 2012; Wang, 2014). Government health prevention and disease control centers and their officials are, as usual, called upon to tackle this problem (Yu & Lu, 2011). In China, health communication is more of a governmental function than none-governmental ones because Chinese cultural tradition emphasizes that the ruler is to look after the ruled; while the socialist tradition stresses the government shall shoulder the responsibilities for taking care of its people's welfare.

Dialogue, defined as "an orientation that value[s] sharing and mutual understanding between interactants" (Taylor & Kent, 2014, p. 388), is believed to promote the establishment of organization-public relationships via communication in an ethical, humane and just way. If so, it is applicable to communication between Chinese health officials and migrant workers on STDs. Hence, this study applies Kent and Taylor's model of dialogic theory as an analytical framework to examine, first, how desirable dialogic communication is to both Chinese migrant workers and government health officials; second, how dialogic the communication between the two may become; and third, what factors, if any, may restrain the process by the measurements of dialogic communication principles.

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2. Literature review and research questions

The concept of dialogue has recently gained currency among PR scholars and professionals. Different from positioning public relations as scientific management of communication (McAllister-Spooner, 2009), dialogic public relations is argued as a tool to help construct relationships between organizations and publics "in the genuine, communicative, interpersonal sense, that are not manipulative or self-serving, but mutually satisfying" (Kent, 2017, p.4).

Drawing on humanistic principles such as trust, unconditional respect for the other, empathy and sympathy, Kent and Taylor (2002) synthesized five principles of dialogue, which included (1) mutuality – an acknowledgement that organizations and publics are "inextricably tied together" (p. 25) to achieve mutual understanding; (2) propinquity – an idea that organizations make themselves accessible to their publics, physically and emotionally alike; (3) empathy – a requirement that organizations recognize the importance of their publics' views, no matter how disagreeable they are; (4) risks – a recognition of "the strangeness of others" (p. 28) and seeing the differences between organizations and their publics, even though entailing uncertainties, as valuable contributions to dialogue; and (5) a commitment – adherence to the process or "genuineness or authenticity" (Bentley, 2012, p. 6), as well as willingness to avail one another the benefit of the doubts when understanding the other side's positions.

These dialogic-communication principles shall prove applicable to the communication between health officials and the Chinese migrant workers on STDs-related. Literature has identified a close link between migration and health problems, both physically and psychologically (Nie & Feng, 2013; Li & Rose, 2017) due to the social-economic inequality, stressing that migrants often suffer from economic hardship, social stigma and discrimination, and personal inability to access public services.

As China is made of a vast land with varieties of regional geographies, cultures, languages and lifestyles, migrant workers are bound to struggle to adapt to urban and unfamiliar areas. Due to the *Hukou* (household registration) system that limits public services only to the locally registered residents, migrant workers without local registration are restrained in employment, health care, education, housing, and other social benefits (Beijing Youth Daily, 2017). In addition to expectation-reality discrepancy and family separation, migrant workers also have to combat acculturation stresses deriving from language barriers, conflicts in values, stigmatization, attitudes and lack of social support networks (Chen, 2011; Nazroo & Iley, 2011; Gui, Berry, & Zheng, 2012; Mou, Griffiths, Fong & Dawes, 2013; Li & Rose, 2017). With these socioeconomic barriers to overcome, a majority of Chinese migrant workers still lives in social exclusion (Li & Rose, 2017).

Their social status, indeed, fits well with what the concept of marginalization describes (Vasas, 2005). Being socially excluded, their needs are ignored, ending up with no voice, identity, or place in societies (Hansen, 2012; Schleicher, 2014). Through direct or indirect processes, they are made to feel less important than urban residents do. It is documented (Jiang, 2016) that Chinese migrant workers enjoyed much less rights than urban residents, including but not limited to: insufficient protection either in or outside of work, taking up low-pay and labor-intensive jobs that urban residents distain, poor housing/working conditions, lack of opportunity for education or training, and more seriously, insufficient guarantee of minimum social security/pension or medical benefits.

Being marginalized, Chinese migrant workers appear vulnerable particularly, when it comes to public health issues such as STDs. Their health impact derives largely from the ways in which they work, socialize and live. Most of the migrant workers live separately from their spouse and family, and consequently, suffer from a sexual depression. Their low level of education and income results in a low level of health literacy on STDs (Li, Lin & Chen, 2016). Consequently, this highly mobile group can be both victims and vectors of infectious diseases. Migrants are found more likely to catch communicable diseases, such as acute respiratory infections, diarrheal, parasitic, and sexually transmitted disease and tuberculosis (Wang, 2014). More specifically, the connection between migration and the spread of human immunodeficiency virus (HIV) has been confirmed (Yang, Gao, Wang, Yang, Liu, Shen, & Zhu, 2017; Yang, 2014; Xue, 2012). It's because migrant workers are more likely to engage in HIV/STI-related risk behaviors, subject to a high risk for STI and HIV infections (He & Cao, 2014). Meanwhile, they are largely excluded from urban services including public health-care. Only 16.9 percent of Chinese migrant workers had limited medical insurance by the end of 2015 (Jiang, 2016).

RQ1: *Do Chinese migrant workers see themselves as socially marginalized and, thus, feel vulnerable to STDs?*

Suffering from the above-discussed social, physical, and psychological strains, Chinese migrant workers are bound to feel worried about STDs.

Their anxiety to acquire the relevant health information and help can be high (State administration for industry and commerce, 2009). However, there still exists a taboo in Chinese culture that treats STDs as "dirty" diseases and perceives the people who suffer from STDs as guilty of committing adultery, prostitutes, or "irresponsible sex" (Xue, 2012; He & Cao, 2014).

Always looking up to government for assistance, they might be in great need for the STDs-related information from and help by government health officials. There were, however, reported complaints by Chinese migrant workers about the ways that government agencies, public hospitals and social groups treated them (Chinagate.com, 2012). Urban dwellers seemed to harbor mixed feelings toward them. On the one hand, they are needed for jobs that urban residents normally would not want to take; on the other hand, they are seen as outsiders with potentially high risks to disrupt urban way of lives. When STDs became a public concern in cities at the turn of the century, the migrant workers were among the first to be finger-pointed as a major source of STD spreading and targeted as the groups for STD prevention (Nie & Feng, 2013). At the frontline, officials of government health offices and disease control centers quickly -- often heavy-handedly -- approached the identified groups of migrant workers. In the name of safeguarding the urban community, their measures ranged from mandatory attendance by migrant workers to publically-held education sessions on STDs, to surprise home and workplace visits, neighborhood watch and, in some extreme cases, forced blood tests (State administration for industry and commerce, 2009). Not surprisingly, the migrant workers felt that they were wrongfully targeted and unjustly treated. In their view, this was so all because that the government health officials looked down upon them (Nie & Feng, 2013; Wang, 2014). Hence,

RQ2: *Do Chinese migrant workers long for the STDs-related information to be communicated to them from government health officials in a fair, respectful, indiscriminating, or dialogic fashion, being treated as equals?*

Recently, there have appeared encouraging changes. Vowed to curtail some of the critical social problems deriving from the fast industrialization, the current regime calls for installation of such social and humanistic values as equality, justice and fairness, as well as respect and empathy. Advocating "government for the people," it requires government authorities to pay particular attention to the socially marginalized and economically underprivileged so as to ensure that these people also "share the dividends of China's economic growths" (State Council, 2014). In response, government health agencies at all levels feel compelled to "rectify" their wrong treatment toward the migrant workers. In regard to the education on STDs, there have been reported rethinking of the ways in which health officials should adopt in engaging the migrant workers (Yu, 2013, State Council, 2014; Chongqing CDC, 2016).

It's noteworthy that the government health offices issued guidelines on how health officials and doctors should communicate with the migrant workers, which dictated largely attitude change as the follows: not to treat the migrant workers as "strangers" or "trouble makers" and; instead, to "show respect and sympathy, be patient and shall be willing to listen, try to interact naturally and personally, and be reassuring for delivering assistance" (Chongqing CDC, 2016; Lu, 2017). The guidelines even contained a set of protocols on how to approach and speak to the migrant workers on STDs. For example, "our offer of help shall never be conceived of as bestowing charity or favors to them but as our government's responsibility to them" (Xinhua News Agency, 2014; Beijing Municipality, 2017).

Many of these requirements seem to have followed the principles of dialogic communication. The required changes of perception of and attitudes toward the migrant workers suggest at least a good intention on the part of the government. Such required or pronounced changes entail, at least, the positive elements that may help facilitate dialogue between health officials and migrant workers. Hence,

RQ 3: *Do Chinese health officials intend to communicate with migrant workers by following dialogic principles, stressing mutual understanding, mutual respect, openness, empathy and commitment? And, if so, how?*

Existing studies on dialogic organization-public relationships have pointed to many factors that may facilitate or restrain genuine dialogue. For a dialogic interaction, Pearson (1989a & 1989b) proposed six rules. They were to govern (1) the process of beginning, maintaining, and ending interactions, (2) the length of time separating messages or questions from answers, (3) opportunities to suggest topics and initialize topic changes, (4) when or if a response counts as a response, (5) channel selection for communication, and (6) for talking about and changing the rules. Health communication studies have applied the principles of dialogue to government communication with general public and/or engagement with special groups in needs.

Evaluating how Canadian public perceived the deliberative dialogues convened by the National Collaborating Centre for Healthy Public Policy for public health policy discourses, Lavis, Boyko & Gauvin (2014) found that deliberative dialogues as a government-public relations strategy tend to support evidence-informed making of public health policies. Testing how community dialogue could encourage behavioral change so as to reduce risks of HIV epidemics in Mozambique, Figueroa, Carrasco, Pinho, Massingue, Tanque & Kwizera (2016) studied the 2009–2010 Tchova Tchova community dialogue program and found that the sessions based on dialogic principles inspired open interaction among participants and subsequently, proved successful in producing structural changes such as gender attitudes, gender roles, and HIV stigma, as well as behavioral changes including acquisition of knowledge on HIV prevention, discussion of health risks between sex partners, and avoidance of having multiple sex partners.

Addressing some critics' concern that dialogue is just too idealistic and might not make it in practice (Stoker & Tusinski, 2006; Lane & Bartlett, 2016), scholarly efforts have been exerted on how genuine dialogue may take place to create more durable and longer lasting organization-to-public relationships. With few positive results, however, studies tended to have identified a number of constraints to genuine dialogue.

By examining dialogic practices of Australian PR professionals, Lane (2014) found that the government tended to exert a heavy hand on professionals to engage with their stakeholders and publics, but without providing them with adequate training in dialogic theory or practices. Finding apparent absence of the components of dialogue in PR education, Bentley (2012) asserted that dialogue should be made more accessible and useful to PR educators. To equip future PR professionals with the theoretical understanding and practical skills of dialogic communication, he called on bringing Kent & Taylor's dialogic public relations model into more PR classes so as to help students see how this model is applicable in the context of real relationships.

Exploring what might block organizations from dialogic communication with the public, Huang and Yang (2015) found that unpredictable outcomes of dialogue and perceived high level of risks might dissuade organizations to embrace dialogic communication. Proposing a co-creational model to guide PR professionals toward dialogic relationships building, Anderson, Swenson & Gilerson (2016) identified several skills of interactive writing that PR professionals need to be equipped for positive dialogic communication.

As a pioneering study, Kent and Taylor (2002) proved that social media might be poor dialogic tools, disappointing many who harbored high expectation on the dialogic potential of social media to facilitate genuine dialogue. While Theunissen (2015) argued that dialogue and persuasion were intertwined, a recent analysis of online practices of communication practitioners in Europe found that the practitioners perceived digital media as of little help with dialogic communication (Moreno, Navarro, Tench & Zerfass, 2015).

Theunissen & Wan Noordin (2012) suggested that dialogue has been incorrectly equated with two-way symmetrical communication, hence, requiring more robust examination of its possibilities. Anderson, Swenson & Gilerson (2016), for example, suggested that relationship initiation, responsiveness, and interactivity should have the potentials to be "necessary building blocks for either regular engagement or dialogue to occur" (p. 4100). There has also been scholarship attempted to reconcile the proposed principles of dialogic organization-public relations across cultures and contexts (Men & Tsai, 2012; Macnamara, 2014).

It can then be assumed that Chinese migrant workers' need of health information on STDs and their strong desire for equality/fairness/respect, and the good intention on the part of health officials to treat migrant workers equally/fairly/respectfully should serve as the potentials to initiate dialogic communication between the two parties to take place. Hence,

RQ 4: *Would the assumed potentials lead to dialogic communication between Chinese migrant workers and health officials on STDs? If not, what are the factors that may be blocking the construction of such communication between the two?*

3. Research methods

This study applied both qualitative and quantitative methods, consisting of focus-group meetings, in-depth interviews, and questionnaire survey. These were conducted in the same sequential order in two selected areas in China: the Yangzi-River Delta area (mainly Shanghai and Jiangsu) and the Pearl-River Delta area (Guangzhou, Shenzhen, Zhuhai, Zhongshan). This study recognizes that as migrant workers in these two economically-dynamic areas are from all over the country, research results holding across these two areas are likely to have wide application.

3.1. Methods

First, two focus-group meetings were held with the migrant workers, who were the main subject for this study. Altogether 16 were recruited via on-line calls, with eight from each of the targeted areas (Hereafter cited as "Focus Group, 2018"). Two meetings took place in July 2018, each lasting for about two and half hours. Each participant was assured of confidentiality and offered a sum of allowance to cover their transportation and other costs. Meanwhile, initial contacts via phone inquiries were made; and telephone interview requests were accepted by six government health officials who, as staffs at centers of disease control (CDC), were in charge of disseminating health-related information and planning and executing information campaigns targeting at migrant workers on health-related education and issues. Three of them were from the Pearl-River Delta area (Zhuhai and Zhongshan), and the other three from the Yangzi-River Delta area (Shanghai and Wuxi, Jiangsu) (Hereafter cited as "Interview, 2018"). Confidentiality was warranted to encourage the interviewees to express their views freely. Taking place in August, 2018, each interview lasted for about 30 minutes.

Results out of the focus-group meetings and interviews were used to help understand the involving parties' views as to what the silent issues along with the problems/difficulties in terms of the communication on STDs-related issues between the migrant workers and health officials. The qualitative data, in turn, helped with the development of the survey questionnaire, as well as the wording modification of the scales for survey. Before the formal data collection via the survey, a pilot study was conducted to test the validity of the questions being asked, establishing the reliability of the measurements, and identifying if there were inappropriate wordings and sentences in the questionnaire. The results were used to revise and finalize the survey questionnaire. The survey was executed in August, 2018. Subject recruitment and data collection were conducted with the assistance of Sojump, a Chinese online research platform. A total of 200 respondents matched this study's request, and thus, were selected and included in the sample; and 180 valid questionnaires were returned and used for analysis. Among them, 102 were at the time, working in the Yangzi-River Delta area, and 78 in the Pearl-River Delta area. Both the processing and the statistical analysis of the data were done with SPSS 22.0.

3.2 Operational definitions

A set of measurement items was developed to avoid ambiguity for the respondents to comprehend the questions.

Health literacy on STDs tells the respondents' knowledge level on STDs, which was measured by 49 items (Cronbach's Alpha=.905) with 16 items loading on typical STDs symptoms, 23 relating to STDs' transmission channels, and 10 regarding the preventive methods. Each right answer scored 1 point with summed higher total scores indicating higher knowledge level.

Marginalization refers to respondents' perceived identity of being socially marginalized. Five Liker-type declarative statements were used (e.g. "I have little access to social benefits, urban services, healthcare, pension or insurance"; "I am often being labelled as 'men from countryside"). Respondents were asked to indicate the degree to which they agreed or disagreed with each of the statements, with 1=extremely disagree to 5=extremely agree.

Perceived level of risks of STDs infection reveals the respondents' perceived level of risks of being infected, which was measured by five items, as the respondents were asked to rate the extent to which they believed they were at risk of being infected on a 5-point scale from 1=extremely low to 5=extremely high.

Perceived level of need for STDs-related information indicates the respondents' perceived level for STDs-related information, which was measured as the respondents were asked to rate the degree to which they would like to have the information on a 5-point scale from 1=extremely low to 5=extremely high.

Preferred mode of communication reflects the respondents' preference for dialogic communication, which was measured by five Liker-type declarative statements; for example, "I prefer those who communicate with us respect us"; "I prefer those who communicate with us understand us as to who we are and what we need and want." Respondents were asked to indicate the degree to which they agreed or disagreed with each of the statements on a 5-point scale from 1 (extremely disagree) to 5 (extremely agree).

In measuring the extent to which the migrant workers long *for dialogic communication*, the respondents were asked to rate on a 5-point scale from 1 (not at all) to 5 (extremely need it), after being given detailed description of dialogic communication.

Perceived obstacles toward dialogic communication were measured by three items, including statements such as: "The government officials have a kind of attitudes and prejudice towards us"; "I can't understand the messages they send to us"; and "They are result-driven instead of having genuine intention to help us." Respondents were asked to indicate to what degree they agreed or disagreed with each of the statements on a 5-point scale from 1 (extremely disagree) to 5 (extremely agree). Alpha coefficients were computed on all the above six indices created as measures of internal consistency reliability, generating Cronbach's alphas of higher than .78.

4. Findings and discussions

Data analyses have produced meaningful results, addressing the research questions. Some entail analytical implications to the understanding of dialogic organization-public relations.

The demographic profile of the surveyed migrant workers, on the whole, resembles that in the government-released report of 2016 (National Bureau of Statistics, 2016). Eighty percent of the surveyed were aged between 20 and 49; and males (N=124, 68.8%) exceeded females (N=56, 31.2%) by a margin of one third. Regarding their marital status, 40.6% (N=73) were either divorced or single; and 59.4% (N=107) were married, of whom, more than half (N=58) were separated from their families, meaning their spouses and/or Children were left behind in the home places. Their average monthly income was around RMB4, 100 (an equivalence to US$621).

Now, we turn to **Research Question 1**, which asks "*Do Chinese migrant workers see themselves as socially marginalized and, thus, feel vulnerable to STDs? "*

Addressing the first part of **RQ1**, the survey results confirmed that Chinese migrant workers, without doubt, thought of themselves as socially marginalized in Chinese society. The evidence of marginalization experienced by the respondents was reflected mainly in the following four aspects: (1) employment and working/housing conditions: those surveyed strongly agreed that they did not have much choice than taking the jobs left out by urban residents that were often labor intensive, dirty, and/or dangerous (M=4.53); and their working and housing conditions were poor (M=4.32 and 4.88 respectively); (2) access to public services/benefits: they believed that they were "denied" social security and medical benefits (M=4.22), and indeed, about 17% of them had some kind of health insurance, which, could cover part of their medical expenses incurred only at their home places; (3) social status: they felt that they were discriminated by urban residents (M=4.89) and often being criticized for interfering with normal way of urban residents' live; and (4) economic status: the salaries they received were very low (M=4.51) as compared to their counterparts of urban residents.

At the focus-group meetings, the participants' expressions and reactions to the questions were sometimes subtle but often emotional. "We are the people who make the cities run, but our contributions are not recognized; moreover, we work longer hours but get paid so little that leaves us neither time nor money to enjoy the city life" one interviewee said (Focus Group, 2018). When asked to come up with a few words that urban people often used when referring to migrant workers, the most-frequently mentioned ones were: countrymen, lazybones, uncivilized, barbarians. "We are sick of being referred to by these derogatory language," one person at the focus group meeting (2018) said with anger. "What bothers us the most is that we don't feel safe or secure at work; some of our fellow migrant workers were sexually harassed by their employers or supervisors; and once get injured at work, we are usually sent back homes without being duly treated and compensated; we are indeed, isolated and marginalized."

The results also showed that marginalization had a strong negative impact on Chinese migrant workers' psychological and physical health. A large number (N=122, 68%) admitted constantly feeling (1) "angry" at the ways they were treated by the city people, (2) "powerless in the society", and (3) "fearful of being sick or wounded at work." Suffering from the social and psychological strains, they expressed little intention to interact with the city people, preferred to live in the periphery of cities, and had little interest in participating at government-sponsored events or any social events.

Addressing the second part of RQ1, however, it is interesting to note that the migrant workers showed a mixed feeling about if they saw themselves as being particularly vulnerable to STDs. On one hand, the survey results revealed that the respondents' rating on their perceived "level of risks for being infected by STDs" was relatively low (M=2.13); and on the other hand, the results from focus-group meetings suggested a different take on the vulnerability issue with several migrant workers acknowledging a high risk of STDs infection. "To be honest," one said, "most of us get to visit our families only once a year, usually during the Chinese New Year holiday, but a person of my age has strong lust" (Focus Group, 2018).

As such, it was very common that many of the migrant workers would form "temporary families" with one or two fixed sexual partners, and others managed to satisfy their sexual needs from prostitutes. "We know people get infected by STDs after having sexual relationships with multiple partners and prostitutes" (Focus Group, 2018b).

When asked to explain why their rating on perceived STDs risk was low, several stated that it was still culturally and socially disapproved for a person to have sex with someone other than his/her own spouse. Therefore, a focus-group participant admitted that he regarded it as "socially desirable to rate the 'level of risk' low because it shows that you are a 'self-respecting/responsible person'" (Focus Group, 2018b). "Refusal to admit openly being at high risk of STDs infection," a health official stressed during the interview, "make migrant workers particularly 'vulnerable' to STDs and naturally become our targets for safe sex education"(Interview, 2018b).

Moreover, the survey results gave good reason for migrant workers to feel vulnerable to STDS since their health literacy on STDs is, in particular, rather low. The average score the surveyed obtained on this measurement was as low as 15 (meaning they ONLY got 15 out 49 answers right).

Research Question 2, specifying *if Chinese migrant workers long for the STDs-related information to be communicated to them from government health officials in fair, respectful, indiscriminating, or dialogic fashion, being treated as equals,* was confirmed by the survey results as well as that of the focus-group meetings.

The survey results showed clearly that the migrant workers felt the urgent need for STDS-related information given the rating on their perceived "level of need for STDs-related information" was high (M=4.15). The data also suggested a very strong desire among those surveyed (M=4.95) that, if the information was to be provided, it should be communicated to them in a comprehensible, friendly, respectful, open, thoughtful, and sympathetic manner.

This statistical data also squared with the comments voiced at the focus-group meetings in several aspects. First, migrant workers disapproved the content of STDs-related information delivered to them by the health officials, which was mostly "incomprehensible" with jargons. "We don't have much education so we don't understand the 'things' they put in the brochures and/or flyers, or in the WeChat messages. If they could include more visuals, like cartoons or photos, we'd be more interested and understand it more easily," one participant said (Focus-group, 2018). Second, they preferred the information to be communicated via "one-on-one or small group meetings" during which, "free and informal discussions" could be encouraged. Two participants articulated their particular dislike of "large propaganda sessions with government officials always doing the talking and, sometimes, forcing us to wear the yellow or red ribbon." Third, they expected to be treated by health officials with "respect" and as "equals," not like "countrymen from remote areas, or strangers from another planet." Fourth, they'd be "more persuaded" to interact if convinced that the health officials had "true understanding of our living situation," respected "our way of life," and shared "our hardship in pursuit of a better life." One participant concluded that "it really turns us off when the officials come to us as if they are shedding mercy on us" (Focus-group 2018). Last, they suggested that the information sessions would be more helpful if the officials agreed to keep the conversations "confidential" and kept their promise of help "without any conditions" (Focus-group, 2018).

Research Question 3 addresses the issue of *whether government health officials have the intention to communication with migrant workers in the way embracing genuine dialogue principles*.

The interview results manifested a clear existence of good intention among all the officials interviewed in terms of their evident willingness to adopt dialogic approach and strong commitment to striving for mutual understanding, mutual respect, openness and empathy. To be more specific, all the officials interviewed expressed a strong sense of urgency to work on and with the migrant workers on STDs prevention, believing migrant workers were among "the most vulnerable" to STDs because of their health and sex behaviors. Among the reasons cited by them were: no or very little knowledge of safe sex, underground and cheap prostitution, common practices of multiple sex partners by convenience, and reluctance and even refusal to seek medical treatment after contracting STDs (Interview, 2018). "Until we make them see the grave danger of STDs," one health official stressed, "these people would not change sex behavior; and their chance of being infected will loom hopelessly larger" (Interview, 2018).

The health officials also voiced a strong sense of responsibility to help the migrant workers. All agreed that "it's so unfair that these hard-working people have so little access to public health services; it's our undeniable duty to extend these services to them" (Interview, 2018). They also claimed that "it is our job to educate the migrant workers because they trust only the government-released information on disease prevention and will accept the practically free services offered only by the government" (Interview, 2018).

In addition, there seemed no lack of willingness among the health officials to improve their way of engaging the migrant workers on STDs. They acknowledged that the old practices such as posting STDs-related information on the doors of migrant workers' apartments, hand-delivering materials to migrant workers at their workplaces, passing out brochures and flyers with gifts or food coupons, holding public education sessions, etc. seemed to be "somewhat inconsiderate, insensible, and thus, ineffective" (Interview, 2018). They admitted having recently "tried different approaches," for example, finding ways of getting acquainted with the migrant workers, asking for permission first before paying visits to them during their off-duty hours, and coordinating private and/or small-group meetings with them. They also tried to "show sympathy and empathy" and "be a good listener" (Interview, 2018).

To sum up, the migrant workers' need for dialogic communication, and the government health officials' willingness to adopt dialogic approaches, proved to be the potentials to initiate dialogue between the two parties.

Hence, **Research Question 4** focuses on *whether these potentials would lead to dialogic communication between health officials and Chinese migrant workers on STDs.* It further explores the *factors that may be blocking the construction of dialogic communication to take place between the two.*

The results from the interviews and focus-group meetings showed that, despite the existing evident potentials - namely, the migrant workers' demand for STDs-related information along with their strong desire for equal, fair, respectful and interactive treatment by the health officials, and the latter's willingness to do so, the communication between the two parties reflected only *partially* what would be considered genuine dialogue.

A majority (n=12, 86%) of the migrant workers participated in the focus groups acknowledged the health officials' efforts to improve the communication with them. When asked to give concrete examples, they mentioned the follows: these officials became "more friendly and approachable than before;" "more small and private gatherings with us were conducted;" "we were given more chances to express our concerns on STDs in our own words"; and, they became "more patient teaching us practical and easier-to-learn measures of STDs prevention" (Focus-group, 2018). Yet, over 50% (n=8) did not feel comfortable particularly with the ways these meetings were conducted, nor were they satisfied with the results. "We expected to learn how to identify STDs symptoms by ourselves and where to find medical help, but the health officials seem to be only interested in giving us the information on STDs risks and urging us to practice safe sex that we were not used to discussing them openly;" very often, the health officials "seem to be task-oriented, dominating the discussions that turned us away" (Focus-group, 2018).

The same was true with the interviews of health officials. Confirming their willingness to "be respectful, open and empathetic so as to enhance mutual understanding," all of them claimed having adopted new measures in approaching and communicating with the migrant workers (Interview, 2018). The measures taken included: agreeing to "meet with them in their chosen time and location with prior permission," letting "them to talk and us listen," explaining the STDs risks "in simple language and with visual aids if necessary," offering help "in ways acceptable to them," and trying to "establish informal contacts with them via social media such as WeChat." While doing so, they also expressed dissatisfaction with the process and the results. One health official said that "small and private meetings are convenient to them but too time-consuming to us." Another added that "no matter how hard we tried, they are simply too stubborn to be reasoned" (Interview, 2018).

Taken as a whole, these data suggested that these potentials are necessary to initiate dialogic communication, but proved to be insufficient to facilitate or warrant genuine dialogue.

In addressing the second part of **Research Question 4**, the data pinpointed to the functioning of several constrains that restrain the communication between Chinese migrant workers and health officials from becoming genuinely dialogic. Quantitative data from the survey of migrant workers indicated three perceived obstacles. First, they strongly agreed (M=4.56) that the health officials still held patronizing attitudes and prejudice towards them. Second, they were keen to believe (M=4.15) that health messages sent to them by the government health agencies were difficult to understand, showing the lack of understanding the best, and negligence the worst, among the government health officials. Third, they highly questioned (M=4.96) the health officials' intention to communicate with them, which were by no means out of true empathy, but rather dictated by their job requirements. Qualitative data can be synthesized as the follows. First, China's lack of a political and social structure critical to nurturing dialogic environment or culture makes dialogic communication very difficult. Civil society is still at its primitive stage where governmental control of and interference with everyday life remain strong; and public participation at policy discourses is at a lower level than in western societies.

With few other institutional mechanisms (non-profit or charity organizations) at work to address the needs of migrant workers for STDs information or help, government health agencies dominate the health communication. In spite of recent government efforts to improve social status of migrant workers, their voices in public spheres, particularly on public health policies, continued to be low and weak. Almost all of the participating migrant workers expressed a strong feeling of being "alienated in the community" and "powerless". They found it hard to imagine having their voices heard by the government or being treated as equals by health officials (Focus-group, 2018).

Second, Chinese traditional perception of and attitude toward sexuality that frame an enduring social stigma on STDs hinders the communication from being open, free or without prejudice. Almost all of the migrant workers surveyed or participating in focus groups admitted their reluctance to talk to "strangers" about sex in general and STDs prevention in particular.

Two females stressed that they would not even "talk about sex with my husband" because of the fear that he "might think of me as bad woman". "It's so insensible for health officials to ask us to discuss sex with our friends or family members," one said (Focus-group, 2018). Three also pointed to the use of red or yellow ribbon in government-sponsored STDs education campaigns as "unacceptable," because they "may give others the wrong impression that we had STDs" (Focus-group, 2018). The same concern was also shared by the health officials. A young female official said that she often felt "embarrassed and shameful to discuss in details or interactively on safe sex" with migrant workers. Another admitted having met constant pressure from her boyfriend and parents that "migrant workers could be bad influence, or working with them may get me STDs" (Interview, 2018).

Third, digital information or communication didn't facilitate timely and instantaneous interactions between Chinese migrant workers and health officials. Almost all of the migrant workers received digital information on STDs from government health agencies but mostly as text messages. As passive receivers, they first took an interest in these messages but quickly found them as nuisances and intrusive (Focus-group, 2018). The later use of WeChat for STDs-related communication did not work, either. Being the most popular social media in China, WeChat is equipped with live video conversation program to facilitate instant, face-to-face or small-group and affordable interactions. The health officials first thought of WeChat as an easier and cheaper platform whereby to build and facilitate interactive communication so as to forage a constructive relationships with migrant workers, but later, had to give it up (Interview, 2018). Five of the interviewed migrant workers explained that "though we use WeChat a lot because it's cheap and convenient, we use it mostly for chat with friends and children or parents left at home; we don't want to add government officials to our WeChat list" (Focus-group, 2018). One young man said that "my friends or family would cut contact with me if they find out by accident that health officials are shown on my list or send me STDs-related messages" (Focus-group, 2018). Two of the health officials interviewed agreed that WeChat was "too private to be of any use" in engaging the migrant workers (Interview, 2018).

Fourth, the lack of training in dialogic communication or personal experience of dialogic practices on the part of health officials certainly restrained dialogic communication. All of the health officials interviewed acknowledged having attended only two or three training workshops by communication experts. When asked about the content, they admitted having mostly learned about "how to acquire personal information from the migrant workers, how to ensure return visits, how to make them bring family or friends to the sessions, how to treat males and females differently, how to speak in every-day language or draw pictures (even cartoons) when talking about safe sex" (Interview, 2018). From what they revealed, hardly any of the training was based on dialogic principles. "What do you mean by dialogue? Isn't it a dialogue when we have a conversation with them," one health official asked this author to clarify during the interview (Interview, 2018).

Fifth, the health officials' awareness of governmental pressure for quick and measurable result weakened their willingness to sustain dialogic relations with migrant workers, reducing their acceptance of risks or unexpected results. All of the interviewed health officials felt constantly pressured to "achieve results" (Interview, 2018). One health official explained that "we're all aware that the top authorities treat this work very seriously because it's about the government's credibility and accountability in the minds of the people" (Interview, 2018). Under the pressure, they felt it imperative to control the communication with migrant workers and influence them through persuasion. "Migrant workers are ignorant of STDs," one health official said, "our job is to make them understand that STDs entail high risks not only to their families but to the general public" (Interview, 2018).

Expected to "inform" the migrant workers of STDs and "make them to change their sex behaviors eventually," the outcome-driven health officials felt it difficult to accept "unpredictable results" of their "engagement" with the migrant workers that could bring about risks unacceptable to the government (Interview, 2018). With such beliefs, attitudes and behaviors, it proved hard for them to embrace truly dialogic communication.

Taken all of the above-discussed as a whole, the identified constraints to dialogic communication between Chinese migrant workers and health officials seem to be in line with many of the findings in existing literature. In this case, some are rooted in Chinese social, cultural and institutional systems, and others resulted from the lack of mutual understanding, trust or respect between the two parties engaged in communication.

5. Conclusion and future work

By invoking Kent & Taylor's model of dialogic theory as an analytical framework, this study explores if the communication between Chinese migrant workers and health officials on STDs can be dialogic in practice and how. A twofold finding is generated.

First, the socially-marginalized migrant workers' need for dialogic communication, and the government health officials' willingness to apply dialogic approaches, proves to be the *potentials* to initiate dialogue between the two; and second, the dialogic potentials seem *insufficient* to warrant genuine dialogue due to the functioning of several constraints, with some structurally rooted and others behaviorally framed.

With the structural and behavioral constraints to dialogic communication identified, this study also suggests possible remedies. They would include: growing a dialogic culture in society, reducing governmental control or interference, providing health officials training based on dialogic principles or practices, and finding innovative ways of using social media. Particularly on the last point: although social media have proven to be a poor dialogic tool in the west, the fast updated WeChat with features of instant interaction, face-to-face or in a group, cost-for-nothing might be further explored as a dialogic platform whereby to facilitate "genuine dialogue" between Chinese migrant workers and health officials.

This is, after all, a preliminary report of an ongoing project on Chinese health communication. The data is rather limited for any attempt to derive more profound or theoretically meaningful implications. A follow-up experiment on, for example, how WeChat may help initiate, facilitate and sustain dialogic communication between Chinese migrant workers and health officials on STDs is expected to produce viable results.

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