Health Communication, 28: 170–182, 2013

ISSN: 1041-0236 print / 1532-7027 online
DOI: 10.1080/10410236.2012.666956

Routledge
Taylor & Francis Group

Health at the Margins of Migration: Culture-Centered Co-Constructions Among Bangladeshi Immigrants

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Increasingly, health scholars have been paying attention to the health experiences of immigrant communities, particularly in the backdrop of the increasing global flows of goods, services, and people across borders. In spite of the increasing public health emphasis on health outcomes of immigrants within the United States, immigrant communities are often constructed as monoliths and the voices of immigrant communities are traditionally absent from mainstream health policy and program discourses. The health experiences of immigrants, their access to resources, and the health trajectories through the life course followed by them and their descendants influence the deep-seated patterns of ethnic health disparities documented in the United States. It is against this backdrop then that the co-constructions of experiences of health among immigrants offer an entry point for understanding the intersections of migration and health, particularly as these intersections offer guidance for the development of culturally situated policies and programs. Based on the culture-centered approach, we seek to understand how low-income Bangladeshi immigrants in New York City, who live at the borders of mainstream American society, define, construct, and negotiate health issues through co-constructions of their localized experiences of health.

Historically, migration across national borders has posed vital questions for the delivery of health care for immigrants (Bollini, 1993; Bollini & Siem, 1995; Hull, 1979; Jatrana, Graham, & Boyle, 2005; Koehn, 2006; Rashid, 2002). As a topic, migration has come to occupy the center stage in health research, particularly so within the context of globalization as more and more individuals, families, and groups have moved across national borders in the search of jobs and economic opportunities in the face of the increasing impoverishment of the poor in the global South (Benton-Short & Price, 2008; Jatrana et al., 2005; Koehn, 2006; Rashid, 2002). Within the United States, health outcomes researchers document the health disparities experienced by immigrants from poorer backgrounds, particularly drawing attention to the poor access to health services, poor quality of care, and poor access to health information and health prevention resources among low socioeconomic status (SES) immigrant communities (Bollini, 1993; Bollini & Siem, 1995; Kandula, Kersey, & Lurie, 2004; Rashid, 2002; Walker & Barnett, 2007). Overall, the health experiences of poorer immigrants demonstrate large-scale disparities from the mainstream population, narrating the experiences of struggles among immigrant populations with the economic lack of resources layered over the difficulties in adjusting to a new culture and finding access to information about much-needed resources (Bollini, 1993; Bollini & Siem, 1995; Dutta, 2008, 2011; Kandula et al., 2004).

Largely missing from the discursive spaces of health care policies and programs implementing them are the voices of the immigrants as co-participants in determining the problems they face and the solutions they desire (Bollini, 1993; Bollini & Siem, 1995). Offering the culture-centered approach as a framework for understanding the material disparities that exist in health care, Dutta (2004a, 2004b, 2008, 2011) notes the relevance of co-constructing localized health problems and corresponding solutions as entry points for change in inequitable health structures. He notes that communicative marginalizations work hand-in-hand with structural deprivations, suggesting that the communities that exist at the margins of the dominant structures of

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health care are also marginalized through their absence from policy platforms and platforms of decision making about their health outcomes (Dutta, 2008, 2011; Dutta-Bergman, 2004a, 2004b). What then are the key meanings of health, lived experiences of health, understandings of barriers to good health, and articulations of relevant policies and programs when low-income immigrants talk back to mainstream structures of knowledge?

In this article, we specifically engage with the culture-centered approach to dialogically co-construct the experiences of health among low-income Bangladeshi immigrants in New York City and to foreground their localized experiences to suggest entry points for change in health policies and interventions addressing their needs (Dutta, 2008; Dutta-Bergman, 2004a, 2004b). A 2000 Census report shows that there are about 100,000 people of Bangladeshi origin living in the United States. This is a 471% increase since the 1990 census. Even at a growth rate of 20% per year, the next census shows at least 200,000 Bangladeshis living in the United States. Of this number, almost 44% of the families live on less than $35,000 per year (most households have an average of 4.2 occupants), and 22% of the individuals live below the U.S. declared poverty level. According to the same census report, the highest concentration of Bangladeshis living in the United States is in New York City with a per-capita income of $10,479, which is less than half of the citywide figure of $22,402. Almost one out of every three (31%) Bangladeshis living in New York City lives in poverty, surpassing the rate of 21% of all New Yorkers. Furthermore, about 37% of all Bangladeshi children and senior citizens experience poverty. Given the high prevalence of poverty and structural deprivation among Bangladeshi immigrants in New York City, a culture-centered engagement with low-income Bangladeshi immigrants offers entry points into theorizing meanings of health from the margins and developing corresponding applications. The purpose of this culture-centered project is to understand how the low-income Bangladeshi immigrants in New York City, who live at the borders of mainstream American society, define, construct, and negotiate health and health care. Through in-depth interviews with Bangladeshi immigrants, we seek to understand the interpretive frames through which our participants understand their experiences of health (Dutta, 2008; Dutta & Basu, 2008). Furthermore, culture-centered interpretations of health, situated in local contexts, draw attention to the highly contested and dialectically constituted spaces in low-income immigrant communities that exist at the peripheries of the global centers of the neoliberal economy[1] (Dutta, 2008).

[1]Neoliberalism refers to the political economic configuration of trade liberalization and privatization that has been accompanied by the increasing migration of goods, services, and labor across national boundaries (Dutta, 2011). In the process of this global interflow of labor, on one hand, rural communities in the global South have been displaced from local forms of livelihood and, on the other hand, have been thrown into global economies without the needed health and economic securities.

CULTURE-CENTERED APPROACH TO HEALTH COMMUNICATION

Criticizing the dominant approaches to health communication, Dutta (2008) notes that top-down approaches to interventions based on theories and concepts such as the theory of reasoned action, health belief model, self-efficacy, and fatalism assume a linear model of health decision making based on universal assumptions of health, without considering the local participants' voices and agency in academic and praxis discourses. For example, top-down interventions that seek to build self-efficacy in immigrant populations begin with the belief that immigrants don't have self-efficacy and therefore can be empowered through efficacious messages (see Dutta, 2008). Such linear models focus on transmission of beliefs from the core health sectors to the sectors at the margins, based on universal assumptions of health, and without attending to the localized contexts within which health meanings are negotiated actively by cultural members. The sectors at the margins are referred to as subaltern sectors because of their invisibility from mainstream program and policy discourses (Dutta, 2008; Dutta-Bergman, 2004a, 2004b). Subalternity refers to the condition of "being erased," and this erasure is achieved through the assumptions of passive target audiences for health interventions in mainstream health communication discourses (Dutta-Bergman, 2004a, 2004b). Critiquing the discursive closures enacted by such top-down models of health communication, Dutta and Basu (2007, p. 38) highlight "the importance of understanding the articulations of health by engaging subaltern voices in the marginalized sectors of the world." By listening to the cultural insiders' voices about their perceptions of health, alternative entry points can be created for addressing the structural inequities and injustices underlying the lived experiences of those at the margins.

The three key strands of the culture-centered approach are culture, structure, and agency. Culture here is seen as constantly metamorphosing, constitutive, and transformative in the domain of health meanings (Dutta-Bergman, 2004a, 2004b). Cultural contexts are dynamic and offer theoretical insights into how health decisions and meanings are negotiated in cultural communities (Dutta, 2008). It is only through engagement in dialogue with the cultural insider that the local meanings of health can be articulated and understood, situated in relationship to the continuously shifting local contexts, which in turn are shaped by the structures within which immigrant communities are situated. Structure is the cluster of material realities that constrains and enables human action, and it is within these constraints that cultural insiders must enact their agency in seeking out health choices (Dutta, 2008). Agency is the capacity of individuals and collectives to interpret structures, to negotiate them in everyday lived experiences, to work with them, and to seek out ways of transforming them.

From the standpoint of application development, the acknowledgment of local agency becomes the basis for identifying locally meaningful problems and the corresponding localized solutions that are directed at addressing these problems (Dutta, 2008; Dutta-Bergman, 2004a, 2004b). Therefore, in resisting the mainstream discourses of health that construct subaltern populations as homogeneous, fatalist, and passive target audiences of top-down interventions with external loci of control, the culture-centered approach co-constructs locally situated meanings of health through dialogic methodologies that engage in conversations with subaltern voices (Dutta, 2011). The foregrounding of these dialogic voices in dominant discursive spaces creates the groundwork for the development of policies and programs that are responsive to the needs of the subalterns.

With respect to global migration, the lived experiences of immigrants are constituted amidst dominant neoliberal structures that bring immigrants into global spaces as sources of cheap labor, and as products of displacements that are often produced by modernization, development, and trade liberalization policies (Bollini, 1993; Bollini & Siem, 1995). It is within this backdrop of the proletarianization of immigrant groups that dominant global structures play out their economic agendas (Walker & Barnett, 2007). Structurally, immigrant experiences of health are often narrated in the realm of limited structural access to health care resources, poor quality of health care services, and limited access to communication resources, interaction resources, translation resources, health information, and preventive resources (Kandula, Kersey, & Lurie, 2004; Walker & Barnett, 2007). In addition to the issues of language that immigrants have to negotiate in their interactions within health care settings, immigration also brings forth the cultural erasures written into mainstream discursive spaces as bodies of immigrants become subjects of universalized interventions, driven by the biomedical model that emphasizes individual lifestyle interventions. Not only are the experiences of the immigrant therefore situated structurally at the margins of the neoliberal economy, but immigrants are also culturally marginalized, constructed as pathologies in need of interventions (Walker & Barnett, 2007). Their cultures are often treated as the barriers to the development of healthful practices (see Dutta, 2008, for a discussion of the oppressive role of cultural portrayals). The basic framework of much health communication work targeting immigrants then is based on the assumption that the immigrant needs to be educated in order to acculturate adequately into the culture. Interrogating this top-down construction of the immigrant as pathology, this article uses the culture-centered approach to co-construct localized meanings of health through the Bangladeshi migrants' localized interpretations that originate from within their lived experiences. The interpretive frames that appear in this article are experiences shared by the Bangladeshi migrants who live in New York City about their conceptions of health, the health issues that encompass their everyday lives, and the ways in which they negotiate health care structures.

BANGLADESHI MIGRANTS TO THE UNITED STATES

The People's Republic of Bangladesh, simply known as Bangladesh, is a small country in Southeast Asia with India bordering its three sides and the fourth side bordered by Burma and the Bay of Bengal. Many European settlers once colonized the region that is now Bangladesh–India–Pakistan until it became independent in 1947 from the British. Bangladesh currently has about 153.5 million people and the population is growing at about 2.022% per year, which comes to about 3 million people each year. The size of Bangladesh is approximately 57,000 square miles, with widespread poverty that affects over half the population of the country (Kibria, 2011). The large population growth, accompanied by the environmental degradation of Bangladesh, has resulted in a large landless population; this increase in the landless population, alongside the rising underemployment and a youthful age structure, has resulted in the large-scale migration of Bangladeshis to other parts of the globe in the search for economic opportunities (Kibria, 2011). Of particular relevance for this project is the acknowledgment of the tremendous structural constraints faced by Bangladeshis in Bangladesh, the widespread poverty in the country, the high unemployment rates, and the minimum access to health care experienced in the poorer sectors of Bangladesh (Kibria, 2011).

New York has one of the highest populations of Bangladeshi immigrants, serving as a gateway city. According to a 2000 U.S. Census report, Bangladeshis make up the sixth highest immigrant population in the state of New York, and of that, 95% live in New York City. According to a report published by the Asian American Federation in 2009 gathered from data from the Census Bureau's American Community Survey (ACS) done between 2005 and 2007, Bangladeshis were among the poorest Asian groups living in the city, with lower English language skills, lower incomes, and higher poverty rates as compared to all New York City residents. Among the low-income Bangladeshis in New York City, most work as restaurant workers, as cab drivers, in convenience stores, and in service industries such as hotels (Jones, 2011). Bangladeshi immigrants maintain a strong sense of home with them in their immigration to the United States, articulating a fluid identity between *desh* (country of origin) and *bidesh* (foreign country) that are dynamically connected (Gardner, 1995).

Historically and sociologically, Bangladeshis reflect a wide variety of worldviews in their negotiations of health. For example, Bangladeshis use a wide variety of health care options, such as allopathy (modern medicine), homeopathy,

ayurveda, and spirit healing. But many of these options are not as widely available/accessible in the United States as they are in Bangladesh. Foregrounding their cultural conceptions, how does this Bangladeshi population living in the United States understand health and illness, and how do community members negotiate their experiences of health care? How do Bangladeshi community members living below the poverty line in New York City come to understand health, and how do they enact their choices in the backdrop of these understandings? Based on the immigrant stories, this article "seeks to inform the process of meaning construction in marginalized spaces" (Dutta-Bergman, 2004a, p. 1109).

RQ1: What are the meanings of health to Bangladeshi immigrants living in New York City?

RQ2: How do Bangladeshi immigrants in New York City negotiate their experiences with the U.S. health care system?

METHOD

Situating our project within the broader framework of the culture-centered approach, we used in-depth interviews as the primary tool for collecting the data. The research procedure and a sample interview questionnaire were submitted to and approved by the institutional review board (IRB). Each interview was preceded by an oral consent in order to explain to participants in Bangla the specific issues of confidentiality, risks, and benefits. The participation of the individuals was voluntary and they were free to not answer any question they did not like. The respondents were also informed that they could stop the interview at any time they wanted to. Additionally, the interviewees were in full control of the language of choice for the interviews, and one out of the 20 participants chose to speak in English; others used all Bangla or a mixture of Bangla and English. Both of us researchers are conversant in Bangla as well as English. One of us conducted the interviews, whereas the other went through the initial analyses and shared the analyses with the interviewer, offering feedback about the protocol. Through this process, we checked our notes, maintained individual journal notes, and recorded and transcribed the conversations with each other.

Participants

The respondents were Bangladeshi immigrants who have been living in the United States for at least 4 years. Each interview was on average 1 hour and 20 minutes in length and focused on health and other similar issues based on the lived experiences of the Bangladeshi immigrants in New York city, asking questions such as: What does health mean to you? What are your lived experiences in negotiating health? What are some of the challenges you face in seeking health? And how do you work through these challenges? We made our initial contacts in the community through local organizations working with immigrant Bangladeshis. Additional interview participants were chosen using the snowballing technique, and we used the screening criterion that the participant had to have a household income that put the person below the poverty line.

We recruited 20 participants, and the number of 20 was arrived at on the basis of earlier culture-centered projects that suggest 20 as an approximate point of theoretical saturation in culture-centered fieldwork (see Dutta-Bergman, 2004a). Because we conducted our reflexive data analyses side-by-side with the interviews, we reached theoretical saturation around 16 interviews, but continued till the 20 interviews were conducted to ensure that there were no additional insights that were being gleaned from the interviews. Each interview thus recorded was translated during the transcription procedure. One of the researchers conducted the translation and transcription, whereas the other researcher, conversant in both Bengali and English, checked the accuracy of the translations. The interviews generated 208 pages of single-spaced transcripts. In addition, the author who conducted the in-depth interviews maintained journal entries that were reflections on the in-depth interviews; the other author maintained journal entries during the data-analytic process. In our study, 12 men and 8 women participated, and all of them lived below the poverty line. Although some of them worked in local restaurants, others worked at a variety of jobs, including construction, cleaning, cab driving, and so on. Most of these jobs were temporary, and did not come with the benefits of health insurance.

Data Analysis

This study sought to explore the contextual meaning of health among low socioeconomic status (SES) immigrant Bangladeshis who live in New York City. The coconstructive grounded theory method was used to analyze the data collected from the interviews, with the goal of coming up with an emergent theoretical framework that developed from the in-depth interviews with the participants (Charmaz, 2000). We took our initial analyses back to the participants in order to conduct member checks, and further revisit our interview protocols. We continually went back and forth with the data throughout our interviewing process, conducting the analysis as we were conducting the interviews, and revising our protocol based on the conversations with participants. In addition, we continually revisited our journal notes and engaged in conversations with each other to make sense of the data. The data were analyzed using open, axial, and selective coding as suggested by Charmaz (2000). Open coding identified the concepts as were explicit from the interviewees' responses. In the next step, commonalities were taken from the open coding and related categories were formed, and these categories were bound together to

form theoretical integration. Our reflexive entries articulated our own reflections as co-participants in the interviews. Here is an instance of a reflexive conversation between us as researchers as we discussed the structural deprivation narrated by participants.

M: The helplessness of knowing that *Khan bhai*[2] would not be able to visit a doctor even in the worst emergency scenario because he would not have money is central to *Khan's* understanding of health. I am struck by his courage in the midst of the knowledge that a crisis could strike anytime and he would not have anything to do (Khan had been suffering from a stomach ache for the last few months; his doctor had recommended getting some tests done but he couldn't afford the tests).

R: You know, when I moved out of Bangladesh, I went and lived in Yemen for many months, working as a migrant worker and doing odd jobs. So I can relate to *Khan's* experience of not having the money to go to the doctor and to get things checked. I remember praying to *Allah* every day that I would be healthy because I simply did not make enough money and could not afford to lose a day's job.

M: I never knew this. So it seems as though this ability to hold a job is essential to ensuring that you have the bare minimum resources.

R: Yes, yes. Without a job, you are on the streets. So holding on to the job . . . Yes. That's why each day you wake up and pray that you are healthy, so you can keep working and send money home. This was my struggle every day.

Reflecting on the personal created an entry point for continually working through the data, and in exploring the convergences between the in-depth worldviews and our understandings of them.

RESULTS

Our analysis revealed three dialectical tensions around which meanings of health are organized in this community of low-income Bangladeshi immigrants. These dialectical tensions include the individual and collective roots of health, structure as a resource and structure as a constraint, and working with and challenging structures. Each of these dialectical tensions constitutes a spatial construction of meanings of health, negotiating between the local and the global at the borderlands, interweaving the linkages among identities, structures, and communicative practices of meaning making. Furthermore, the voices of participants point toward an ecological model of health seeking among low-income Bangladeshi immigrants that ought to take into account the individual and collective enactments of agency amid the interactions between the structural and cultural features of the environment. Essential to the localized theorizing of health in this low-income immigrant community is the emergence of the localized meanings of health in relationship to the globalized structures that are experienced through locally specific spaces of access and through local mobilization of resources.

Individual and Collective Roots of Health

The participants articulated the notion of health being situated at an individual level as well as being a collective entity. For *Karim bhai*, "Health is not just my own. It is also the health of everyone in my family. The health of my neighbors. But to help everyone else, I have to be healthy." This relationship of health being an individual responsibility and a familial/collective resource is a theme that resonated throughout the in-depth interviews. This individualist–collectivist construction of health focused on the question of ownership of health, continuously negotiating between the multiple spaces of ownership within which health is articulated by the participants. Here is an excerpt from a conversation:

Ashraf Mia: So health is not just your own thing, no? Health doesn't belong to you, and also belongs to you.

R: What do you mean by that, it belongs to you but also doesn't belong to you?

Ashraf Mia: It belongs to you meaning you have to take care of it. You are in charge of it and you have to do everything possible so you can make a living and take care of your family.

R: And how then does it not belong to you?

Ashraf Mia: The idea is that it is not your property, at least not just your property. It is a resource that helps you do the things you need to do in order to provide for your wife and children, to take care of your parents, to take care of your extended family, and to be there when anyone in the community here or back in Bangladesh needs you. So that I can do all these things for the people around me, I need to be healthy. Their life depends on my health.

Although the participants often discussed about their personal experiences as central to their understanding of health, they also referred to others in their social network who were vital to their health. Furthermore, they often referred to the community as the context within which health meanings and health experiences were constituted, articulating the ways in which the broader relational network of relatives and community members became the source of support when one

[2]We have use fictitious names in order to protect the identity of participants. Whenever we have used qualifiers such as *bhai* or *apa*, our intent has been to attend to the role of respect that defines the terrains of relationships based on age. So if a participant was perceived by the interviewer as being older than him, he referred to the participant as *bhai, apa, chacha, chachi*.

was not well. Reflecting on this intersection of the individual and the relational dimensions of health as noted in the preceding interaction, we two researchers engaged in a conversation about how we as immigrants struggled with this loss of community-wide support structure of health when we migrated to the United States:

> M: *Ashraf bhai's* story is a story I can relate to. When I first came to the United States in this college town, I didn't know whom I could turn to when I fell sick. You know, back home, when I would fall sick, say have a high fever, my whole family would be around me. The knowledge that there were so many people all around would heal me. The touch of my grandmother's caring hands, my uncles checking in on how I was doing, my aunts watching over my diet, these are all memories of back home.
>
> R: Yes, this part I also missed greatly, and that's when I felt the most lonely when I came to the US. Not having people around, not having others I could rely on, but as I lived here longer, I gradually developed this network with other Bangladeshis. Over the years, we tried to create that for each other, trying to be there for each other.

Similarly, to *Ismail bhai*, health is both an individual resource as well as a collective resource:

> Personally, to me, I believe, health is the physical and mental well-being. That includes not only me, but myself, my family, and the community as a whole; since I live in a family and in a community, everything that happens to anyone in the community, that could affect myself as well, because I am part of the community. For instance, if somebody gets affected by tuberculosis in my community, and I have to deal with that person, let's say at work or at a hospital or in my family, I am affected directly or indirectly. To summarize, health means to be concerned about the physical and mental health of myself, my family, and the community.

As *Ismail bhai* notes, health is intertwined within a continuous web of meaning-making that brings together experiences, ownerships, and responsibilities at multiple levels that range from the individual to the community. The social network of others in the community is integral to the participants' conceptualization of health. Here, the intertwined locus of health emerges through the localized meanings shared by participants that foreground the health of the collective. The personal ownership of health is interconnected with the relational, familial, and collective ownership of health. What happens to others in the family and the community influences the individual and his or her health.

Individual ownership is important; simultaneously, family and community ownership extends the purview of what is considered to be healthy. Similarly, for *Shoeb*, "My family's health is my most important responsibility. If everyone else is healthy, then I am healthy." Therefore, health is thought of in terms of the experiences not only of the individual, but also of the family and the community. The extension from the family to the community plays out in constructions of a wider network of support within the Bangladeshi immigrant community: "People help each other out. If something happens to a brother or his family, we have to go and help. I can expect others here to help me also. In this community, everyone helps each other out." In this interconnected web, health at the individual level is deeply connected with health at the family and community levels. Therefore, caring for one's health as an individual goes hand-in-hand with caring for the health needs of one's own family and community. *Shogru chacha* further goes on to elucidate this nature of the community:

> Community health like I said, if I live in a community, a city or town or my neighborhood, all part of my community, if I work the part of my community, if I go to school the part of my community, people who I deal with, people I see, people I meet every day at work, at home, at my health center, they are part of my community.

The notion of the community refers to a geographical space within which health is constituted, including various institutions, organizations, and organizing structures within this space who come to constitute the community. The different organizations and networks that a person comes across in that person's everyday life all constitute a part of the person's community, and therefore, responsibility is played out in these different realms. The importance of the collective in health seeking and decision making is also noted by *Ujjol*:

> People who live alone without their family, they don't think about taking care of their health because they have no one around, and they also don't have close relatives in their homes to take care of them. A brother of mine who lives here was in great danger. So we came and recovered him to go the hospital. Then he had to face more problems for waiting all that time, and not having gone to the doctor immediately. He had breathing problems for that. If we were here, we would have noticed things and taken him to the doctor much earlier. Things wouldn't have gone bad. Yes, people who live alone are less conscious about their health. So we came and took him to a hospital. He used to work as a vendor. He didn't go to the doctor since he lived alone and I think he didn't have insurance either. Yes, money is a big problem. So we came, put together the money, took charge of him and brought him to the doctor.

In *Ujjol's* understanding of health as responsibility of the family, the family and the collective play important roles in the negotiations of individual health. Family members are more likely to notice someone's illness, and then take responsibility for the problem, bringing the patient to the physician and getting the patient treated, as well as offering care. In this sense, health is constituted not only in individual experiences and meanings, but also in interactions with

others, constituted in the interconnected webs of meanings negotiated through these interactions with family members and the broader community. In the context of his brother's health, because his brother was living by himself, there was no one to take care of him. As a result of this, his brother ended up not going to the doctor, which, according to *Ujjol*, adversely affected his health. He further points out that when he figured out that his brother was sick, he got together with other community members and pooled together the necessary economic resources in order to secure access to treatment for his brother.

For *Saibal*, "Health is not just about whether I am healthy or not. It is really also much more about my parents, whether they are healthy. My nephews and nieces; whether they are healthy." The conceptualization of health once again is constituted in terms of relationships. Noting this interconnected web of help and support, *Rehan* compares the sociocultural network of health in the United States with his experiences in Bangladesh, stating, "But people will help you in Bangladesh. This country is not helping." The juxtaposition of the community in Bangladesh with the lived experience in New York City constructs a sense of being disconnected from one's community (referring to the community of origin in Bangladesh), and therefore being unable to tap into the community resources of support that were once available in Bangladesh. This redefinition of the community juxtaposed into the spaces of New York is rooted among localized understandings of the community as situated in spaces "back home," referring to the community of origin in Bangladesh. Even as participants refer to the strong networks of support that existed in rural Bangladesh (most participants in our project talked about coming to the United States from some rural area of Bangladesh), they discuss how they work toward creating these spaces of support in New York City by trying to be there for each other. This point is well articulated by *Majhar*: "We help each other in this community. When I have a health need, I will go to *Idris bhai* and *Karim chacha* for help. Each of us like this has people that we can go to. It is not ideal like Bangladesh where that really close friendship in the community is very strong. But it still is very helpful that we try to be there for helping others."

Structure as Resource and Structure as Constraint

Health is continually discussed in reference to the structures that constitute it. For *Ayub bhai*, health is situated structurally in terms of one's (in)ability to have access to health insurance. Here, structure acts a barrier to the ability to secure health. One's economic viability as a participant in the workforce dictates whether or not one will have access to health insurance and therefore be able to afford health services.

> To me, insurance. Like I said, I don't have a job, I don't have insurance. Now if I get sick I have to . . . I always try to be careful, if I get sick I have to kill myself. I don't have access to the doctor, as what I have to pay is very expensive. So health care . . . because of health insurance . . . is very expensive. If I had insurance, I would like to check my blood once a year, I would like to do a physical once a year, but if you don't have health insurance how would you be doing that.

The capability to seek out health services and the capacity to take preventive measures are both tied to the ability to find and keep a job that would pay for health insurance. Therefore, for *Ayub bhai*, what continued to be highlighted in our conversation is the importance of job as a resource for securing access to health. In the absence of insurance, he is unable to seek out treatment when he is sick; in addition, not having health insurance prevents him from engaging in preventive measures like getting his blood checked or getting a physical. Note here the keen sense of awareness that *Ayub bhai* has about the things he needs to do in order to keep himself healthy (such as getting his blood checked or getting a physical), juxtaposed on the backdrop of the lack of economic resources for securing these preventive health measures.

In order to provide for health for oneself and for one's family, it is pivotal to have health insurance. The pivotal role of health insurance in securing access to health is also noted by *Ishan bhai*:

> I have a steady health insurance for the past 5 years. Before that, I didn't have my full health insurance. My kids had them. But me and my wife didn't have any health insurance. At that time it was like, we didn't have basically anything. So for the last 5 years, I have a pretty well health insurance. Like at the birth of my younger son, the insurance company paid over 200,000 dollars, because he was premature and he stayed in the hospital for 1 month and they charged like 155,000, and in the delivery time, they paid another 75,000. So, health insurance to me is a big deal. I took my health insurance from my work. It covers my whole family.

Idris bhai points out that one basically doesn't have any access to health services until one has health insurance through work. Having insurance, however, provides for most of the cost of visiting the doctor and securing treatment. When he didn't have insurance, *Idris bhai* notes that he literally didn't have anything. However, once he received insurance from work and received coverage for the entire family, *Idris bhai* could afford visits to the doctor and treatments for his family. Similar articulation of health in terms of the ability to seek out and keep a job is also noted in the story of *Javed bhai*. This is what he has to say:

> Bangladesh is one of the poorest countries of the world. But tell me what America is doing to help us? Here everything is expensive, rice, veggies, etc. Now you work, earn money, and can buy medicine. But if I am sick and can't work for a month or 15 days, no one will help me. No hospital will

> help. They will tell me "No money. Go, go away." They won't help even if you request. Even if you die, no hospital will help you.

Health is constructed in terms of the (in)ability to secure access to basic resources such as food and medicine, which in turn depend upon the ability to have a job. Further, as *Javed bhai* notes, becoming sick makes an individual incapable of participating in the workforce, which also then limits that person's ability to secure access to health services. Noting the economic nature of health care access in the United States, he states that he is unable to receive health care without having the economic capacity to purchase it.

Noting further the role of structural constraints in the realm of immigrant health experiences, *Kareem chacha* says:

> What can I say/ Here I am at a hospital; waiting 3 hours, but no one cares. They are having meetings inside. No one cares. I think the problem is poor hospital maintenance—the administration is not doing their work properly. The administrators are not watching things properly. The bad treatments include making me wait and being rude . . . not giving any explanation . . . perhaps she was in a bad mood because of her family. . and she was taking it out on me. I waited 3 hrs for a piece of paper—I had to wait 3 hrs just to find out when my next appointment is. It took 2 hrs for the doc to see me, all tests took 2 hrs, she took 3 hrs, equaling to a total of 7 hrs. If I come to the hospital for 7 hrs, how will my family survive, I asked.

Kareem chacha points to the role of structural constrains in being able to access health. Foregrounding a resource-based understanding of health, he talks about waiting for three hours to see a doctor and not being able to see one. He discusses the wait time and the rude behaviors of staff. After having waited for three hours, *Kareem chacha* was told about his next appointment. He reports that he spent seven hours in total for his hospital visit, which took away time from the hours he could have spent working. The ability to access a hospital therefore is situated in contrast to the ability to work for the day and earn money to feed the family. From a resource-based standpoint, the resources expended in seeking care (in this case, time) are rationed against the backdrop of other valuable resources (such as food) that one could procure with one's limited access as a low-income immigrant. Also evident in *Kareem chacha's* articulation is the reference to mistreatment by the hospital staff.

Similarly, *Jehangir bhai* notes:

> The hospital people . . . I think that they hate ("*ghinna*") us. Probably because we are foreigners. Perhaps that's why they give us the runaround, and subject us to such hard times. It is not only with me, I have asked other Bangladeshi people. Same story. They have said the same things. Long waits and ruining that day's work. So are we going to work or go to the hospital/

Similar to *Kareem chacha*, *Jehangir bhai's* articulation of his experiences with the hospital system draws attention to the rudeness of the hospital staff and the mistreatment in the hands of the staff. He explains this rudeness by referring to his status as a foreigner, stating that the hospital staff probably hate him and other Bangladeshis because of their foreigner status in the country. He discusses having to wait in long lines, often having to lose a day's work in order to make a trip to the hospital. This, he says, is the main structural constraint that prevents people from accessing the hospitals. Note here the interplay between the material and symbolic realms of structural marginalization, particularly as they relate to communication and the long wait times at the hospital. The communicative practices within specific dominant structures work toward keeping these structures inaccessible among the Bangladeshi immigrant community. The minimal visits to the hospital among community members are tied to how poorly they are treated at hospitals and the long lines they have to wait in, which imply lost hours working in order to make money for a living for the day.

Working With and Challenging Structures

Even as the participants discuss the structures that constrain and enable their experiences of health, they also narrate the everyday practices through which they negotiate their agency with respect to the health structures that marginalize them. Structures, as noted earlier, refer to systems of organizing. The participants in this project continuously draw attention to the health structures that constrain their experiences with health; they discuss both material and symbolic/communicative aspects of existing structures that disenfranchise low-income immigrants. They also consistently discuss the importance of having a stable job and health insurance in order to secure access to health resources. It is against this backdrop that *Kallol* states:

> Well, the problems are like language based when you are new here. You don't know too many people here. People who have lived here long enough, you can go them for help. And about the insurance when you first come here, at first everyone has to pay. If I work at a company and if I apply for insurance then it's a plus point since you do not have to pay much then. They'll pay for you. You can see a doctor there as well. You won't be able to earn all that money on your first time here. Like if you are here and you are working, then you keep aside some money for your health so that you can go to the doctor once every two three months. Yes, I'm solving my money problem by going to the doctor late, like when you first come here, you don't have much money. When you find work and earn some money only then you can go see a doctor and get a checkup.

Kallol is deeply aware of the difficulties that are faced by an immigrant, including problems of language, not having information about a new culture, and not knowing people in the new culture. Symbolically, lack of access to communicative resources such as language and information about the new culture stands as a barrier to accessing health for

new immigrants. However, community-based social capital in terms of knowing others from Bangladesh who have lived in the United States for a long time acts as a health-enhancing resource. Noting the importance of getting health insurance in order to be able to go see a doctor, *Kallol* foregrounds the importance of finding a job immediately after one arrives in the United States in order to support the visits to the doctor. Furthermore, attending to the limited income a new immigrant from Bangladesh is going to have, he notes the importance of saving some money for the purposes of health. He solves his money problem by increasing the duration between his visits so that he pays for a limited number of visits to the doctor, and by rationing his allocation of money to health resources.

Similar references to optimizing the number of visits or delaying checkups are made by participants in the project. *Amjad* points out: "I will not go to the doctor unless it is serious. I will wait for a few days to see it will heal by itself. If not, and it gets pretty bad, then I will go to the doctor." So the visit to the doctor is rationed out based on the severity of the problem. Similarly, *Kareem* notes:

> To solve the insurance problem as I said, like if you work at a company, then you could buy the company insurance policy, like we're given our insurance from our company. No, not everyone though. Like our boss, he didn't have insurance actually. So he applied a few days back. He still hasn't received it though. They are saying they'll give him.

For *Kareem*, he has to work in order to secure access to an insurance that would then pay for the health needs. Working at a company allows an individual to purchase an insurance policy. For *Rashida apa*, considering the kind of insurance offered with a job is one of the most important factors to be considered in the decision to take up a job. Here's her articulation:

> Getting another job, before I find a job, before I accept the offer, I make sure what kind of health care they provide. When I don't have a job I'll try to see if I could apply for Medicaid or something if I am eligible. I'll take it while I'm looking for a job. The problem is finding a job, what kind of insurance they have. . . . Meanwhile keep myself active physically, make sure watching my diet, that's why I don't have to get sick. Oh that's the main headache. Insurance, if I don't have insurance, I have to have . . . I'll be really really concerned. I'll go apply for Medicaid. I don't know if they would accept which I haven't tried it, because of their way. Medicaid is kind of a welfare insurance . . . health insurance. For people who don't have jobs or don't have money, the government provides Medicaid. Medicare is federally funded which are for elderly people, when you become 65 plus. You are eligible for Medicare. . . . So I believe, every state has their own standards. Some states say if you earn fifteen thousand and below, you are eligible. It depends . . . but I would like to constantly check these things.

Rasheeda apa articulates a complex web of decision making in considering the insurance attached with a job offer, continually rationing health resources. She states that one needs to know as much information as possible regarding the insurance offered with a specific job, and then base one's decision accordingly, as health care is expensive. She further establishes an action plan for going about securing health care if she didn't have insurance, including applying for Medicaid. Simultaneously, in the absence of the structural resources for accessing health care, she would be particularly cognizant of her health and consciously try to keep herself healthy by making healthy choices such as watching her diet and staying physically actively. She also discusses actively seeking out information before making a decision, pointing to the importance of information resources in health decision-making. Here, individual agency is constructed in the discursive space as a way of negotiating the limited structural resources, trying to limit the number of visits to the doctor and taking care of one's health.

In addition to working with the structures of health, participants also discuss their critical interrogations of structures. Agency is enacted through the articulations of interpretive frames that disrupt the hegemony of the dominant articulations of biomedicine within agendas of profiteering. Here is what *Ayub chacha* had to say:

> They start giving medicines because they want to make profits. The doctors they have their own businesses. They have their own clinics. So if you want to go to a laboratory. . . . I used to go to a doctor here in Hysteria . . . he convinced me to take his medication for cholesterol. . . . I only had 200 cholesterol, which is the borderline, so he told me to take all these medicines . . . because I had good insurance, he tried to make money from my insurance. I can tell you how. He sent me to 3 different clinics. One to do my nuclear test, stress test. When I went there, I saw him there. Then I finally found out he is the owner of the clinic. The third clinic he sent me, he told me I had to monitor for a 7 days . . . he installed a monitor, which I had to carry for 7 days with me even when I went to sleep, going to the gym, going to work, all the time just to monitor my heart. There was no problem, but he made money from that.

By noting the commercial base of biomedicine and by drawing attention to the profit-making interests of the doctor, *Ayub chacha* disrupted the sacred base of biomedicine that is often constructed out of its inherent capitalist interests. He further pointed out that the doctor prescribed all the medications and tests because he could make money out of them. The profit-making function of biomedicine becomes foregrounded in this localized interpretation of *Ayub chacha* narrated through his experience, and through this foregrounding, the dominant narratives of biomedicine are disrupted and challenged. *Ayub chacha's* discursive enunciation disrupts the mainstream structures by noting that the doctor made money out of him, by sending him to do tests that he didn't need at clinics that he owned. Similarly,

Rasheeda apa points out, "Here, everything is about the money. If you don't have the money, you can't get to the doctor." *Kallol* shares, "Because I don't have money, I can't go to the doctors when I need to. Tell me, who makes the rule that you have to have money to see the doctor/ Don't people like us have health needs/" In these narratives of health, the taken-for-granted assumptions underlying the political–economic configurations of structures of health care are questioned by the participants. That the practice of medicine is attached to making money becomes foregrounded as an interpretive frame.

In addition to suggesting alternative interpretive frames for questioning the taken-for-granted assumptions about how health care is organized in New York City, participants also discussed the everyday acts they participated in as they negotiated their experiences with the dominant structures of health. These acts offer entry points for disrupting the structures of oppression that the Bangladeshi migrants have to negotiate in New York City. In one such example, after narrating his poor treatment at the hospital and his experience of having to spend an entire day waiting to receive treatment, *Rashid bhai* spoke up, narrating the story of how he interrupted the marginalizing practices of the structure by drawing attention to it and by talking back to it:

> I told her that sorry does not cut it. I told her that because of such reasons we do not come to the hospital because if this behavior, because of their carelessness, we lose one day's job and not able to bring home money to feed the family.

In this case, the status quo is ruptured through the enunciation of *Rashid bhai* that "sorry does not cut it." *Rashid bhai* pointed out his experience to the hospital staff and then explained the effects of the hospital staff's behavior on the lives of individual patients who lose one day's job because of hospital carelessness and then are unable to feed the family. The articulation offered by him to the hospital staff thus introduced the alternative frame of interlinked communicative and material marginalizations into the discursive space. For *Kareem chacha,* being rude back to the staff and providers is a way for enacting his agency. *Nurusa* similarly notes that she avoids going to the hospital because she cannot afford the long waits at the hospital in order to get to the doctor, thus enacting her agency in avoiding a visit to the provider.

DISCUSSION

Immigration constitutes the borders of contemporary neoliberal health structures through the flow of labor as a cheap resource for the global economy[3] (Dutta, 2011; Walker & Barnett, 2007). This flow of labor is marked by the proletarianization of labor, with the location of immigrants at the material margins of mainstream societies (Dutta, 2011). The marginalization of immigrants is evident in health care in the form of the structural disparities experienced by immigrants in terms of their access to health, the quality of health care they receive, and their lack of access to health information and preventive resources (Bollini, 1993; Bollini & Siem, 1995). Walker and Barnett (2007) note that immigrants consistently experience barriers to accessing health care, also played out communicatively through language and literacy barriers and the lack of adequate professional interpreters within health care settings. Bangladeshi immigrants in the United States constitute one such marginalized sector, with a large proportion of Bangladeshi immigrants living below the poverty line. New York City, with the largest number of Bangladeshi immigrants living below the poverty line, is a site where Bangladeshi immigrants continually negotiate their structural marginalization. Our engagement with the culture-centered approach in this project sought to create discursive openings for listening to the voices of Bangladeshi immigrants living below the poverty line in New York City, with the hope of offering discursive entry points for engaging the practice of immigrant medicine, for developing conceptual suggestions for the redesigning of health care delivery systems to provide care that is timely, safe, efficient, equitable, and patient centered (Walker & Barnett, 2007).

Our discursive engagement with the participants in this project situates low-income Bangladeshi immigrant health at the margins of mainstream U.S. health care, amid the dialectical tensions between individual and collective roots of health, structure as resource and structure as constraint, and working with and working against structures. These dialectical tensions constitute the discursive spaces in marginalized sectors as continuously contested, being open to multiple interpretations, and serving as sites of change through the articulations of new possibilities as they emerge amid these tensions. The negotiation of multiple meanings in the discursive space highlights the importance of culturally complex and contextually embedded treatments of health communication, grounded in the localized articulations of cultural members. What we learn from these complexities is the necessity to treat immigrant medicine within complex and dynamic contexts, with an openness to engaging the lived experiences of immigrant patients with respect, cultural humility, and compassion (see also Walker & Barnett, 2007).

[3]Although it is important to point out that immigration movements of the middle and upper middle classes across nation-states (such as well-educated South Asian immigrants who immigrate to the Silicon Valley) occupy the financial centers of neoliberalism, a much larger percentage of immigration happens in the context of economic and structural marginalization. For example, as an aggregate, Bangladeshis in New York City have lower incomes, have higher poverty rates, devote large portions of their incomes to housing costs, and live in more crowded housing as compared to all New York City residents (AAF, 2009).

What we learn from these dialogic co-constructions with cultural members is that culture is nuanced, complex, dynamic, and often contradictory, and therefore can't be reduced categorically to a construct such as collectivism in order to explain health behaviors (see Dutta, 2008).

In the example of the locus of responsibility for health, we see the dynamic relationships among individual, familial, community-based, and societal loci of health. What this means for the restructuring of immigrant medicine is that rather than developing checkboxes for communicating with specific cultures on the basis of specific recipes for effectiveness based on reductionist notions of cultural sensitivity (say, in this case, a cultural sensitivity recipe for interacting with Bangladeshi immigrants), the training of providers needs to begin with teaching providers in methods of dialogic engagement and listening, attending to the diverse and contradictory worldviews of patients. What immigrant community members such as *Ashraf Mia* teach us through articulations such as "Health doesn't belong to you, and also belongs to you" is that there are no straightforward answers when engaging with the complexities of cultures and the ways in which these complexities play out in the lived experiences of individual patients. In this instance, when responding to the sense of individual responsibility of the patient for his health, immigrant medicine also needs to be responsive to the familial and community-based loci of decision making and the role of important others in caring for *Ashraf Mia's* health. On one hand, such an articulation challenges the universalized biomedical model that treats health as an individual construct and emphasizes individual-level decision making. On the other hand, the simultaneous existence of the individual and the collective in conceptualizations of health contradicts the universal assumptions in cross-cultural studies of health communication that categorize cultures in terms of distinct and stable constructs such as individualism and collectivism (Dutta, 2008). Rather than being categorized into a reductionist box of constructs on the basis of stable characteristics, culture here expresses itself in the midst of the negotiations of structure and agency, tapping into the many nuances of decision making as participants negotiate the structures within which their health experiences are constituted. Systems of patient information processing that render salient issues of privacy from individualistic perspectives therefore need to be made responsive to relational, collective, and community-based notions of care, along with wider loci of information processing and decision making regarding the health of the patient.

Particularly for low-income immigrants such as the participants in this project, experiences of health are deeply structured amid spaces of inaccess. Structure becomes salient in terms of shaping how immigrants go about seeking health care, their use of health services and treatment options, and their likelihood of allocating limited valuable resources to taking care of their health. In the stories of the participants, we witness the ways in which they enact their agency by rationing the limited structural resources available to them and by relying on their social and community networks. The participants in this project discuss their own roles in taking care of their health, and simultaneously underscore the important role of the family and the community in taking care of each other and in offering resources for prevention, as well as in seeking out health resources. This emphasis on individual roles and responsibilities situated in the context of the responsibilities of the collective demonstrates the simultaneity of distinctly opposing conceptualizations in the interpretive frameworks of health. Different culturally situated meanings become relevant at different points of meaning making as participants enact their agency in negotiating the structures within which they find themselves, and draw upon a range of individual and collective resources. For the Bangladeshi low-income immigrants in our project, their community ties provide strong sets of resources in an environment that offers them very little in terms of resources.

When patients discuss the ways in which they ration their budget to prioritize their treatment options, they demonstrate the need for centering conversations and policies on the core issue of accessibility to health care among low-income immigrants. Issues of language, communication, understanding, and time spent at the hospital are rendered salient, because they play critical roles as structural impediments to patient access to health care. When a patient loses a day's work trying to make an appointment with a doctor, he is unlikely to make the visit to the doctor, as this also means that he would not be making the money that he needs to make working for the day. So visiting the doctor in this instance minimizes the ability of the community member to provide for his family. Policy-based solutions therefore ought to focus on the development of resources that minimize the amount of time that community members have to spend waiting for their visits with the provider.

The voices of the participants not only discuss the absence of resources as framed within the dominant structures of health, but they also discuss the access to health resources created by certain structures. Referring to the necessity for having health insurance in order to access health resources, participants discuss the constraining nature of "health insurance" as well as their decisions to seek out jobs that offer insurance. Finding a job is articulated as a stepping-stone to accessing health care because health insurance often comes with jobs. As new immigrants, they learn about these intricacies regarding securing health resources from others in their social networks. Participants spend a great deal of time speaking with others and seeking out information before taking a job, and this decision is primarily guided by the question of whether the job offers health insurance or not; here, community and interpersonal networks serve as important sources of information for securing access to material infrastructures.

Within these constraining and enabling roles of structures, the participants suggest the primacy of work to the

accessibility of health. Drawing attention to the proletarianization of labor in the realm of immigration, this discourse highlights the commoditization of health. Health becomes accessible only as long as it is tied to work; the ability of the migrant to participate in the neoliberal economy as a worker determines his or her capacity to secure access to health resources. This suggests the necessity for culture-centered interrogations that deconstruct the hegemonic configurations in dominant discourses of health (Dutta, 2008). The margins of health in the global landscape are created precisely because they get situated at the peripheries of the global discourses of health that emphasize health as an economic commodity tied to the sources of labor. What are the implications of commoditizing health in a global economy, and what are the discursive possibilities for challenging these configurations/ Future scholarship and praxis in health communication ought to interrogate the public policies that construct health at the margins, constituting it as a commodity in the market-based capitalist economy. From policy standpoints, these discourses point toward the creation of structural and communicative resources such as access to health services, cross-cultural communication and communication competence training programs for hospital staff, translation services, and so on.

Finally, as the participants in this project discuss their co-constructions of the dominant health structures that constrain and enable their opportunities for accessing health, they also bring forth their understandings of working with and working against these structures, thus drawing attention to the complexity and contradictory nature of agency as it works with and against the structures. Even as agency works with structures in order to seek access to health resources, it simultaneously challenges structures with the agendas of transforming them. The discursive introduction of alternative narratives that challenge the hegemonic control of the biomedical narrative demonstrates the enactment of the agency through the articulation of alternative interpretive frames. These interpretive frames then challenge the assumptions that circulate in the dominant structures of health communication, thus creating openings for change. Participants also reinterpret structures by interrupting the hegemony of biomedical interactions, articulating narratives that question their marginalization.

The presence of hitherto marginalized voices in the discursive spaces of knowledge production foregrounds the stories of pain, suffering, struggle, and meaning-making among those very marginalized sectors that are traditionally stripped of agency in dominant discourses of health. The presence of the voices of Bangladeshi immigrants in New York City in this project suggests the relevance of engaging policymakers with these stories of oppression and marginalization, and of working together with Bangladeshi immigrant communities in seeking spaces for structural transformations in securing access to health resources. The lack of communication resources and the difficulties of understanding as Bangladeshi immigrants living below the poverty line navigate the health care system in New York City point to the necessity for developing training programs for providers that foreground understanding, compassion, respect, and cultural humility. Engaging these immigrant voices in dominant discursive platforms creates openings for change by disrupting the assumptions that circulate in mainstream public spheres about the subaltern sectors of the globe; it is precisely through the presence of alternative subaltern rationalities in these platforms that the dominant assumptions of health and well-being are disrupted, thus also creating entry points for transformations.

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