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Culture, Structure, and Health: Narratives of Low-income Bangladeshi Migrant Workers from the United Arab Emirates

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ABSTRACT

Increasingly, health scholars are paying attention to the health experiences of immigrant communities, particularly in the backdrop of the global flows of goods, services, and people across borders. In spite of the increasing public health emphasis on health outcomes of immigrants within the Middle Eastern (ME) countries, 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 ME. Based on the culture-centered approach, we engaged in in-depth face-to-face interviews, and focus groups discussions with a total of 44 research participants, to understand how low-income Bangladeshi migrant workers in the United Arab Emirates (UAE), who live at the borders of mainstream Arab society, define, construct, and negotiate health issues. Participants articulate in their narratives their nuanced cultural understanding of good health as a complex, holistic practice, the achievement of which is obstructed by barriers such as immigration and insurance structures. Further, they enact their agency in resource impoverished circumstances to protect their mental health and physical well-being through daily strategies and acts of resistance.

Introduction

Globalization and neoliberalism have made labor-based migration both desirable and dangerous for the migrants traversing national boundaries in search of better livelihoods and opportunities. Temporary migrant laborers, by definition, exist in a precarious space in their host countries both professionally and personally. A large body of literature documents such a concept of precarity described both as a labor condition (Bourdieu, 1998) as well as a distinct class (Standing, 2011) suffering from a lack of traditional protections by the state including job security, the right to unionize and the right to citizenship, relegating them to a lower socioeconomic status devoid of mainstream voice. Furthermore, those who have not lived in the host country for a given number of years also contend with limited residency rights, restricted access to the job market, as well as severely truncated social security and healthcare benefits (Bollini, 1993). The aforementioned barriers faced by migrant bodies are compounded by the racial and ethnic discrimination they experience in accessing health services which pathologize the migrant patient and culture as inappropriate and inferior (Bollini & Siem, 1995). It is within such spaces of discrimination that the culture-centered approach (CCA) to health communication envisions transformative possibilities. It locates agency in the unheard voices of marginalized bodies, displacing top-down health interventions as expertise and instating in its place the epistemology of culture as knowledge.

The challenges of culturally ineffective health information and health resources for low socioeconomic status (SES) immigrants, such as temporary migrant labor have been well-documented (Bollini & Siem, 1995; Dutta, 2008, 2011; M. Dutta & Jamil, 2013; Kandula et al., 2004; Rashid, 2002; Walker & Barnett, 2007). Such critical research poses a challenge to traditional health communication literature conceptualizing marginalized communities as lacking agency and positioning marginalized bodies as sites of prescriptive interventions by health and communication experts (Airhihenbuwa, 1995; Dutta & Basu, 2008; Dutta-Bergman, 2004a, 2004b; Ford & Yep, 2003; Jamil & Dutta, 2011, 2012; Mokros & Deetz, 1996; Ray, 1996). The transmission model of communication adopted for context-rich experiences of health lacks the nuance required for effectively defining problems and co-constructing solutions with community partners. Furthermore, such prescriptions create message frames based on individual-level behaviors as opposed to considering the role of context and culture in the messaging responses of patients (Dutta & Basu, 2008; Jamil & Dutta, 2012; Murray-Johnson & Witte, 2003). Such assumptions of health behaviors marginalize migrant and ethnic communities and devise solutions based on individual scales, often dissonant with the communal linkages utilized by these groups when describing their health experiences. In response to calls for more community-centric health interventions, the CCA prompts a recognition and utilization of the agency of structurally

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marginalized groups in improving health outcomes (Airhihenbuwa, 1995; Dutta, 2008; M. Dutta & Jamil, 2013; Mokros & Deetz, 1996; Sharf & Kahler, 1996).

In our research, we specifically engage in dialogic co-constructions of the experiences of health among low-skilled, blue-collar Bangladeshi migrant workers in the United Arab Emirates (UAE), serving in the construction industry and as domestic labor. Bangladesh, a small country suffers from a combination of widespread poverty, inadequate healthcare structures, environmental degradation and largely underemployed young populace (Kibria, 2011). This network of lack of access and infrastructure has precipitated the migration of its citizens globally in search of better opportunities, albeit as low-skilled labor (Kibria, 2011). Here an important distinction is to be drawn between the experience of low-income migrant labor and that of highly educated, socio-economically privileged migrant communities from the global South (such as Silicon Valley workers in the U.S.). Here we attempt to foreground the localized experiences of low-income migrant labor to suggest critical co-constructions of lived experiences of health and access for change in health policies and interventions. Given the communicative and material marginalization among Bangladeshi workers in Middle Eastern countries, a culture-centered engagement with this community offers entry points into theorizing meanings of health from the margins and developing corresponding applications. This culture-centered project aims to answer the following research question (RQ): How do the low-income Bangladeshi immigrants in the UAE, who live at the borders of mainstream Arab society, define, construct, and negotiate health and healthcare? Through in-depth face-to-face and focus group interviews with low-income Bangladeshi immigrants, we seek to understand the interpretive frames through which our participants understand their experiences of health (Dutta & Basu, 2008; Jamil & Dutta, 2012).

Literature review

Global labor challenges and the Middle East

Temporary migrant labor, particularly that of low socioeconomic status (SES), faces a lack of access to health services in addition to dangerous labor conditions. These are coupled with a dearth of protections in physically demanding jobs resulting in poor physical and mental health outcomes (AWARE (Alliance for Workers Against Repression Everywhere), 2016; International Organization for Migration, 2018; Meyer et al., 2014). There has been wide-ranging coverage of issues affecting temporary migrant labor in the United States such as transposed Latino farmworkers suffering from alcohol dependence (Finch et al., 2003), prevalence of STIs (Apostolopoulos et al., 2006), as well as mental health issues (Magana & Hovey, 2003; Ramos et al., 2015). Furthermore, studies in other parts of the world have also identified risky sexual health behaviors among Tajikistani workers in Russia (Weine et al., 2013), workplace accidents among Nepali workers in the Middle East (Adhikary et al., 2019), and high depression and suicide rates among migrant workers in the UAE (Al-Maskari et al., 2011).

Taking on hazardous and low paying jobs that citizens of the receiving countries are unwilling to take (the "3-D" jobs – dangerous, dirty, degrading (Benach et al. (2011)) such as mining, agriculture, construction, and domestic work, low SES migrant workers are restricted from giving voice to any health or workplace safety concerns due to fear of deportation (International Organization for Migration, 2018). Exacerbating the effects of poor healthcare and insurance usually reserved for those with citizenship status (Strauss & McGrath, 2017; Yea, 2017), communicative marginalization works to silence the dialog required to improve health services and outcomes for this precariously positioned community. Dutta-Bergman (2004a, 2004b) and Dutta (2008, 2011) see such health inequities as symptoms of a lack of co-constructive engagement with migrant labor voices which are ritually subject to expert prescriptions of healthy practices within the mainstream discourse. In traditional health communication interventions, top-down knowledge dissemination occurs with the assumption of a static and passive public. Airhihenbuwa (1995) and others (Kreuter & McClure, 2004; Rogers, 2000; Svenkerud & Singhal, 1998) have criticized the lack of a cultural lens in such expert-driven initiatives, calling for a more inclusive strategy resulting in improved health outcomes in marginalized communities. Dutta (2008, 2011) further notes that erasure from communicative spaces concomitantly acts as a barrier to structures of healthcare, advocating for the community as the expert. Based upon such community-driven voices and agency, the present research unpacks the marginalized narratives of low-income Bangladeshi laborers in the UAE. Drawing upon the cultural knowledge and agency of community members, the core tenets of the culture-centered approach (CCA), this research aims to create solutions to healthcare barriers through unique community-derived solutions.

Context – Bangladesh

Situated in south Asia, and bordered on three sides by India, the People's Republic of Bangladesh is a small country which became economically and structurally fragile after its independence war against Pakistan in 1971 ("Bangladesh", 2018). Due to unemployment (4%), high underemployment (40%, with people working few hours for low wages), and poverty, people have migrated to Middle Eastern countries for better economic opportunity, with a migration rate of 3.1 for every 1000 citizens ("Bangladesh", 2018). A 2017 report shows there are roughly four million Bangladeshis living abroad with about three-quarters of them living in the Middle Eastern countries, specifically in the Gulf Cooperation Council (GCC) countries (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates) ("Bangladeshis in the ME", 2018). A majority of these workers fall under an unskilled visa/work category known in the Arab world as the *kafala* system.

The kafala system

This system "restricts family reunification for unskilled migrants, ties them to a single employer, disallows them

from marrying locals, and enforces other restrictions on rights and movements so that migrants stay as transient workers" in their work countries (Rahman, 2015, p. 205). The workers in the kafala system typically work in the domestic and the construction sectors. The employer of a worker is responsible for all legal matters (legal immigration status, visa renewal, health insurance, etc.) while employed in the country. Many human rights organizations consider the kafala system as a tool for forced labor and human rights violations (Rahman, 2015). While some countries have tried to address the limitations and criticisms of the kafala system by formulating more equitable laws, there continues to be a need for substantial changes, in addition to minor ones as well as better oversight for the implementation of the same. For example, the UAE has reformed laws to ensure domestic workers have at least one day off from work every week and get eight hours of rest in a 24-hour period ("Migrant Workers UAE", 2014). However, questions remain "about the implementation and adequacy of these reforms" ("For a Better Life.", 2012) with places like Qatar continuing to be in the news for construction labor abuses during construction for the 2022 FIFA Football World Cup (Renkiewicz, 2016), without any remediation of the same (Conn, 2018). Although this research has focused primarily on the UAE, publicly available information and workers' experiences shared on social media show very similar responses across the Middle East in terms of their struggles, challenges, sufferings, and hopes.

Culture-centered approach

The traditional paradigm of health communication research has focused on a linear, top-down model of health intervention assuming a passive audience's automatic reception of health messages (Dutta & Basu, 2008; Lupton, 1994, 2003). Challenging this assumption and heeding the call for a dialogic incorporation of marginalized voices in health policy (Dutta-Bergman, 2004a, 2004b; Mokros & Deetz, 1996; Sharf & Kahler, 1996) the culture-centered approach (CCA) locates community agency and culture at the foreground of health communication theory and practice. CCA further encourages health interventions to be devised with an awareness of the context-rich community input of marginalized voices, where meaning-making based on one's lived cultural experience is considered central to an effective health communication. It emphasizes the central tenets of culture, structure, and agency, locating within localized communities' understandings of health their agentic capacity to affect change by alternately drawing on the enabling powers of structures while simultaneously circumventing their constraining effects (Dutta & Basu, 2008). Kreuter and McClure (2004) also note that the inclusion of culture as a lens to guide health communication practice can enable more effective strategies for eliminating health disparities.

Dutta (2008) sees culture as a complex framework of localized meaning making and context, subject to shared meanings, interpretations, interactions, and values, that renders culture as both "transformative and constitutive" (Dutta-Bergman, 2004b, p. 241) Envisioning CCA as a dialectic process where understandings of health are primarily co-created by cultural members in conjunction with health communication experts, as opposed to traditionally top-down interventions (Basu & Dutta, 2007), creates possibilities for sustained change within health structures. These structures are seen as an amalgam of material realities that both enable and constrain cultural participants, negotiating their health choices and access to resources within set structural parameters (Dutta, 2008; M. Dutta & Jamil, 2013). This enactment of choice drawing upon the cultural understandings of health of community participants necessitated within aforementioned boundaries are seen as manifestations of their inherent agency, as opposed to relegating them to the status of passive health message audiences. Thus, the CCA focuses on the agentic practices exercised by groups at the periphery of policymaking dialog within the confining and enabling spaces of migrant labor structures (Dutta, 2008).

In this paper, we attempt to foreground the marginalized voices of those "systematically erased from dominant discursive spaces of knowledge production" (Dutta, 2011, p. 3), in this case, specifically Bangladeshi migrant laborers in the UAE whose voices are made absent from discourse surrounding their health and safety. Neoliberal trade policies have increasingly transposed bodies of the global South across international borders as containers of cheap labor to "courtesan" states such as the UAE which actively promote migration from surplus labor countries to those with high-capital and low labor supply (Benton-Short & Price, 2008; Mittelman & Johnston, 1999). Ironically the migrant labor experience is characterized by immobility (Silvey, 2008) with their existence limited to the strict boundaries set by their employers. There is a further erasure of their physical and mental health needs through restrictions on any form of collective mobilizing such as forming unions or protesting at the risk of arrest or deportation (Dutta, 2018).

Low or unskilled migrant laborers are systemically marginalized through a combination of acculturation issues including language barriers and low socioeconomic status. The resultant structural penalties to good health are erected in the form of health information gaps and inaccess to healthcare resources (Dutta, 2017; M. Dutta & Jamil, 2013). Within such a context, it becomes increasingly important as health communication researchers to co-construct meanings of health with displaced labor communities like the Bangladeshis, in an attempt to disrupt the status quo of neoliberal policies within the UAE, exploiting the health of migrant bodies as sources of cheap labor. The exacerbated health experience of these migrant workers as being of low socioeconomic status, bound into a precarious existence in hazardous professions with scarce avenues for accessing reliable health structures, needs to be explored further to ensure localized solutions to address the gaps in current healthcare practices. This becomes urgently relevant in the context of the accelerated development of the UAE as an emerging tourist and employment destination in collaboration with other developed nations as outlined above, to highlight and overhaul health and labor policies specifically affecting those shouldering a majority of the burden of such progress.

The aim and goal of this research is to specifically look into the health constructions of low-income Bangladeshi migrant

workers living in UAE. Unlike the dominant biomedical model of interrogating health experiences of involved communities, this research focuses on the role of culture, cultural insiders, and their detailed engagement regarding their health experiences.

Methodology

The primary source of data for this research is semi-structured, in-depth, face-to-face interviews, and focus groups with Bangladeshi low-income migrant workers living and working in the UAE. This project is part of a larger ongoing project under the broader construct of the culture-centered approach (Dutta, 2008) that started in 2015. The entire research process and sample questionnaire were approved by the primary author's Institutional Review Board (IRB) (Appendix B). All the data are kept confidential by the primary author using password protected systems (Appendix A, Table 1).

A total of 44 community members participated in the interviews/focus groups. Personal connections in the community were used to find relevant participants, and then a snowball method of recruiting was used to recruit more participants. Such technique is useful for elusive populations or sensitive research topics (Lindlof & Taylor, 2002). Also, while not a conscious recruiting choice, this snowball sampling evolved into a predominantly male workforce in physically labor-intensive jobs such as: laborers at construction sites, restaurant workers, custodians at public places, and housekeepers at hotels. Given the recommendations provided by these participants for further recruitment, the final pool of participants, based on a snowball strategy resulted in a male-only sample, an acknowledged limitation of this study. The age range of our participants was between 20 and 48 years. We checked to ensure that all the participants had been living in the UAE for at least one full year so that they had sufficient experience with the rules, laws, and challenges of working here. Participants' formal education ranged from being uneducated (n = 3) to finishing a three-year college degree (n = 2). Everyone preferred to speak in Bangla (the national language of Bangladesh).

Two focus group discussions (each group had eight participants) and 28 individual face-to-face interviews were conducted. All interviews/focus groups were conducted at places and times chosen by the participants. The focus groups emerged based on participant preference, often manifesting itself in the form of a group discussion with additional participants requesting they be part of the dialogue, with the express consent of the original single interviewee. The individual interviews ranged from 19 minutes to almost 80 minutes, whereas the focus groups, moderated by the primary author, were about two hours long. The interview protocol was the same for interviews and focus groups. As the participation was voluntary, the participants were free to share as much or as little information as they preferred. We continued with the data collection and findings after data saturation was reached to ensure we did not overlook any key data points. The interviews and focus group discussions were audio-recorded following consent to do so from the research participants. The recordings were transcribed and translated from Bangla to English, verbatim where possible, resulting in roughly 375 single-spaced pages. Besides this, the interviewers kept personal journals (roughly 20 single-spaced pages) to reflect on the conversations and experiences about the interviews, that were analyzed simultaneously with the interview materials.

A consent agreement was verbally shared in Bangla (as many participants could not read or write apart from signing their names) to explain "specific issues of confidentiality, risks, and benefits" (M. Dutta & Jamil, 2013, p. 173). Additionally, the participants also signed a written consent form, after it was read out to those unable to do so themselves. All of the participants were informed about the voluntary nature of the interview and clearly informed about their choice to stop the interview at any point of time.

Using co-constructive-grounded theory (Charmaz, 2000), the researchers analyzed the data to explore "emergent theoretical framework(s) (M. Dutta & Jamil, 2013, p. 173). The data were analyzed into open, axial, and selective coding in order to co-construct meanings as shared by the community members, and to create "an entry point for continually working through the data, and in exploring the convergences between the in-depth worldviews and our understandings of them" (M. Dutta & Jamil, 2013). For example, participants talked about health and wellbeing in terms of home cooked meals, being with loved ones, a caring touch (open codes), that got categorized as role of family in being healthy (axial codes). The themes that emerged in the analysis are presented in the following section.

Results

The data analysis of participant narratives reveals the dialectical tensions (M. Dutta & Jamil, 2013) of understanding the nuances of good health while simultaneously being restricted from healthy practices due to structural barriers such as underinsurance and visa restrictions, while struggling without any familial support to balance work-life stressors. We unpack these contrasts and negotiations in the following categories: i) health as a complex, holistic practice ii) healthcare and immigration add-ons as structural barriers and iii) enacting agency within spaces of structural constraints. These themes or dialectical tensions construct 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" (Dutta & Jamil, p. 173). Thus, in the following themes, we note the intersectionalities of these Bangladeshis as migrants from a low to high income country, the role of their cultural identities in constructions of health, and their subsequent dialectic and material strategies for dealing with structural marginalization.

Health as a complex, holistic practice

One of the key dialectical tensions which emerges from the narratives of the workers is an understanding of the complex and necessary practice of taking care of one's health, while simultaneously encountering barriers. This cultural

complexity surrounding the conceptualization of health is what CCA locates as expertise and is evident in the lived experience of the Bangladeshi labor community in the UAE. Shahjalal, a 23- year-old man who works at a publishing press, articulates the interconnectedness of all healthful practices:

> What a person needs in order to stay well is health. It does not matter what medium it is in: food, staying clean, practice, exercise, any medium would do. Using them is being healthy. By practice I mean getting up in the morning, praying the *Fazr* prayer, going for a walk in the cold morning weather is good. So I do that. [Fazr is the first of the five daily prayers that Muslims around the world try to pray before sunrise.]

Shahjalal's understanding that health is comprised of not one, but numerous interdependent parts, such as nutrition, and physical as well as spiritual practice is demonstrated above. His narrative focuses on the active pursuit of health as a practice, as opposed to merely disease prevention, directly in contrast with the top-down prescriptions of health focused solely on the compartmentalized eradication of disease. We further note how religious practice is central to Shahjalal's localized construction of health, with the requisite of engaging in Fazr (prayer) as part of his daily routine. This spiritual/metaphysical construction of health emerges in other narratives too, with mental well-being intricately tied to physical well-being. Kuddus, a 28-year-old married man, says, "Health means, if someone's health [physical health] is in good condition. If he feels happiness and comfort from his heart and feels happy. Yes, that would also mean health is directly connected with and related to mental wellbeing." This location of health beyond the physical does not preclude an understanding of the physical aspects of good health but is in addition to them. Other participants like Ata also articulate this connection between good health and rest, noting "for physical health exercise and food [are needed], and to be completely physically healthy sleeping and eating." However, in addition to such understanding of health, he, like others also refers to the will of God (In sha Allah) in keeping him healthy, demonstrating a strong belief in the connection between physical and spiritual practice. Saiful, a 30-year-old, states that "There must be a "joint" between tension and body," noting that when such mental "tension" prevails he is unable to rest and sleep to recuperate for the next day's work. Sadaf, 36-years-old, shares this belief in this connection between the materiality of taking care of one's own (and family's) health, and his spiritual practice as a Muslim. He says:

> When started to come to the mosque, I mean as a Muslim we start coming to the mosque from childhood, from then I got it in my brain that this thing [prayer] offer goodness if done. And I am not having any troubles … When tension for family is gradually increasing I don't even feel it when I say 5 prayers. The rest is the wish of Allah. Like in my family 20 thousand taka is needed monthly. Often 20 thousand Taka is not required 10 thousand is enough. I have no tension in other side. Like I have to pay the doctor, my children, wife, mother is sick, I have to pay the doctor. This kind of things don't come to me. That is why I am saying who stay in the path of Allah, they don't have any fear … You require more, what is the reason? Because of your trust. You will get nothing until you are in the path of Allah. Then religion is a remedy to our tension.

Many participants further articulate the need to nourish and hydrate themselves thoughtfully, while avoiding practices which result in poor health. They construct an intricate picture of good health as a balancing act involving numerous factors.

Sukhen a 42-year-old man from a family of 10 also shares how health is a complex combination of several factors. He says:

> Actually we need to be conscious about our health. Health needs to be given more importance than other aspects of life. About eating, lifestyle, sleeping, about each and every matter, it is important to remain alert, I think. To keep the body healthy it is necessary to do things like exercise, sleep well, eating in a timely fashion, among other things for a completely healthy body. I eat regularly according to my needs, although sometimes a little less. I try by myself to understand which part of the body the food I am eating is affecting then I try to avoid that food if I consider it harmful. Whatever food is appropriate for me in my opinion, I try to eat those foods. I try according to the requirement of my body.

Such understandings of health are common among the workers we interviewed, with Kuddus also noting that "Eating vegetables, fish, milk, and sometimes meat is good for health and keeps a person healthy." Similarly, Ripon, a 24-year-old single man who has been in the UAE for over six years states that, "The first and foremost thing for good health is drinking water." He further explicates that he tries whenever possible to eat a variety of foods, which he knows is healthier, as opposed to eating the same kinds of food every day. He shares Kuddus' view about the need to avoid monotony and provide one's body with a variety of nutrition, and in Sukhen's practice of being mindful of the daily actions which affect his health in a negative way.

Sukhen further demonstrates his culturally derived knowledge, about the need to ensure adequate rest, as well as being mindful of a controlled diet to maintain one's well-being. Ripon too, when asked about the source of his health-information says that it is something that his parents taught him from a very young age – to drink sufficient water and eat a variety of foods. While such nuanced and detailed conceptualizations of a healthy existence are often assumed to be exclusive to the biomedical top-down interventions, we see the same sophistication of belief and practice in culturally transmitted health information. We see health as formulated not just as a construct but as a practice, including the right nutrition and hydration. This is in contrast to the traditional (albeit clinically disproven of late) Western conceptualization of health as merely being disease-free, rendering the patient body as one to be intervened upon. Instead, these community experts lay out health as a set of practices, to be actively engaged in deriving from one's cultural past as well as familial practices.

However, despite this recognition and nuanced understanding of health as a complex, holistic practice, we found an experiential tension between understanding health as a set of facts, beliefs, and practices, and the inability to carry out the said practices due to structural barriers. Thus, while, on the one hand, our participants clearly articulate the elements

of a healthy existence, they also observe the existence of material barriers which keep them from leading a healthy life.

Healthcare and immigration add-ons as structural barriers

Structure exists as the cluster of material realities that constrains and enables human action, and it is within these realities that cultural insiders must enact their agency in seeking out health choices (M. Dutta & Jamil, 2013). The tensions in the narratives of the Bangladeshi participants are most strongly illustrated as the contrast between their nuanced understanding of healthful practices, and the difficulties in their lived experience of trying to realize such practices in the midst of structural barriers. Answering one of the primary research questions about the healthcare barriers they negotiate, the migrant narratives illustrate the dialectical tensions which exist between culture and structure. They accurately depict in the first theme a comprehensive knowledge of a healthy lifestyle derived organically, but as is discussed below, also struggle with the realities of structural barriers, while negotiating how to keep themselves physically and mentally healthy. Two primary barriers which emerge are that of mandatory but inadequate add-ons such as health insurance costs and visa fees.

Sabbir, a young man between 18 and 25, who has been in the UAE for a little over three years purchases health insurance from his employer but is dissatisfied with it due to the ambiguity surrounding its usage. He notes that he is often unsure how much his co-pay is each time he has prescribed medication, as often it ranges from approximately 25% to more than that. He says that "whatever the pharmacist says" he needs to pay he pays. All he knows is that the insurance saves him some money but is not sure how much. Sabbir adds:

> Insurance is managed by us, although the company buys it for us. What I mean is that the company makes us buy insurance from them and we have to pay the full price and the company does not contribute at all. I paid 600 Dirhams [roughly 160 USD] to the company for buying this for me. I did not have a choice. If I wanted to work for them I had to buy the insurance and pay full price. It would have been better if the company I worked for provided this insurance to us.

Faruque, another participant corroborates this drain of insurance and visa fees on his income saying "They take half taka (earnings) with visa. They take half taka from insurance". In the UAE, most companies provide health insurance based on governmental requirements (often the bare minimum to be compliant), or based on the economic viability of the employee – the more easily replaceable, the lesser his/her chances of securing usable health insurance coverage. While the formal insurance structure is theoretically supposed to enable and encourage healthy practices among migrants, in practice it deprives through underinsurance and obfuscation of user rights, a disturbing observation also found in other culture-centered scholarship (Dutta & Basu, 2007; M. Dutta & Jamil, 2013; Jamil & Dutta, 2011). While the migrant workers receive health insurance coverage, they rarely have clear ideas about what that entails or how it can be utilized. Faeemur narrates his lack of understanding, saying, "No, actually I don't have much idea about the insurance. I only know if there is any problem the insurance card will be used to manage. That's it."

Cumulatively, in addition to the charges the Bangladeshi migrants pay for their visa petitions (discussed below), airfare, and sometimes accommodations, they now have to spend an additional 600 Dirhams on insurance. To provide a sense of scale, in many instances the Bangladeshi workers earn less than this amount (600 Dirhams) every month from their labor. As a result of this, after migrating, for the first few months to a year, they have no choice but to grapple with structural burdens such as the numerous expenses noted above. In this initial period, they are primarily paying off the debts they accrued as a gamble toward a more secure future.

It becomes evident that for Sabbir and the other participants, their lived experience of healthcare is filtered through a constraining structure. Unemployment, and subsequent deportation, constantly loom on one hand, with chronic underinsurance in a physically demanding job as a bleak backdrop. Rafik, a fellow worker adds that he finds even the 30% co-payment of his medical expense as a steep demand, since he is already strapped for resources. He says that a 10% co-pay is more manageable for him, given the already low salary he gets. Shamim, a 31-year-old man, having been in the UAE echoes this sentiment. He says that his previous consultation with a doctor only cost him 20 Dirhams, but the three vaccinations he prescribed were 50 Dirhams each, at a personal cost to Shamim. Describing his struggles with this insurance complex he says:

> That was very difficult for me with my current job and salary, working as a cafeteria assistant in a company. So not only did I have to buy insurance from the company and pay for the whole cost of getting the insurance, but now I see that when I really need it, the insurance is not being of much help. The insurance did not bear the cost.

This inadequate healthcare, in conjunction with other migration structures adds to the financial burden of the laborers and creates an additional mental and physical stressor for them. Intekhab and Mustafizur both articulate similar concerns, saying that they are required to pay 30 percent of their doctor's fees and 70 percent of their medical costs, which cumulatively are too steep given their low wages. Intekhab also states that while he is required to keep up with paying his insurance fees each year, he "Actually, don't have any idea about it [insurance structure]", and sees it as a barrier to saving money to send home. This corroborates the experiences of Rafik and Shamim who also narrate similar issues with the required insurance payments.

Most of the participants articulated this struggle of the add-ons required through immigration processes including insurance and visa costs, which are inescapable financial constraints if one is to be employed in the UAE. All of them are bound to one employer through the work visa they provide (a requirement of the kafala/sponsorship system), failing which they risk deportation. Here the negotiation of structures CCA sees as constraining and enabling entities emerges clearly, revealing the real cost of such mandatory insurance and visa

fees. Posing as structural points of access, they are in fact a burden to bear for Bangladeshi migrants already laboring from a position of financial insecurity. Many participants afford the requisite 3500–4500 USD to come to the UAE by borrowing money from several community sources and sometimes selling meager familial land holdings in Bangladesh. Added on to this is the recurring cost of visa renewal fees which they have to bear on a regular basis. This is demonstrated through the narrative of Enayet, a 30-year-old man living in the UAE for about 7 years, working as a farmhand. He talks about his difficulties with personally paying for the cost of visa renewals, which are technically supposed to be borne by the employer. To pay off this loan, Enayat says that he has to lose the equivalent of three months' salary in a year, with this process repeated every two to three years due to governmental restrictions on labor visas. The only refuge is for them to find another employer who is willing to transfer the work visa to the new employer's name, which too has become problematic with the UAE government now imposing restrictions on visa transfers for Bangladeshis. Essentially, they are deprived of the choice of purchasing their preferred insurance or seeking any options other than those provided by their employer due to visa restrictions. Any refusal to pay such inherent and hidden costs puts their job at risk. Thus, participants constantly negotiate the tensions which exist between an understanding of the importance of healthy practices but are unable to fully realize them due to structural constraints such as poor healthcare coverage and stringent visa regulations.

The structural complexities faced by these migrant laborers demonstrate how context and meaning-making led by community voices, a central tenet of CCA, lie at the core of any meaningful health interventions for subaltern populations. Participants such as Shamim, Sabbir, Faruque, Faeemur, Intekhab, Mustafizur, Rafik, and Enayet articulate how these add-ons required by the employment-immigration nexus act as ubiquitous structural barriers. It is only through an examination of the localized cost-benefit analysis articulated by these migrants that we uncover the real implications of mandatory health insurance and visa fees. Upon closer examination, the benefits offered by healthcare and immigration structures seem to evaporate within the cultural constraints of being a low socioeconomic migrant viewed merely as a container of labor, located at the margins of mainstream society.

Enacting agency within spaces of structural constraints

The participants repeatedly talk about how structures of labor and migration have limited their access to health and well-being living in the social and economic margins of the UAE. Whether it is working overtime (virtually seven days a week), lack of health insurance, or low wages, the participants' narratives portray a daily existence marked by negotiations between deprivation and agency. Various existing structures, communicative and material, continuously threaten to disenfranchise them and negatively impact both their physical and mental health. Within our dialogs the workers demonstrate how they devise daily strategies to transform these constraining spaces into transformative ones and protect themselves from the eroding effects of such regulation. Some of the key agentic strategies which emerge are communal support-seeking, mindfulness and safeguarding mental health, and ongoing management of limited resources such as food and money.

Practicing mental wellness

In addition to the barriers noted above, participants note the strategies they use to combat isolation in a foreign land, marked by the loss of family, particularly when in poor health. Having stayed in the UAE for almost seven years, Kuddus says,

> I would say the health care available in Bangladesh is better for me. Why? That is my own country. The weather there is good. In this country most of the time it is hot here, no rain. I can easily count how many times it has rained in this country in the past seven years since I have been here. I consider Bangladesh better in every aspect. There I have my parents and everything. They watch after me in sickness. Here I have no one to look after me. Family or the support of family is the main thing. Often we cannot do anything even after having money. Money is not the factor, family is. The assistance is better there in Bangladesh. Parents, relatives are present there. It is better there. Actually, hospital or doctor is not very important. It is more important to get rid of your heartache than anything else. Once that is taken care of, everything else can be managed.

Many participants, including others like Nasser, a cleaner, and Ripon convey the importance of familial and communal proximity as support structures, which would otherwise alleviate the mental stressors associated with such difficult circumstances. They discuss the simple but powerful effects of caretaking by their loved ones through acts such as "caressing my forehead," or "getting me a glass of water," as practices which boost their recovery through mental support and physical comfort unavailable to them in a foreign country. However, labor immigration rules especially for low-skilled workers in the UAE prohibit any meaningful family interactions. They restrict both the ability of the workers to bring their families with them, through formal and informal structures. For example, immigration rules make it impossible for family members to accompany these laborers, and the informal set up of many labor sites are camp-like and not conducive for family-style living. As a strategy to combat the resultant isolation they seek out or create other family-like structures. Many of them talk about using community-belonging as a tool to combat the depression and ennui that accompanies their restrictive and monotonous existence. Ripon talks about how he uses strategies such as establishing contact with extended family and friends and using them as a buffer against daily stressors:

> We face many barriers living abroad and working so much, with so little pay sometimes. And when we get sick, and do not feel physically or mentally well, we feel the problems could be solved by communicating with the people from home. By people from home I mean my family and close relatives from *Chandpur* [a city in Bangladesh]. I contact people from Chandpur and my relatives, and discuss with them what can be done about my problems.

> Fortunately, I have some relatives living here with me in this city, and the next city beside us. So, it is easier for me to talk to them.

We see the participants organizing and interacting in ways that mimic their original family structures, as a way to destress from the problems they encounter on a daily basis. Such interactions through networks of other Bangladeshis, specifically from their part of the country serve as supplemental forms of care and well-being in an attempt to fill the gaps left by formal structures. Another strategy for combating the constant stress associated with such isolation and harsh working conditions is discussed here by Rajib, who says being cheerful is his key to living well. In his words:

> I think staying happy and cheerful keeps the mind good. This has been my experience here in the UAE. I have not thought of it before. I mean, imagine, there is no tension in life. Like I am hanging out with you, sharing a few jokes, laughing together. Maybe I would have another tension in life, but by talking with you and doing some fun and laughter, that tension will fade away. Then my mind will be at ease. Staying jolly and happy is good for health. This is what I found.

Ensnared in institutional constraints, participants like Rajib travel to the UAE for what they assume is a temporary situation, but end up staying much longer in oppressive work conditions, progressively raising the daily stress levels for them. In an attempt to combat such negative impacts, he uses the power of positive thought processes in overcoming physical and mental stress – a practice now strongly supported by neurobiological research. Similarly, Sacchu, a 41-year-old male, and primary breadwinner in his family recognizes that "as there is not much I can change about my work" and as a result focuses inward, toward mindfulness practices such as "staying silent for six to seven hours in a day". He combats the stress associated with isolation, being the sole supporter of his family, and labor camp conditions with an almost meditative state of mind which he says helps him keep his mind calm. Thus, both Rajib and Sachhu utilize their mental capacities to deal with the harsh realities of working as low-wage labor, in practices which are now gaining popularity in the Western world as mindfulness exercises.

Combating material realities

Despite utilizing their mental faculties to deal with some of the aforementioned issues, the Bangladeshi migrants daily negotiate the material deprivations of their individual, and family's physical health. They engage in frugality and self-regulation as tools for managing the health of their family as a collective. For example, when talking about managing expenses for his personal medications, Niamot says "you have to cut your coat according to your cloth," only buying some portion of the medication prescribed to him – "200 Dirhams medicine if 500 Dirhams medicine is required". The savings he accrues then benefit the health of his family in Bangladesh, which relies on him as the primary breadwinner. Similarly, Amir talks about how 'controlling' his own expenses assisted him in providing for his wife's medical treatments in Bangladesh. He says, "My wife has undergone an operation few days ago where I spend almost 30–40 thousand Taka [roughly 1700 Dirhams]. I had the Taka with me, that's why I was able to send it to my home." Amir illustrates how he controls his personal choices and self-regulates to ensure the well-being of his family. Afsar says, "As we are in abroad, actually we may face many problems. If I face any problem I try to manage it by myself as much as I can. But if fail to do so, then I discuss with others and go for the good solutions available." All three community members illustrate one of the key constructs often missing in traditional top-down health interventions – health as a collective resource as opposed to an individual privilege and practice.

These articulations demonstrate that health goes beyond disease prevention in low-income communities to involve daily practices and choices where the entire family and community is considered a part of the health experience. It is also a reminder for health communication scholars that community members use the lens of their entire lived experience to deconstruct their state of health, as opposed to the isolated state of their bodies and minds.

Here we see that in addition to controlling one's own mental state, the workers engage in practices which control their physical bodies as well. This is a reminder that community agency while powerful, challenges low-socioeconomic communities in very tangible and material ways. A prominent example of such daily challenges is articulated by Alam, a male Bangladeshi domestic worker who originally worked in construction. Alam confirms many of the struggles broadcast through popular media about the dismal living conditions of low-wage migrant labor in the Middle East. He recounts his labor camp days with tens of thousands of workers at construction sites, crammed into cell-like rooms, and sleeping in "shifts", so when one went to work, the other would occupy his bed, waking up for his shift when the first person returned. Cost cutting by the employers entails many such practices, including controlling the bodies of the workers through rules about food and rest, or lack thereof (other CCA work involving migrant workers in Singapore also shares such findings; *see* Dutta, 2017). Alam, describing the daily meal schedule, says:

> The meal served in this camp is plain white rice and lentil soup two times a day for lunch and dinner every day of the week. Only during Friday lunch they are served one piece of egg or one piece of fish. Many times the food is stale or has started to smell by the time the workers could sit down to eat. On top of this, no one is allowed to bring in any food from outside inside the camp.

The harsh material realities the workers encounter are a result of labor, migration, and health structures entrenched in the capitalistic conceptualizations of the human body as a dispensable container of labor. Eventually, despite such oppressive rules, many workers find unique ways to exert their agency. Alam says many workers, including himself, creatively work around this rule: they bring food while returning from work, sit outside the walls of the camp, finish eating, and then enter the camp. This brings to mind the articulations of the workers about the necessity of a variety of food for adequate nutrition as well as for physical and mental health. Thus, what Alam describes is how within the impoverished culture of Bangladeshi migrant labor communities in the UAE, the workers manage to carve out spaces of agency to

combat the almost unlivable conditions imposed upon their marginalized bodies.

It is in such discursive spaces, then, that individual agency surrounding health-related practices is constituted as a mode of negotiating and navigating the limited structural resources facing the participants: through choosing to be mindful and positive, creating family-like structures, actively managing one's limited resources and circumventing rules about food and rest. A reflection of the resilience of such communities is that noticeably in these narratives there is almost constantly talk of managing mental and physical stressors as opposed to getting rid of them – implying a complete understanding of the material realities of their circumstances, with agency built into the everyday practices of working through such barriers for managing one's well-being.

Discussion

Temporary migrant workers across international borders, especially those in low or unskilled employment such as agriculture, construction, and domestic work, often face unique health burdens associated with both cultural barriers, as well as being of low socioeconomic status (Dutta, 2017, 2018). Immigrant bodies are subject to structural disparities such as poor access and quality of healthcare, insufficient health information and a lack of access to preventive resources (Bollini, 1993; Bollini & Siem, 1995). Such constraints also play out in the daily communicative experience of lack of language resources and interpreters in healthcare settings (Walker & Barnett, 2007).

Despite similar structural constraints in this project, we are presented with the enactment of agency by Bangladeshi laborers in the UAE through daily strategies of negotiation. They attempt to preserve their physical and mental well-being by circumventing isolating employer treatment as mere containers of labor. Utilizing CCA we aim to bring to mainstream health communication literature, the community-driven, discursively created knowledge of such a marginalized population by exploring their negotiations of structures within structures, shaped by their cultural knowledge. CCA conceptualizes culture as a central, metamorphosing entity characterized by relationships and interactions contributing to a communal knowledge base about health issues. This contrasts with the Western biomedical model which often pathologizes culture as a barrier to any meaningful health knowledge or positive health outcomes. Structures are seen as enabling and constraining in the form of healthcare regulations, immigration law, employment, and visa sponsorship rules established by the UAE for its large population of migrant labor. We locate in the strategies articulated, the agency of the workers negotiated within such structures.

Discursively deconstructing the experience of Bangladeshi labor, we note the dialectical tensions of culturally derived and factually accurate good health practices in juxtaposition with the structural constraints preventing such practices. What emerges is a sophistication of meanings emphasizing the holistic nature of well-being. Narrators such as Shahjalal and Kuddus move past concerns about the physical stressors of their labor, to the spiritual and mental health aspects of neoliberal labor migrations. The narratives reveal not just the labor-camp conditions of living in cells, with a lack of proper space for rest, but also the inadequacy of mental destressors such as proximity to family, and privacy to decompress during difficult circumstances. Others like Ripon also discuss, nutritional variety and hydration as important, but in subsequent narratives, we hear of structural obstructions to such fulfillment. Health is further conceptualized as not just an individual, compartmentalized construct, but interwoven with faith, family, community, and a positive frame of mind. It is experienced not as an individually earned privilege, but an accumulation of the knowledge derived from one's identity as a Bangladeshi, drawing on the collective family and community unit in knowledge-seeking practices. Such understanding of health percolates through an organic network of health information, derived from parents, families, and cultures and does not necessarily come from formal channels of top-down information dissemination.

In addition, based on CCA's critical practice of relocating community members as experts in devising health interventions, we are compelled to examine the role of education as a barometer for expertise, given that both Kuddus or Ripon were unable to afford education beyond the fifth grade, and Sukhen not being able to do so beyond tenth grade. Despite such a seemingly insurmountable educational disadvantage, they construct health in all the complexity often associated with clinical knowledge. Their narratives illustrate a complex system of facts as well as values and beliefs about localized meanings of health, drawing upon the communal identity of participants as Bangladeshi migrants. Deriving their health-information from their culture as a space of shared meanings, values, and interactions (Dutta, 2008), they illustrate a grasp of a series of medical facts, which have in recent times been borne out through numerous clinical trials. Their collective voices articulate the importance of nutrition, hydration, adequate sleep, mindfulness surrounding one's body, the practice of spirituality and mental health, all now considered by clinical health experts as important parameters of a healthy lifestyle.

The participants' meanings encompass the range of their lived experience as Bangladeshis with unique cultural practices and strong familial and community ties, to migrants with resource-dependent families, and spiritually aware, mindful human beings. Such context-rich and relevant immigrant understandings of health need to be accorded space within mainstream health literature and praxis as possible entry points guiding medical outreach, with a stronger likelihood of generating organically sustaining health interventions. Such narratives demonstrate the expertise of localized community-based health information in contrast to the global caricaturing of migrant labor (specifically low socioeconomic labor from the global South) as a health illiterate entity to be vaccinated and isolated to protect mainstream citizenry (Falla et al., 2018; Sakowski, 2012). Such holistic and complex conceptualizations of health resonate throughout the present in-depth interviews and have also been reflected in previous culture-centered explorations (Dutta & Basu, 2008; M. Dutta & Jamil, 2013).

Akin to other scholarship using the culture-centered approach, health is framed here in terms of the structures that create it and for many participants, "health is situated structurally in terms of one's (in)ability to have access to health insurance" (M. Dutta & Jamil, 2013, p. 176). Such discussions are common in other CCA studies as well (*see* Dutta, 2017, 2018). In addition, migrant laborers face the dual burden of immigration structures which require visa compliance tied to specific employees, who mandatorily require insurance purchases, often sorely lacking in substance. Thus, a cumulative oppressive effect is created, with compulsory structural investments which serve to deplete the resources of migrants already living outside the protections of mainstream Arab society. The key barriers the workers face are health insurance and visa payments, within the larger immigration structure. While these appear to be superficially innocuous requirements for participating in the labor force, the narratives reveal hidden complexities in navigating them. What emerges is an informal and exploitative system veiled by immigration laws. As Sabbir states, the employers are officially required to provide insurance to its employees as mandated by the government but find ways to circumvent such regulations. Instead, the employers stay compliant by charging the entire amount to the workers themselves which they then incrementally pay off as loans. Similarly, workers are also saddled with visa renewal fees, a mandatory government requirement every couple of years. Such guidelines constrain workers both materially and mentally become additional stressors in an already resource-deprived environment. Thus, not only do these profit-making neoliberal practices affect tangible resources such as wages and labor conditions of migrants but also manifest in the form of mental oppressions. Barriers of insurance, visa, labor, and immigration operate insidiously upon migrant bodies by subjecting them to the toxic stress of material deprivation, familial isolation, and secondary socio-economic status. Based on the aforementioned barriers, such research warrants not only an integration of community voices into mainstream health literature but the establishment of an actionable agenda for the reworking labor migration laws, particularly those affecting migrants from low to high socioeconomic countries. It is only through engagement with migrant voices that the dual nature of structures such as insurance is revealed not as enabling but preventing the pursuit of well-being.

Within these structural limitations, our participants articulate strategies for utilizing their agency through daily acts of agency, in a bid to be healthy despite debilitating circumstances. To combat the isolation of being away from family due to visa restrictions, the workers engage in seeking support through already established or newly created networks of Bangladeshis. Participants like Kuddus narrate the importance of familial support during illness as aiding quicker recovery. As a proxy for such support, many participants unable to visit family due to immigration restrictions and material constraints, make do with support from within their community of migrants. They engage in destressing mechanisms such as sharing their problems and devising strategies with relatives or friends in the UAE. Further, they distance themselves from the bonds of hard physical labor and mental worry by actively practicing positive thinking, lighthearted banter, and mindful awareness. In addition to grappling with such issues, the workers face additional barriers to the basic right of nutrition and hydration. Alam notes that in a country known for very hot temperatures averaging around 100 F, "By the time we come to the dining hall after a 12–15 hours workday, the intense weather here and the poor storage of food sometimes ruin the food beyond consumption." In response (as noted earlier in the results section) the workers circumvent the rule of barring outside food, by eating outside the walls of the camp compound and rejecting the spoiled food. However, this is not a viable practice for many workers on a regular basis, forcing them to oftentimes skip meals as a way to preserve their health prevent workday absences, risking a lost job and subsequent deportation.

The accumulation of all such structural negotiations constitutes the lived reality of the Bangladeshi migrants. As Dutta notes, such "Structures constitute these contexts, working hand-in-hand with cultural narratives and interpretive frameworks that are anchored in culture" (Dutta, 2017, p. 11). The culture of the Bangladeshi migrant workers emerges as one anchored in cultural traditions surrounding good health practices for oneself and for one's family. Culture then is a tool for the negotiation of the neoliberal context of labor camps in the UAE, carving out spaces of resistance within stringent immigration and labor laws. The health of low socioeconomic migrants traveling as labor for capital faces a continuous erasure as demonstrated through the above narratives. More dialogic forms of engagement such as those carried out from a culture-centered perspective are needed not only for giving voice to the margins but for empowering health structures and policies to serve them in more effective ways.

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Appendix A. Participant Characteristics

Table 1. Participant characteristics.

Total Participants	44	Education:	
		No education	3
Sex – male	44	Grades 1–5	16
Sex – female	0	Grades 6–10	21
		Grades 11–12	2
Married	25	Grades 13–16	2
Single	19		
		Age Range (years):	
Min Family Size	3	18–25	9
Max Family Size	10	26–35	20
Avg Family Size	5.7	36–45	12
Avg Earning Member/Family	1.6	46-55	3

Appendix B. Interview Guide

(please make sure to go over the consent form clearly before starting conversation)

Section I: General Questions

Demographics

1.Sex: M F
2.Age 18-25 26-35 36-45 46-55 55+
3.Number of family members:
4.Number of earning members in your family:
5.Highest education completed:
6.Marital status:

Health related question

1.What does health mean to you?
2.What are the key health issues in your life?
3.What health facilities do you have access to?
4.What are the major barriers to health?
a.Why/how do you consider these to be the main barriers
b.Do you think your being a male/female makes a difference – if so how
5.How do you address these barriers?

Section II: Health & Bangladesh

1.What was your occupation in Bangladesh?
2.Tell us what/how you decided to come to UAE.
3.Tell us about your expectations about working in UAE.
4.Tell us the process you used to come here
5.Frequency of hospital visits: …./week ….month ….year
6.What did you do when you got sick in BD?
7.Please compare that with your access to health care in the UAE (explore in depth)

Section III: Health & UAE

1.How long have you been in this country?
2.What do you do now? [first job?]
3.How long do you work a day/a week?
4.Tell us about a typical workday for you.
5.Tell us about a typical off day for you.
6.Give us an estimate of your earnings.
7.Give us an idea about your spending.
8.What do you do when you are sick? (explore in depth)
9.What do you do for medication?
10.What happens if you have to miss work?
11.Are you familiar with health insurance here? (explore)
12.What are your experiences about the way you receive health care in UAE?
13.What changes, if any, do you suggest for people in your position?
14.How might you suggest the changes be brought about?