Research Article

Labor, Health, and Marginalization: A Culture-Centered Analysis of the Challenges of Male Bangladeshi Migrant Workers in the Middle East

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Abstract

Based on the culture-centered approach, we examine the meanings of health and negotiations of health care structures among low socioeconomic status (SES) Bangladeshi male migrant workers in the United Arab Emirates (UAE). We engage in coconstructive problem definition and strategizing through 44 semistructured in-depth interviews/focus groups about health, migration, and well-being. Our analysis of the participants' narratives elucidates the intersectionality of health as a lived experience of migrant labor within neoliberal structures focused on labor extraction, highlighting health not as a static or purely epidemiological construct, but as a combination of the physical, mental, spiritual, and socioeconomic material realities within which they are located. These include a recognition of the importance of interconnectedness of physical and mental well-being, drawing upon one's cultural and familial roles and responsibilities, as well as locating health within structurally exploitative practices. Specifically, the participants articulate the absence of substantive health and labor protections that result in poor health outcomes for them.

Keywords

culture; health; migration; marginalization; Middle East; Bangladesh; migrant population; culture-centered approach; qualitative

The issue of global migration has taken center stage with the growth of neoliberal capitalism accelerating movements of large groups of migrants for refuge, as well as for labor opportunities. Massey (1999), in analyzing connections between emigration and immigration, notes the role of wage differentials between developed and developing economies in the flow of international labor from lower to higher wage economies. He further observes that laborers from developing economies move transnationally temporarily as a risk-hedging practice against the vagaries of their local markets. Lastly, he points out the active recruitment by host countries of such unskilled laborers in an attempt to compensate for the dearth of native workers in low-paying and undesirable jobs. Benach et al. (2011) describes such unwanted jobs as dangerous, dirty, and degrading, which are often taken on by migrant laborers of low socioeconomic status (SES).

Implicit in this process of selling and purchasing labor in the international market, particularly in industries such as mining, agriculture, construction, and domestic work, there is mounting evidence of a network of structural exploitation. Neoliberal processes simultaneously provide encouragement of unfettered movement for participation in production as well as slave-like labor conditions including human trafficking for those traversing national boundaries (Anderson, 2010; Banki, 2013; International Labour Organization [ILO], 2012; Khurana, 2017; Lewis et al., 2015; McDowell et al., 2009; Swider, 2015; Wills et al., 2010). Torres et al. (2013) note the desire of the neoliberal enterprise to subdue labor's power and cut costs, which for unskilled migrant labor further translates to marginalization in terms of political, social, and legal protections. Such a precarious existence examined as a labor condition (Bourdieu, 1998) has also been explored as a distinct socioeconomic class (Standing, 2011), oftentimes sorely lacking the basic rights bestowed by citizenship and more permanent forms of employment in host countries.

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Stemming from such systemic biases, Kour and Spilker (2017) have evidently demonstrated the poor health outcomes experienced by migrant communities suffering from discrimination and exploitation. These outcomes result from dangerous employment in isolated environments and are usually "undesirable, low-skill positions characterized by flexibility, insecurity, precarious employment, and long working hours with low pay" (Benach et al., 2011, p.2; Moyce & Schenker, 2018). Combined with low SES, the precarious nature and isolation of migrant labor are independently recognized as risk factors for poor health outcomes (McKay et al., 2003). Although the definition of "health" by the World Health Organization (1948) as a state of complete, physical, mental, and social well-being and not merely "the absence of disease or infirmity" is most often utilized, this study draws upon Dutta's (2008) and Zoller's (2012) critical articulations for defining health as political and contextual. Bates et al. (2019) further argue that as opposed to a universalized definition of health, we use the culture-centered approach (CCA) for a more community-centric definition utilizing the expertise of lived experiences of community members.

Dutta (2017), examining the health experiences of Bangladeshi construction workers in Singapore, problematizes the application of the traditionally individually focused health interventions, which fail to account for the aforementioned structural inequities of migrant blue-collar work. He notes the productivity-driven nature of this work combined with tropes of efficiency and safety training serving as replacements for substantive health protections for unskilled labor. Scholars such as Airhihenbuwa (1995), Dutta (2008), and Lupton (1994) have critiqued these top-down health interventions as unable to produce meaningful change in the health outcomes for marginalized communities as a result of lack of input from the community members. They call for a paradigm shift, recognizing the agency of communities as opposed to strategies imposed by health communication experts, which lack sustainability due to lack of trust and buy-in from the communities they aim to serve.

The current research responds to this call within health communication by utilizing the CCA (discussed further below) to draw upon the expertise of low SES Bangladeshi laborers in the United Arab Emirates (UAE), as agentic entities. Here, we coconstruct the meanings of health explicated by this migrant labor community, with the eventual goal of organic intervention creation and dissemination. Dutta and Basu (2008) emphasize the participation of community members through dialog, and an exploration of their health narratives as the core principle of community-driven health interventions. Through in-depth, semistructured interviews with Bangladeshi laborers, one of the top labor markets for unskilled labor from South East Asian countries, we carve entry points into explications of health, deprivation, and agency, guiding recommendations for a meaningful intervention in this marginalized community.

Literature Review

The Migrant Health Experience

Bollini and Siem (1995) point to the lowered entitlements migrant groups and ethnic minorities suffer from in consonance with worse access to health care services resulting from the nexus of cultural, political, and social barriers, not encountered by native populations. Extrapolating from such observations, they propose an even closer look at temporary migrant labor populations, which they categorize distinctly as facing a steeper cost given the lack of citizenship rights and the severely truncated "right to reside," "right to work," and "right to social security benefits." In Europe and the United States, they found that processes such as accessing health care, as well as rates of occupational accidents and disabilities for migrant workers and ethnic minorities were much higher than those for majority native populations (Bollini & Siem, 1995).

In the United States, scholars Kandula et al. (2004) and Walker and Barnett (2007) have also documented the issues of lack of health information and infrastructure access for low SES immigrants such as temporary migrant laborers. Substantive research has explored the health experience of transposed Latino farmworkers in the United States suffering poor health outcomes including a prevalence of addictive behaviors such as alcohol dependence (Finch et al., 2003), as well as a range of mental health issues (Magana & Hovey, 2003; Ramos et al., 2015). Apostolopoulos et al. (2006) further note the high incidence of sexually transmitted infections among this population, a well-documented health outcome associated with temporary migrant labor movements. Similarly, risky sexual behaviors have been identified internationally among Tajikistani workers in Russia (Weine et al., 2013). High rates of workplace accidents among Nepalis in the Middle East (Adhikary et al., 2019), as well as increased depression and suicide rates among workers of various nationalities in the UAE (Al-Maskari et al., 2011) and female domestic workers in Lebanon (Zahreddine et al., 2013) have also been observed.

Within the category of temporary migrant labor, unskilled laborers often face a grueling existence marked by isolation and compounded by their low SES. They endure rigorous manual labor, poor access to health information and infrastructural resources, while struggling with woefully inadequate protections from host countries (International Organization for Migration [IOM], 2018). In

targeting such populations for health messaging, conventional health communication interventions have positioned health as a practice in the realm of the individual, as opposed to accounting for health as a communally and contextually derived experience (Murray-Johnson & Witte, 2003; Dutta & Basu, 2008; Dutta-Bergman, 2004b). The framing of messages is undertaken with health communication experts targeting messaging toward subaltern bodies assumed incapable of an active voice in defining health problems and solutions from within marginalized communities (Airhihenbuwa, 1995; Dutta & Basu, 2008; Dutta-Bergman, 2004a, 2004b; Ford & Yep, 2003; Mokros & Deetz, 1996; Ray, 1996). An increasingly strong body of literature has arisen in reaction to such Eurocentric health interventions with scholars (Airhihenbuwa, 1995; Dutta & Basu, 2008; Dutta-Bergman, 2004a, 2004b; Mokros & Deetz, 1996; Sharf & Kahler, 1996), calling for a recognition of the capacity of marginalized communities to redefine health outside of the individual frames traditionally adopted. They encourage a reframing of health in context, namely, of deriving expertise from within the experience of marginalized communities negotiating the capacities and constraints of mainstream health structures. Coconstructed knowledge through dialog between the researcher and community participants serves as the foundation of problem definition, culminating in a community-driven intervention based in local contexts. Emerging from this theoretical foundation, the current research examines the lived health experiences of Bangladeshi migrant laborers in the UAE, well-recognized as a destination for unskilled labor from surrounding South Asian and South East Asian countries, with the goal of creating a sustainable and meaningful health communication intervention within this community. These workers operate at the margins of society, primarily engaged in construction work and domestic services under the unskilled visa category of the Kafala system, a sponsorship-based program holding workers in bondage to their primary employer or sponsor.

Bangladeshi Immigrants in the UAE

The People's Republic of Bangladesh, a small south Asian country, bordered by India, Myanmar, and the Bay of Bengal, was formerly both a part of present-day India and a British colony till 1947 (Central Intelligence Agency, 2018; Dutta & Jamil, 2013). Later known as East Pakistan, a Muslim-majority country, it eventually became what we know today as Bangladesh after its war of independence in 1971. A relatively new democracy with its share of economic and political problems, it suffers from a 40% underemployment rate, low wages, and poverty.

With a majority of its labor force subject to such low-paying opportunities, there has been emigration at the rate of 3.1 for every 1,000 people, with Middle Eastern destinations serving as primary labor markets for them (Central Intelligence Agency, 2018). Because the average monthly wage in Bangladesh is around US$33 a month, comparatively lower than wages offered in the UAE, the workers frequently gravitate to these countries for construction, domestic work, and other unskilled labor. According to the IOM's World Migration Report of 2018 (InfoSheet No. 3) on migration patterns in Asian countries in the year 2015, approximately 90% of the population of the UAE (more than 10 million people) was comprised of foreign-born migrants. In a recent 2017 report on "Bangladeshis in the Middle East" (2018), it was found that of the approximately 4 million Bangladeshis outside the country, three quarters live in the Gulf Cooperation Council (GCC) countries (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the UAE). Most of these workers are classified as "unskilled visa" holders (Rahman, 2015, p. 205), sponsored by employees under the Kafala system, which overtly prohibits any family reunification in a bid to maintain the transient nature of their employment.

Although migrants from such developing countries travel in search of opportunity voluntarily to the Middle East, scholars such as Price and Benton-Short (2008), Mittelman and Johnston (1999), and Dutta and Jamil (2013) note the active recruiting strategies such states as the UAE engage in to promote immigration from underdeveloped economies with surplus labor, which are likely to be more open to lower paying jobs in high capital economies. In a bid to streamline this process of importing unskilled labor, the UAE government has since 1971 used the Kafala system, based on an unskilled labor visa sponsorship category initiated and maintained by employees seeking workers (Malit & Al Youha, 2013; Morin, 2013). This system, roundly criticized as channel for forced labor (most recently implicated in the construction of renowned global organizations such as New York University, the Louvre and Guggenheim museums, and the soccer World Cup stadiums), without union or systemic protections has undergone minor revisions in some Middle Eastern countries. For example, Qatar recently allowed workers the previously denied right to exit the country without employer sanction, though there continue to be many unofficial mechanisms such as withholding documentation that employees engage in with minimum governmental oversight (Khan, 2014).

Culture Centered Approach

It is within marginalizing structures such as these that the CCA locates the agency of communities. At the core of its philosophy, is a focus on deriving solutions for issues from within communities, incorporating the voices of

members in both problem definition and solution creation. According to Dutta and Basu (2008), "The culture centered approach is based on dialogue between the researcher and the community members, with the goals of listening to the voices of cultural members in suggesting culture-based health solutions" (p. 560). Resting upon this foundation, the current research focuses on the utterances of the Bangladeshi migrant laborers in the UAE, with the eventual goal of these narratives informing a community-driven health intervention.

Of primary concern is the experience of health derived from the interaction between communally defined cultural norms, structurally enabling and constraining forces, and the agentic use of strategies by community members to navigate the health care challenges encountered. Dutta-Bergman (2004b) defines culture as a transformative and constitutive force existing "in terms of local contexts, frameworks of meaning making and interpretation, and spaces of shared meanings, values, and interactions" (Dutta, 2011, p.9). Thus, meanings of health and health care go beyond a clinical understanding to encompass the intersection of individually and communally defined lived experience of health through the lens of community culture. Contrary to traditional top-down interventions, Basu and Dutta (2007) conceptualize effective health interventions based upon such meanings of health, and issues and solutions cocreated by cultural members within communities.

This approach has arisen as a response to the traditionally expert-driven interventions that operate in a linear fashion (Lupton, 1994, 2003). With minimal room for community participation and feedback, such health interventions operate upon the taken-for-granted assumptions of a passive audience (Dutta & Basu, 2008), with absolute receptiveness to health messaging from medical and communication experts. Thus, they operate at the risk of ignoring the inherent capacity of communities to navigate health care structures in uniquely strategic ways to create more effective, meaningful, and sustainable health interventions.

CCA defines such structures as a combination of material realities, enabling as well as constricting, encountered by community members, in their navigation of the process of ensuring good health for themselves as well as for their families and communities. Dutta (2008) and Jamil and Dutta (2012) note such active enactment of choice for cultural participants within set structural parameters and highlight the inherent strength community voices bring to effective health intervention practice. Such engagement with community participants moves beyond the individualistic frameworks focusing on communication as a tool of persuasion utilized by experts for designing culturally sensitive messages (Dutta, 2017), and instead to a more inclusive belief of the migrant community as experts with a voice guiding policy and practices of health. For the current study, we utilize such a CCA to bring to the forefront the voices of marginalized communities of temporary migrant workers in the UAE, subject to harsh working and living conditions akin to indentured labor at the hands of citizen employers. Specifically, we explore the meanings and constructions of health as enacted within such strict boundaries, the challenges, both mental and physical of isolated migration, as well as the logistical difficulties inherent in the negotiation of health care in challenging circumstances. Given the CCA of this study, we focused on answering the following two questions drawing on the tenets of culture, structure, and agency.

Research Question 1: What are the complexities of constructions of health as experienced by migrant workers?

Research Question 2: How do these workers navigate structural challenges and exercise agency in their negotiations of a foreign health care system?

Method

Context and Data Collection

The data for this coconstructed research inquiry came from the low-income migrant workers from Bangladesh who live in the UAE, primarily in the capital city of Abu Dhabi. All the participants in this research project work under the Kafala system that is common among all Middle Eastern countries (as discussed above). A snowball sampling technique was used to contact and recruit participants, where the primary researcher used his social contacts among the community participants, and then used their recommendations and referrals to talk to other members of the same community. Snowball sampling is useful to interact with elusive populations, or when the topic of the research might be sensitive (see Lindlof & Taylor, 2002). Because of the sensitive nature of the topic and concerns of the participants about any possible consequences due to information shared, snowball sampling was also appropriate, given that such recommendations help with trust building within the community.

The bulk of the data came from semistructured, in-depth, face-to-face interviews ($n = 28$) and two focus groups ($n = 8$ each; total $n = 44$). Such method allows researchers to understand and collect deep, complex, and contextualized behaviors and practices of community members involved in the research, "without imposing any a priori categorization that may limit meaning creation" (Basu, 2011, p. 396), which is the core of the CCA. The interviews ranged from roughly 19 minutes to about 2 hours in length. The data thus collected were translated and transcribed, resulting in roughly 375 single-spaced pages

of text. In addition, the primary researcher made journal entries during the research period. This researcher has also been involved in social and research capacities with many members similar to the research community here for over a decade, that also contributed to understanding the contextual fabric of this communities' responses.

Participants

All the research participants live in Abu Dhabi and have low-skilled jobs such as street and park cleaning, housekeeping, and custodians at hotels, malls, laborers at construction sites, office peons, and laundry staff. Due to the physically demanding nature of these jobs, all the participants the researcher recruited through snowball sampling were male (not a conscious recruiting choice, and one of the acknowledged study limitations) between 20 and 48 years of age. Low-income Bangladeshi female laborers in the UAE tend to work primarily as full-time housemaids or as live-in nannies and thus they did not form part of the pool of participants recommended to the researchers. We followed two basic criteria for interviewing these Bangladeshi men: First, they had to be more than 18 years of age, and second, they had to be in the UAE for at least 1 year (to demonstrate familiarity with most of the basic choices about health, rules, and regulations of working/staying in the UAE).

All participation was voluntary in nature, and a small research grant from the university allowed the researchers to compensate the participants for their time. Based on existing literature, and researchers' experiences within the community, an interview guide was created and followed to maintain consistency of the interview process. Many of our respondents were unable to read or write (no formal education), except for signing their names. Accordingly, everyone was first verbally informed about consent, and then, a formal consent letter was read out verbatim to those who could not read on their own. The interview guide is attached as the supplemental material. All protocols were approved by the primary researcher's academic institutional review board (IRB). All the interviews took place in locations chosen by the participants for their convenience, comfort, and privacy. Detailed steps were taken to protect all privacy concerns, including using pseudonyms for participants, keeping the data under digital and physical lock and key, and not sharing any sensitive information in any form with those outside of the research team.

Data Analysis

The semistructured interviews focused on open-ended questions such as the following: What does health mean to you? What are the primary challenges you face in seeking health care? What are your experiences in negotiating with the health care system in UAE? What do you do to address them? Many of these questions are central to other culture-centered interrogations of health (Basu, 2011; Dutta, 2018). All interviews were conducted in Bangla—the native language of the Bangladeshi respondents—as they were not conversant in English. All the interviews were conducted by the researchers (university faculty) who are fluent in both Bangla and English among other languages, and both played active roles in translating and transcribing the interview data and assuring for quality. Many of the participants utilized English words and phrases interspersed with Bangla throughout the interviews, which have been retained in single quotes in the "Results" section, whereas the Bangla sentences have been translated into English and are in double quotes where required. In addition, an independent and bilingual translator checked the data linguistically. The researchers have combined experiences in investigating migrant workers' health constructions (Bangladeshis and others) in other parts of the world that assisted them with knowledge about the cultural and structural foundations of this research. This knowledge helped to appreciate and analyze the gravity of what was shared by the community participants in the UAE.

The data collected were analyzed using coconstructive grounded theory (Charmaz, 2011). The first stage of this involves looking for explicit and/or implied meaning—and creating as many categories as possible (open coding). Categories that relate to one another were then sorted into broader categories (or conceptual clusters) during axial coding. Finally, all the clusters were analyzed and sewn into a meaningful theoretical framework during selective coding, so that the cultural and contextual meanings of the participants' narratives emerge organically. Whenever possible, member checking was done, where the results were discussed with the participants, to ensure appropriate representation and coconstruction of participant voices. Although some of the participants were understandably emotionally expressive when sharing their hardships in the country with us, none of them demonstrated any significant distress requiring the provision of professional counseling resources. Data saturation was achieved around interview number 37, but all data were analyzed to make sure no themes were overlooked. The analysis resulted in the following themes, as detailed in the "Results" below.

Results

This culture-centered inquiry through dialog with the community members results in the emergence of the interconnectedness of the tenets of culture, structure, and agency. Participants reveal their own cultural understandings of health as Bangladeshis, and the barriers they encounter as

a result of such an isolated existence and their daily navigations of the same. The following primary themes emerge from their everyday lived experiences in the UAE: (a) health as intersectional experience of migrant labor and (b) structural absence of labor protections.

Health as Intersectional Experience of Migrant Labor

The participant narratives surrounding cultural meanings of health lead to definitions that go beyond the Western biomedical conceptualization of health as individual-level disease prevention. As noted in similar CCA research (Dutta, 2017; Dutta & Jamil, 2013; Jamil & Kumar, 2020), our community participants define health as a confluence of the physical, spiritual, and social. Good health is described not only medically as the need for nutrition and rest but culturally also in conjunction with family, religion, and income. Health, then, exists not as a static construct but as a contextual experience situated at the intersection of one's physical, mental, and spiritual well-being; familial caregiving and responsibility; and material deprivation. This intersectionality is particularly relevant as not just interacting elements defining health, but as an entire belief system constructed to safeguard one's well-being as a marginalized low SES migrant worker. We note in the narratives that despite living in physical hardship as unskilled and exploited laborers in an unfriendly foreign system, the participants demonstrate agency by foregrounding spiritual and mental strength despite the constant physical and structural exploitation they experience.

One participant, who has been living in this country for almost 2 years now initially defines health as primarily physical, but in further conversation reveals an inherent assumption about good health as being a blessing from God. He says good health implies his "physical condition being good, 'In Sha Allah.'" *In sha Allah*, a very common Arabic term used by most Muslims around the globe meaning "if Allah wishes" is based on the foundational belief that all that happens in the world—including one's own well-being transpires as a result of God's will. Deconstructing his narrative we see that health is not physical well-being in isolation, but at the intersection of his culture as a Muslim. He derives solace from and defers to a higher power as having a hand in keeping him healthy in addition to his overall physical health. This juxtaposition of health, wellness, and religion is also a common finding in other culture-centered inquiry (see Dutta, 2017, 2018; Jamil & Dutta, 2012). Corroborating this, another participant, who has been living and working in the UAE for more than a decade, says "health, specifically good health to me means being physically well. 'Ma sha Allah,' I am in good health, and do not want to upset Allah." Meaning "all praises to Allah," he too considers himself a religious man, a practicing Muslim who identifies religion as an inseparable part of his identity and well-being. He adds that "Health is . . . physical health, exercise and food. These things will ensure good health and the body being in 'proper' condition." Utilizing the lens of CCA, we see the underlying foundation of culture and beliefs as a Muslim, tied into the mental and spiritual agency, which both these participants clearly reveal as important elements for their overall health.

This understanding of health as a combination of physical and spiritual also extends to the complex and holistic realization that being healthy as a marginalized foreign worker is also a product of mental well-being. One participant, working as a building attendant, says, "Health means, if someone's health is in good condition, he feels happiness and comfort from his heart. Happy." Of interest is the fact that his job as a custodian is physically demanding, involving cleaning the building facilities, and acting as the security personnel, but his primary lived experience of health is focused more on mental well-being. Whereas the apparent burden of his duties is on his physical health, what he deems most important is being mentally happy—a construct further tied into being surrounded by family and friends. He narrates how in the UAE when he is unwell, the mental strength that would otherwise help him heal is missing because of the lack of familial ties as a migrant worker. Such familial caregiving is a stark absence for a majority of such low SES Bangladeshi workers. He says,

> Like now I am suffering from illness. I don't have the strength to drink a glass of water by myself but even that I have to do it on my own. No other way. But in Bangladesh my mother, brother, sister, wife will do it for me, which makes me feel mentally better . . . At home my mental state is good, and the mind is everything.

These workers articulate health not just at the intersection of physical and mental, but within the material confines of being absent but necessary bread earners for their families back home. A second participant notes such distance from family as a stressor in an environment where mental strength is a necessity. He says,

> If we are tense—mentally worried, sad, or just not in a happy mood or "tensed" about family—these things are harmful for our health. Our mental health matters a lot. If your mental health is disturbed, physical health will also be impacted.

He draws the connection between how one's state of mind affects the ability to be physically healthy, to rest and the harm that such deprivation can do to the body. He

further notes that if a person suffers mentally, no matter how tired they are, they cannot rest, sleep, and recover from the physical labor of the day. Thus, familial ties operate as both a source of stress and a source of strength, with the respondents stating how their families can operate as both negative and positive influences, an assertion well-documented in current medical literature, affirming that the quality of one's social ties can affect health.

Living away from their families for extended periods of time ranging from 3 to 15 years, all the participants echo thoughts about missing their families and the caregiving provided by family members and close relations, especially during times of illnesses. Family as a vital element for health is articulated by one participant, saying, "Your family lives so far away from you that you cannot even see them or touch them when you want to. Your heart aches for them even more when you are sick. Such isolation is extremely painful." They further articulate the additional burden of being deprived of familial caregiving due to the migratory nature of their job, as well as bearing the heaviest burden of providing for the family members left behind, again demonstrating the tension between family as a stressor and source of mental strength. Grappling with these dual and conflicting experiences, one participant says that each month he has to manage to not only pay his own living expenses, additional food charges, and deal with cyclical visa and insurance regulations (every year/every 2 years), but also manage to save up enough money to send to a family of six back in Bangladesh with no substantive economic prospects. Another participant also narrates this common problem among many Bangladeshi workers in the UAE. He says,

> Everything depends on my income, as I am the only earning member. Every few months, only after I send money from here do my mother and subsequently my family get their food supplies for the upcoming month. So before spending each time I have to think about how much I can spend on myself, versus how much I can save up and send to my family back home. My food and other expenses depend on it because I am the only earning member. If I buy all of the food I need, I won't be able to send money home. If I don't send money to them, they won't be able to eat properly. It is not possible for me to eat two good meals a day, knowing that as a result, my family will eat only one time a day and starve the rest of the time. Because I am the eldest, it is difficult for me [as there is the social expectation that I provide for my whole family].

For this participant, his being in good physical health by taking care of his nutrition is not a privately experienced concept, but one which is intricately tied to his role as the primary provider for his family. His own health needs can only be understood as a balancing act in consonance with the health of his family.

Thus, deconstructing these articulations through the lens of health as a contextual lived experience based on the CCA (Dutta & Basu, 2007), meanings of health emerge on multiple levels. Health gets constructed through the lived experience of physical and material hardship, and the role of spirituality and family in garnering much needed mental strength when living a hand-to-mouth existence as an unskilled laborer in a foreign country. Unlike top-down health interventions devised on scales that may not account for the cultural knowledge of participants in informing their health practices, such a CCA-based inquiry opens up a space not just for dialogic exploration but also for creating mainstream discussions in scholarly spaces through the direct voices of low SES migrant workers such as those from Bangladesh.

Structural Absence of Labor Protections

Although our participants define health at the intersection of lived experiences, they also locate such meanings of health in spaces of absence. Specifically, health is constructed as an absence of basic labor rights, such as adequate physical and mental rest, symptomatic of a larger issue of lack of labor protections. While recognizing the need for rest as fundamental to good health including time off from work, engaging in recreational activities for relaxation, and recuperation, the community participants also articulate an inability to achieve this, due to a lack of substantive structural support.

One participant, while discussing what factors he considers most important for good health, notes the lack of sleep as a major factor affecting one's ability to recuperate from such hard labor and a stressful job. Describing "proper sleep," he says,

> Sleeping at least seven hours every day. If you cannot get the seven hours in, then your health will deteriorate. A doctor told me some years ago. Some time ago I was sick and consulted a doctor about it. He told me I need to sleep at least seven hours a day. He did not tell me if it is only for me or for everyone though. He said I have issues with blood pressure, and I must try to get my seven hours in every day.

Another participant has been grappling for some time with financial stressors arising from his meager remuneration as an unskilled laborer. This stress, or "tension" as he calls it, affects his sleep, which in turn makes it difficult for him to be in a positive, well-rested frame of mind. He says,

> So, as the mental stress gets worse [due to work conditions], "tension" enters my mind and as a result of this I cannot eat or sleep properly. If there is an absence of rest and proper food, there is a much stronger likelihood of falling sick.

> When I don't have any "tension," I can eat and sleep properly, and I think that can make all my health problems disappear. But if I become tense, I don't feel like eating any food. If I am tense, I am unable to sleep "time to time." For example, I go to sleep at midnight but because I am tense, I wake up at 2 a.m. Even if do sleep, it is an interrupted sleep cycle and I start to feel tense again. So if I am tense at night there is an interruption when I am sleeping, and I only end up sleeping for one to one and a half hours. When I sleep so less I start experiencing health problem.

Although multiple participants demonstrate a clear recognition of the role of rest in staying healthy, structural barriers and material realities such as employment-related duties and financial worries due to their low-paying jobs keep them from achieving a minimal amount of rest in their stressful jobs. For instance, one participant talks about how despite knowing his high blood pressure diagnosis, he is unable to follow through on resting enough because he is the live-in domestic helper for his primary employer or Kafala sponsor (a visa system that ties in the employee to a particular employer). He says that his employer often sleeps at 1 a.m. and he is only able to sleep after that as well. This participant has to wake up early to say his prayers and thus manages only an average of four hours of sleep a night. He notes,

> I have to wake up at 5.00 am and say my *fazr*[1] prayer. I also have to make tea for my boss as he wakes up at 5.30 am and drinks tea, before leaving the apartment around 6.15 am for his work. It is very difficult. Sometimes I can take a nap in the afternoon, but sometimes my boss comes home early for a break and then leaves again. So, I cannot sleep when he is home. Also, afternoon is the time for Asr prayer, and I have to keep that in mind. As you can see, I cannot get my seven hours sleep even though my doctor has asked me to, simply because of work. Only during the weekends when the boss goes home that I can catch up on some sleep.

As is evident, participants' experiences of health are played out at the intersection of their identity as migrant workers in a foreign land, tied closely to the evaluation of their employers, their familial responsibilities as bread earners away from their families, and also their cultural experience as observant Muslims. Although this intersection of culture and structures of migration and employment can be enabling in some instances, they can also deprive these participants of the ability to recuperate from continually harsh working conditions. Furthermore, these articulations reveal how structures such as visa sponsorship and migrant labor status act not only as barriers to any health safeguards for employees in the UAE and other Middle Eastern countries but in fact further enable to exploitation of such workers under the guise of legal requirements such as visa sponsorship and health insurance (discussed later in this section). The recognition of the need for rest as an integral part of their employees' health, is subsumed under the capitalistic need for extraction of labor. Participants state that even if they are sick, they have to report to their duties. One participant, who has been here for several years, echoes a similar experience as the others. He says,

> When we are busy, we do not get any days off in a week. We have to work nonstop, and sometimes for 12-14 hours a day. We have to "continue" without rest. I am able to go for a walk in the Corniche [seaside] sometimes, but most times I cannot even do that. Without rest, I cannot focus or concentrate on my work or anything else.

For multiple participants, their health experience is marked not just by disease prevention, but in terms of survival. Being healthy is a daily struggle in the midst of structural barriers such as inadequate labor protections, the inability to return home to be with their families, and being trapped in a vicious cycle of labor, debt, and meager opportunity. Furthermore, the community members describe an existence marked by a network of exploitation, affording very little structural protections for low SES labors. They articulate the inability to be guaranteed any form of protection against the vagaries of the immigration process, resulting in continuing stress for them as foreign workers. For example, one participant, whose employment visa is sponsored by his "master" as a tailor to the UAE was told he would earn a certain steady commission (1,500–1,600 dirham) based on a consistent number of customers, but learned upon arriving there were only 2 months out of the year, during Qurbani[2] and Ramadan that customer flow was enough to maintain the earnings he was promised. He said,

> While coming, I was told I would be paid according to piece (of clothing). Per piece 20-25 taka. I was given an idea that per month 20-22 thousand taka might be sent (home). The person from whom I took the Visa (said this). He is an outsider. The shop where I work, that person got the Visa from that shop. He bought it. He is also Bangladeshi. He took some profit. How much I don't know.

Although technically the burden of visa fees, health insurance is to be borne by the employer as mandated by the state, there is an informal practice of charging the employees themselves for these benefits. According to the laws of UAE, each employer is required to provide health insurance to all its employees and their dependents, based on the level of the employee's salary and their work designation ("Health Insurance UAE," 2019). The low-income levels of temporary migrant workers do not grant them high levels of health insurance, and, on average, they are required to pay 30% of the doctor's consultation fees and 70% of the pharmacy costs, according

to our participants. Like one participant says, "If the cost is 100 Dirhams for the doctor, I pay 30 Dirhams, and if the medicine costs are 100 Dirhams, I pay 70 Dirhams." Another participant, too, narrates a common occurrence with temporary workers saying,

> The company prepares the insurance card for us and for that they take 600 Dirham from us. He (the manager) took 600 Dirham to make this insurance card. Now, I only get 600 Dirham as my salary—and with that shall I buy food or send money home or pay to get an insurance card? If we give him (the manager) 600 Dirham, then he will prepare the insurance card and put the signature of the owner and then he will give us the new card. He will not return a single penny.

As becomes evident, the workers themselves bear great financial burden first to come here and personal risk of securing their visas through essentially illegal middlemen. While struggling for survival, they are not only denied proper health coverage, but in fact subject to the constant stress of inconsistent wages, and a loosely based set of rules, often working against them. Furthermore, the Kafala system of visa sponsorship functions akin to indentured servitude. Because the workers are tied to a particular employer for sponsorship, without which they risk deportation, they are forced to labor under stressful conditions such as excess overtime, physically demanding labor without rest, and the inability to seek medical care due to wage cuts for lost hours, despite being charged for insurance. As a result, many participants note that they often suffer in silence and try to bear out the illnesses as much as possible, because complaining about poor health can have dire consequences. One participant tells us of an incident in the past where workers were deported as a result of asking for breaks from increasingly laborious work. He says,

> We demanded that the employer give us a holiday, but they did nothing. Many from our group were "canceled" [visas revoked] only because they raised their voice. At the beginning we were 35 people working here now we are 12 people and the rest of the people were "canceled." Those workers had to leave their jobs only because they raised their voice. If anyone voluntarily wants to resign the job, then the employer doesn't let them to leave. He even legally implicates them through various "cases" and problems. He has Arabs and money. He manages everyone by money and "wasta" [personal connections].

He demonstrates the structural penalties imposed upon them despite being provided minimal protections as migrant laborers. Within these structures then, health gets constructed as a space of absence and not a right. Such lived experiences of health amid hunger and cultural practices become particularly relevant as data points for developing a CCA-based intervention. These narratives encourage a community-led intervention focusing on contextually situated health meanings, in contrast to traditionally epidemiological interventions in migrant populations focused on state health mandate compliance. What is needed then is a further exploration and engagement with such marginalized communities, to redefine what health means to them—whether it be marked by concerns of family, employment, or structural constraints, to create more meaningful and culturally relevant health policy.

Discussion

International migrant labor, particularly low SES temporary labor, bears a disproportionate burden of disease both physical and mental. Substantial health literature has documented the poor health outcomes experienced by this population, as a result of, but not restricted to social discrimination (Standing, 2011), structural exploitation (Al-Maskari et al., 2011; Torres et al., 2013), and communal isolation (Dutta & Jamil, 2013). This material marginalization emerges from communicative marginalization and vice versa, denying health care access and voice to migrant laborers in spaces of neoliberal policy making focused on extraction of labor. Dutta (2008) advocates utilizing the CCA as a tool to incorporate voices at the margins into mainstream health policy. He envisions coconstructed health interventions with communities, emerging from dialogic meaning making. The current research responds to this call for a more critical approach to health communication interventions by exploring constructions of health by low SES Bangladeshi workers in the UAE. It does so with the eventual goal of creating a community-driven intervention to disrupt mainstream, top-down initiatives, focusing on individual-choice epidemiologic health models.

In dialogue with the Bangladeshi workers, we find evidence of contextual complexity in defining their health experience while negotiating structural barriers, cultural intersections, and strategic agency. Health is constructed beyond the epidemiological bounds of individual-level disease prevention in migrant bodies. As evidenced in other CCA investigations (Dutta et al., 2018; Jamil & Dutta, 2012), health is experienced at the intersections of our participants' struggles as structurally unprotected foreign laborers, as well as their identities as practicing Muslims and the primary, but absentee, bread earners of their families. Participants demonstrate a unique focus on the mental and spiritual aspects of well-being despite grappling with extremely harsh working and living conditions. They articulate the role of their belief in Allah as a source of strength and examine the nuances of family as both a source of stress (due to financial obligations) and strength (familial caregiving during poor health). Migrant

workers, particularly South Asian workers in the UAE also experience a unique combination of race and class discrimination (Jureidini, 2005), the stressor of isolation and structural exploitation against the backdrop of neoliberal growth. Thus, health gets articulated not just as one's well-being but as an economic resource (Dutta & Basu, 2007; Hughner & Kleine, 2004) to be maintained through mental and physical agency derived from cultural support structures.

Some of the primary structural barriers that emerge for low SES Bangladeshi laborers are the pressures of migration from low- to high-income countries, including restrictive visa policies, and exploitative middlemen working at the behest of UAE employers, exacerbated by a blatant lack of labor protections once they arrive at their labor camps or sponsored employment location. The visa system (Kafala system) is structured upon the individual satisfaction of employers who are the only legal source of authority for legitimate migrant status. As revealed through the narratives of different participants, many workers are compelled to forgo proper rest and nutrition to cater to the exacting standards of employers. This is a common disregard for human rights experienced by workers in labor camps as well as for smaller scale employees such as domestic workers and those in cottage manufacturing industries. To even get access to such labor markets is an exercise in negotiation for our participants. Despite recognizing the precarity of illegal middlemen, they are compelled to utilize their services, and risk derailment of the immigration process at the slightest protest. The same dynamic pervades and acts as a consistent stressor beginning with their entry to the UAE labor market and extending to the rest of their term of indentured servitude, in many cases lasting decades.

Within such structures, although there are overt health, wage, and immigration protections, the participants emphasize an insidious undercutting of these. They note the forced health insurance payments, legally meant to be borne by employers, couple with the inability to use health services for fear of the perception of reduced productivity. Seemingly guaranteed standards of rest, housing, and nutrition are pervasively ignored as standard practice when dealing with low SES migrant labor. In addition to the physical stress of such labor, mental stressors present in the form of visa regulations mandating labor isolation, as well as the inconsistent and low wages, which in many cases serve as the sole source of income for workers' families in Bangladesh. These claims are supported by a recent Amnesty International report on the state of migrant workers in the Middle East (Conn, 2018). It further observes the low wages of workers that fail to secure an "adequate standard of living" for them due to the high cost of living in the UAE. Our participants additionally note that any protests against such exploitation are met with threats of deportation and replacement, demonstrating the capitalistic process of suppression of labor power.

Recommendations

The CCA prioritizes contextualizing health within social and political structures played out on the bodies of migrant labor. The severe lack of labor rights for low SES labor in the UAE is underpinned by the pervasiveness of socioracial discrimination. This is further codified and reflected in the lack of citizenship rights for foreigners who take on dangerous, dirty, and degrading jobs (Benach et al., 2011), in the local economy. The demand for cheap labor continues unabated with the accelerated development of the GCC countries as tourist and business destinations, foregrounding the competing forces of capitalism and labor rights.

In this backdrop, our participants demonstrate an acute sense of precarity, voicing hidden health concerns among personal networks but staying away from formal complaints known to yield dire consequences such as job loss, deportation, and blacklisting from entry to the UAE. In many qualitative needs-assessment exercises, there exists the possibility to propose straightforward solutions to community health issues, drawing upon community voice. These recommendations bear the presupposition of successful implementation, given the eventual financial and material support to do so. However, in the current case, as with other precariously positioned communities, political and local realities require safeguarding community voice while concurrently elevating it. In this case, as is evident from the narratives about the deportation of fellow workers due to protests about health and labor rights, there is a strong incentive for the political apparatus and local employers to maintain the status quo. Hence, we outline our recommendations based on two key strategies—first, collaboration with mainstream structures to ensure the safety of our participants' status in the UAE and second to utilize and strengthen the existing informal networks of solidarity to serve as channels for information sharing about health and labor rights, as well as to exert pressure through external international sources.

The first strategy is to utilize health, hunger, and faith as entry points for engaging with mainstream organizations in the UAE such as local nongovernmental organizations (NGOs), charitable organizations, and hospitals. Although most of these organizations directly or indirectly fall within the purview of the UAE government, there exists scope for such collaborations to help implement immediate changes on the ground for workers while awaiting policy change on a structural level. Current examples of these in the Middle East include PAVE, sponsored by the IOM and Tamkeen, a Jordanian organization working to increase awareness of workers' health rights among others in the region (Lemon, 2015). Similar scope for partnership exists between UAE

NGOs and local private hospitals with large outreach initiatives both from public relations and service perspectives, tying into the Islamic notion of paying Zakat or charitable giving, one of the key tenets of Islam. Based on the needs of the workers for preventive services, local hospitals could provide monthly or biweekly clinics, which cater to communities without regular access to preventive services, either due to lack of insurance coverage or lack of time to avail of such services. These clinics could serve patients at the location of their labor camps or at a central location in the city with easy access for those working as domestic help or in cottage manufacturing industries. Such regular screenings can serve as a much-needed resource for those grappling with issues related to stress, lack of rest, proper nutrition, and mental health, and as key checkpoints for timely health interventions and recommendations to employers.

Given the preponderance of religious practice as Muslims for several migrant workers such as those from Bangladesh, Pakistan, and Indonesia in the UAE, a collaboration with faith-based organizations may help promote this agenda for existing workers within the framework of such recognized institutions. This may be particularly relevant based upon the strong sentiment of spirituality as a protector of health as outlined by our participants, with the scope for developing mental-wellness programs surrounding the same. Specifically, based on participant experiences and barriers, such a multipronged approach would include tackling key prerequisites of nutrition, health, sanitation, mental health, and time off from work under the umbrella of general health and wellness. All three types of organizations noted above, could also create gender-specific health initiatives to cater to both male and female migrants in the region. A primary reason for utilizing this strategy is to circumvent the inevitable politicization of labor rights issues leading to charges of engaging in subversive activities levied upon foreign workers. To the contrary, utilizing health, hunger, and faith may prove to bear more sustainable and acceptable change in UAE society. Furthermore, collaborations with governmentally approved agencies may boost chances of the successful implementation of medical clinics and health support services through increased resources available to mainstream structures.

In addition to the structurally collaborative strategies outlined above, a second strategy is to commandeer the current labor networks of solidarity as channels for disseminating information to workers about health resources and rights while exerting external pressure upon the state apparatus to provide better labor protections within the UAE. These networks could also be utilized to spread information about local clinics, hospitals, and other organizations available to those grappling with hunger, chronic illness, or mental health issues. This strategy draws upon health meanings expressed by workers as the lived experience of structural exploitation faced by low SES workers and its insidious impact on their health. It further highlights the need to shift the lens of health interventions from the epidemiological, the standard fare of much low-income migrant labor health, to issues of structural inequity, creating such health care access gaps. The structural exploitation outlined earlier, namely, the Kafala system, the employee-borne burdens of health insurance and visa fees, coupled with inconsistent, low wages for exacting labor, result in continuously poor mental and physical health outcomes for this population. Thus, strategically, it would make the most sense to use this network of workers to seek legal and other counsel on structural issues at the core of such poor health outcomes. These channels would serve as sources of legal assistance on visa and labor rights issues, two key stressors in this population.

Tactics would include word-of-mouth spread of information about available assistance, possible collaborations with external media sources, as well as registering formal but anonymous labor complaints with national embassies of countries to which a majority of this labor belongs, such as Bangladesh, Pakistan, India, Sri Lanka, Indonesia, and Thailand. These tactics are geared toward creating a critical mass of dissent through structures outside the purview of the UAE governmental apparatus, subverting the control mechanism of precarity used by them to prevent workers from exerting their agency in the face of structural exploitation. Organizations such as Human Rights Watch (banned in the UAE) and other media organizations continue to use these quantitative measures in addition to anecdotal evidence of labor abuse and health care issues to generate international dialog and attention toward these abuses in the region. Thus, the direct voices of communities are a key catalyst for maintaining international pressure not only on the UAE government but also on capitalistic Western businesses such as New York University, FIFA, and the Louvre which have been thrust into the spotlight for their part in exploiting migrant bodies for profiteering.

In conclusion, this research demonstrates the structural health care barriers that construct the experience of migrant health for Bangladeshi workers in the UAE. Through participant narratives, it maps out possibilities for envisioning a holistic intervention for better labor health outcomes, in contrast to individually focused epidemiological health initiatives. It creates an entry point for meaningful health interventions drawing upon the agentic capacity of marginalized groups, iterated through religious, cultural, and social practices within exploitative neoliberal structures.

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Notes

1. *Fazr* is the name of the first of the five daily prayers that Muslims offer every day. This prayer typically takes place before sunrise. Similarly, Asr is the third and the late afternoon prayer.
2. *Qurbani* is the festival of sacrifices (livestock) that Muslims around the world celebrate once a year.

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