

# Health Seeking Behavior of the Bangladeshi Migrant Workers in Malaysia: Some Suggestive Recommendations in Adjustive Context

A. H. M. Zehadul Karim<sup>1</sup> & Nurazzura Mohamad Diah<sup>1</sup>

<sup>1</sup> Department of Sociology and Anthropology, International Islamic University Malaysia, Gombak, Kuala Lumpur, Malaysia

Correspondence: A. H. M. Zehadul Karim, Department of Sociology and Anthropology, International Islamic University Malaysia, Gombak 53100 Kuala Lumpur, Malaysia. E-mail: ahmzkarim@yahoo.com

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## Abstract

**Background:** Recently, there have been an increasing number of literatures on health seeking behavior of different segments of society in the urban and non-urban regions but rarely have these studies emphasized the health care issues related to migrant workers. With this paucity of investigation, this research focuses on the needs and assessment of Bangladeshi workers working in Malaysia and thus contextualizes it to their health care situation.

**Methodology and Data Sources:** This study is an outcome of a baseline survey conducted in and around Kuala Lumpur city in Malaysia. Based on the snowball technique, the research identified a total of 200 workers through convenience random sampling and interviewed them face-to-face, most extensively with a set of structured questionnaire. The research was further supplemented by a few FGDs.

**Findings:** Until recently, the bulk of migrant workers from Bangladesh come to Malaysia because of bilateral agreements signed by both governments from time to time since 1992. Among these Bangladeshi migrant workers, there is a lack of health facilities in part because of the absence of any precise specification in the agreements. Most of the Bangladeshi migrant workers in Malaysia therefore, are fully devoid of having any Medicare facilities from their respective place of employment and working farms. This is evident when it was pronounced by 87% of Bangladeshi workers who said clearly that they do not receive any medical support or health protection and privileges in times of necessity and crisis. Since they are not protected by any medical insurance whatsoever, they are always afraid of seeing a medical doctor or to visit any health clinics or hospitals. Moreover, due to not having proper documents and also because of other problems and complications, many illegal workers are often denied access to this medical assistance. Most of the workers for that reason either bring some medicine from their back homes or remain sick without getting any proper medical treatment.

**Conclusions and Recommendations:** Because there are no specific agreements on health care issues between Bangladesh and Malaysia, it directs us to conclude that the health care aspects of the foreign workers which are their rights are being ignored. Although foreign workers in Malaysia are accorded equal rights with that of the locals, due to absence of any precise specification on health aspects, these workers are unable to get benefits from the system. For that reason, in the later part of the research, we have concluded with a recommendation saying that since Malaysia is providing placement for a huge number of Bangladeshi workers, it is therefore the government of Bangladesh who should provide initial health support to these workers through a team of medical professionals employed at their foreign mission located in this country.

**Keywords:** Malaysia, Bangladeshi migrant workers, health seeking behavior, adjustive contexts

## 1. Introduction and Background

This paper on health seeking behaviour of Bangladeshi migrant workers in Malaysia is conducted in and around Kuala Lumpur city areas between 2013 and 2014. A large number of temporarily employed labour-force from many Asian and South East Asian countries including Bangladesh has been staying in Malaysia working in various sectors of the country. Evidence indicates that Bangladeshi workers in Malaysia have been providing excellent services and performing well in all working sectors of development (e.g., Karim et al., 1999; Karim, 2013b; Dannecker, 2005; Abdul-Aziz, 2001). Despite positive performances, they often face a few difficulties

and constraints with regard to their health and hygiene which however, is not very unlikely for many expatriates in different parts of the world living in foreign lands (see Baglio et al., 2010).

In rationalizing the significance of this research, it has been posed that the health seeking behaviour of migrant workers is significantly related to the socio-economic development and human resource needs for a newly-developed country as well as the subsistence-survival of a poor economy. Contextually to make a comparison between Malaysia and Bangladesh, it is clearly documented that Bangladesh is now an extremely poor country having been placed in 142<sup>nd</sup> position of the medium HDI index ranking among the countries in the world (see UNDP, 2014). The economic situation of the country has further deteriorated when it shows a persistent current account deficit, with a continuous downward trend in its international exchange rate (see Rahman et al., 2006). In terms of demography, Bangladesh is tremendous pressured with the highest population density in the world, facing a rapidly squeezed farming land which effectually pauperizes a huge number of workless farmers compelling them to migrate to the cities and towns looking for immediate employment (see Karim, 2014). "It also faces exorbitant unemployment statistics in both public and private sectors with perennial poverty situation for at least one third labour-force of the country" (see Karim, 2013b, p. 178). This structural economic condition, low level economic activities and high incidence of poverty denominator have compelled many educated and less-educated younger work force in the country to search for opportunities in many foreign lands including Malaysia, to work temporarily as migrant workers as an alternative source.

Conversely, Malaysia is a rapidly industrialized country having enormous economic development necessitating a huge demand of foreign workers to shoulder these responsibilities as supplementary work-force. To meet up with the deficiencies, workers from a few neighbouring South East Asian countries like Thailand, the Philippines and Indonesia are brought in. At the same time, workers from South Asian countries like India, Pakistan, Bangladesh and Nepal are also imported. Bangladeshi labourers first arrived in Malaysia as plantation workers in 1986, but later on, due to a bilateral agreement signed by both countries in 1992 Bangladeshis are allowed to enter as workers in different development sectors (see Karim, 2013b).

As Bangladeshi workers come to Malaysia, a question is often raised regarding their performance at work. This question has been responded in a few studies where their performance has been rated as exceedingly satisfactory and admirable (see Karim, 2013b; Dannecker, 2005; Abu-bakar, 2002). Nevertheless, many of these studies however, frustratingly mentioned that these workers often face acute problems in regard to their health and hygiene (see Karim, 2013b). Having highlighted such problems, this research has been designed to find out their mechanisms pertaining to improving their health conditions and overcoming their illness. The main points of investigation in this context is to find out the treatment methods for their illness that the workers seek in this country and the measures they take to overcome them.

This research on health seeking behavior of the Bangladeshi migrant has been conducted in and around Kuala Lumpur city of Malaysia. Being the central capital of the country, Kuala Lumpur is the most developed and rapidly urbanizing city and booming with many industrial plants, manufacturing industries, production location and business offices. It covers 7960.84 km area with a population of about 4.7 million in the year 2005 (Karim, 2013b). Most of the foreign workers are placed at Kuala Lumpur because of their first arrival destination and also finding it a more suitable place for availability of jobs.

## **2. Methodology and Data Sources**

Data for this research were gathered in November 2013 through February 2014 where a total of 200 workers were interviewed face to face most extensively with a set of structured questionnaire. Based on convenience and scattered random sampling, the workers were identified through snowball technique. Although the research is open and non-selective in nature in identifying the workers from a few areas like Rawang and Gombak in Kuala Lumpur; these areas were specified because of the reason that these are most suitable locations for availability of Bangladeshi workers who live in large number to those areas nearer to their work-plants.

Apart from collecting data through structured interviews of a large number of Bangladeshi workers, two FGDs (Focus Group Discussions) were also conducted to learn about their health seeking behavior and practices in their everyday life which allows us to gather some additional qualitative information on health and lifestyle issues from a formal interactive discussion method.

## **3. Reviewing of Related Literature**

There is an abundance of descriptive studies on health seeking behaviour but empirical investigations combining these issues of foreign workers and their health perspectives remains scanty (e.g. Nagi & Havio-Mannilla, 1980; Karim, 2013b; Zain, 2000; Rust, 1990; Mobed, Gold, & Schenker, 1992; Young et al., 2005; Collins et al., 2002).

To fill the dearth of knowledge, this research on health care issues of Bangladeshi workers in Malaysia is very much relevant and fascinating. Although there is a shortage of literature in this regard, we are reviewing a few of them which are found contextually related to this issue.

The evidence (see Hui, Bun, & Chan, 1998; Aziz, 2001; Karim, Moha, & Isa, 1999; Karim, 2013b) suggests that migrant workers enter Malaysia mainly to work in the construction, service and manufacturing sectors. A recent study (see Karim, 2013b) clearly focuses on the positive performance of these workers in the developmental sectors of Malaysia and the research in its concluding recommendations rightly pinpoints to the health care problems of migrant workers, which reminds us of the necessity and usefulness of a special investigation on their health care issues. As recently as in 2002, Dato Zain Mohd Zain published an article entitled "Health Problem of Foreign Workers" showing an integrated need to examine health issues related to foreign workers. Zain (2002) mentions that although foreign workers are often authorized to visit government hospitals, the utilization of those facilities remain complicated due to various barriers.

Mahmood (1994) has written an important paper entitled "Adaptations to a new World: Experience of Bangladeshi in Japan" based on the information gathered on their socio-economic adjustability through personal interviews of the respondents living and working in Japan. In this paper, he discusses the health and Medicare problems faced by the workers and found the inaccessibility of the medical benefits where many employers refused to bear medical expenses of those who were sick or had an accident. The research clearly identifies many problems of the Bangladeshis working in Japan who are fully devoid of having any medical facilities.

Rust (1990) conducted an analytical research by searching the migrants and transients in the United States between 1966 and 1989 where he found a clear predominance of a number of diseases among migrant farm workers during that period. Since most of them were under-privileged, it was quite obvious that remaining in poverty and being powerless, they suffered from many infectious diseases which often caused death. It is important to realize that these under-privileged people required special attention in terms of their health, illnesses and treatments. Benach, Muntaner, Chung and Benavides (2009) have written on immigration and health with the purpose of developing a research agenda. After carefully investigating, a significant number of scientific literatures, they have shown the health consequences of migrant workers. The research clearly uncovers the fact that migrating workers are often placed in hazardous jobs for which they suffer from illnesses, serious abuse and exploitation at workplaces.

Baglio, Saunders, Spinelli and Osborn (2010) conducted another study entitled "Utilisation of Hospital Services in Italy: A Comparative Analysis of Immigrant and Italian Citizens" which examined the hospital utilization of the immigrants coming from LDC, having lived in the Lazio region. The study found that the rate of hospital use remains almost similar in the case of local Italians and immigrant labourers but markedly it is lower in the case of immigrants (see Baglio et al., 2010, p. 606).

Priebe and his associates (see Pribe et al., 2011) wrote an article entitled "Good Practice in Health Care" for immigrants and through structured interviews based on open questions and case studies identified the professionals working with higher proportion of migrant populations in 16 countries. The research identified the problems of which lack of familiarity with the health care system is one prime issue for the professionals.

Hesketh, Jun, Li Lu & Mei (2008) investigated the living and working conditions, health status and health care access of Chinese migrant workers in rural areas temporarily moving to urban centers, those who are permanent rural and urban residents. As this study indicates, there has been little concern about the fact that migrant workers lack health insurance, for which a few have to bear a high expenditure for health care in Hangzhou. Consequently many migrants and poor urban workers have limited access to health care system. Young et al., (2005) and his co-researchers have authored another study on health care services in rural Bangladesh enquiring as to who are actually the recipients of these services in a particular time of the year. Based on Anderson and Adamy Model (Note 1), the research tested a possible application of the model among the rural people in Matlab areas of Chandpur District in Bangladesh (see Young et al., 2005) (Note 2). In this study women have been identified as the most disadvantaged group having very little access to health care. The study also indicates that the minority Hindu people always have the tendency of getting the least account of health care attention which is consistent with that of immigrant labourers in other rural areas who also receive little attention in this context. The reviewed articles above have highlighted the situation of migrant workers in regard to their health and illness. Since there have not been much empirical studies in the Malaysian context, we have conducted this study on the health care situation of Bangladeshi workers in Malaysia.

#### **4. Socio-economic and Demographic Correlates of the Migrant Workers**

In the prelude to this study, it is clearly indicated in the form of objectives that this research has a two-fold

purpose: first, it generates a substantial amount of quantitative data on the socio-cultural background of the Bangladeshi migrant workers employed temporarily in Malaysia and secondly, the research provides enormous qualitative information on the health care practices that these workers experience in their everyday life here in Malaysia. Data on socio-demographic traits and cultural background is essential to have an idea about the Bangladeshi workers employed in Malaysia as it helps us to make an evaluation in regard to their health status. Young et al. (2005) mentioned that “knowing something about the demographics of a population allows us to predict statistically a picture of the health status of the population under study” (p.16). Accordingly for that reason, we have generated some background data based on the socio-demographic correlates of the Bangladeshi workers in the following discussion relating them to their health seeking behavior. It prompts us to learn as to whether the workers employed here are capable of adjusting socio-culturally and from a hygiene point of view in an alien environment.

#### 4.1 Age, Education and Income Status

Most of the Bangladeshi workers in Malaysia are young (64.5%) and middle-aged (32%) persons. People who were 50 years old (3.5%) are not very eager to travel outside their country, leaving behind their big families at home. The trend of younger persons in migration seems to be happening everywhere around the world as younger people are comparatively more dynamic and open to challenges in making shifts in their life (see Lie, 1994; Karim et al., 1999; Karim, 2013b). Younger persons usually move out of their countries seeking employment since they are often unmarried and thus remain unburdened to seek adventure (see Karim, 2013b). This is what exactly happened in the case of Bangladeshi migrant workers working in Malaysia.

Table 1. Migrant workers' viewpoints regarding health care as evidenced in FGD No.1

Respondent's Name*	Age	Education	Occupation	Problems identified by participants in regard to health care issues:
Baset Matin	32	Class Ten	Workshop helper	a) Bahasa Malaysia is our second language, and we are acquainted with some simple basics. But whenever we are sick, we cannot communicate with the local doctors and nurses very clearly and comfortably.
Ali Md. Rahamat	33	Class Eight	Mechanic	a) I know very little Malay language and I am not very proficient in this language which impedes me in explaining the diseases to a Malaysian doctor.
Ahmed Jasimuddin	44	Class Four	Workshop Helper	a) In the hospitals and clinics, we have to pay fees which become a burden for us. b) The fee as a foreigner seems to be a little higher which we cannot afford.
Shahidul Haque	37	SSC	Mechanic	a) Malaysian treatment system is suitable for Malaysians; for the internationals, it seems to be ineffective.
Md. Basar Ali	26	Class Three	Cleaner	a) There is a communication problem for which we avoid seeing a doctor. b) Malaysian medicine is not effective for us.
Billat ali	42	Class Ten	No fixed job	a) I never become sick, but I find some of our friends often become sick. b) Since I brought some medicine from back home, I sell these medicines to my friends and colleagues to earn some extra money.
Md. Alamgir Hossain	26	Class Five	Garment worker	a) Once I became sick and had a big problem in explaining my sickness to the Malaysian doctors perhaps for that reason, I was wrongly treated. I suffered a lot and then went home to receive treatment from the Bangladeshi physician who finally cured me.

• All names mentioned in tables and texts are anonymous.

Evidences on the educational background of the Bangladeshi migrant workers show that they are not illiterate or fully uneducated as most of the workers interviewed in this research have at least some basic education. It is

reflected from our data that a great majority of the migrant workers (68.5%) had basic schooling below secondary level and among the remaining respondents, 18.5% have passed their secondary school certificate or SSC examination which is a formal public examination for entering pre-university programs in colleges. Six of the migrant workers (3%) in this research are college and university graduates; one among them is Rabiul Bepari who passed his MA in Economics from a university in Bangladesh. Finding no job in the country, a disappointed Rabiul came to Malaysia to work at a PETRONAS station as a pump attendant as well as to keep accounts. Rabiul is pretty smart and quite fluent in both English and *Bahasa* Malaysia.

Clearly, the migrant workers are poor and their average earning is likely to be minimum compared to other professionals because they are employed in low level occupations. Although we do not have any specific sample-based quantitative data on income from this field-based research, data on income have been supplemented by seeking information from the FGDs of this research. It is reported that the income of the Bangladeshi migrant workers from all sources roughly ranged from RM1000 to RM1500 ringgit a month. In order to ascertain accurate statistical data on income, we additionally relied on our previous study where we find that a few of the workers (12%) always have better opportunities to earn between 1500 and 2000 ringgit a month. In the same research, it is documented that 6% of the Bangladeshi workers even earn more than 2000 ringgit a month (see Karim, 2013b, for details).

Table 2. Migrant workers' viewpoints regarding health care as evidenced in FGD No.2

Respondent's Name	Age	Education	Occupation	Problems identified by participants in regard to health care issues:
Md. Nazmul Ahsan	23	Class Five	Cleaner	a) Most often Bangladeshi workers do not possess legal papers for which many workers are reluctant to see doctors in Malaysia. b) Bangladeshi medicine seems to be more effective for us. c) Bangladeshi doctors are more suitable for us.
Nasiruddin Hoja	27	Class Five	Factory worker	a) We cannot utilize the work-plant medical facilities properly. b) It would have been much better if we could have our own doctors assisting us with initial medical treatment.
Md. Ali Ilyas	57	HSC	Mechanic	a) Consultation fees for foreigners are higher than for the locals. b) Medicines here are not very effective for us. c) Problems are the payment of fees and medical expenses as nothing is catered for by the employer.
Md. Mozibar Hossain	41	No formal Education	Mechanic	a) I broke my hand last year and treatment was partially paid by the employer.
Md. Ahmed Hossain	30	Illiterate	Garments worker	a) Economic problem in making treatment; as it is very costly here.
Md. Altaf Ali	48	Up to SSC	Garments Worker	a) I am very afraid to see a doctor here as there are many formalities. b) It would have been better to consult a doctor who understands my language.
Basiat Ali	25	Class Five	Garment Worker	a) I do not get any medical support from my company. b) Cannot afford treatment here as it is very expensive.

## 5. Health Care Practices of Bangladeshi Migrant Workers in Malaysia

Health is a revealing indicator for socio-cultural adaptability and work efficiency of the migrant workers as it is very much related to their physical fitness. Migrants working in factories, construction sites and other hazardous work locations are very much prone to sickness, accidents and temporary physical disability. Due to laborious

work and extra physical pressure, many of them often become seriously sick. Most of these workers originally come from rural areas in Bangladesh and their poor socio-economic base allows them only minimal health care facilities. This trend continues to occur even in Malaysia. A recent study conducted by Masitah et al. (2008), clearly documents that the incidence of malaria infection among migrant workers in Malaysia has been increasing steadily due to multifarious reasons even though Malaysia started Malaria Eradication Program (ERD) in 1967, later converting it to Vector-Borne Disease Control Program during the 1980s.

Foreign workers suffer from multifarious diseases and this is evident when 116 (58%) of the Bangladeshi respondents in our sample mentioned that they suffer from serious diseases which could have been treated through proper and early medical diagnosis. But whatever their suffering may have been, these workers never get any medical treatment whatsoever from their companies in Malaysia. This is affirmed when 158 (79%) respondents in our study clearly mentioned that they do not receive such support from their employers and this worries them too much. When we asked them to indicate their sufferings and difficulties, a variety of issues relating to health care aspects of the migrant workers emerged.

As the number of migrant workers from Bangladesh increases, it becomes quite important to know about their suffering and health needs and their coping mechanisms in their everyday life. Lists of diseases they frequently suffer from are fever, jaundice, piles, asthma, gallstone, back pain, tumors, eye problem, ulcer, etc. These migrant workers have equal access to public hospitals in Malaysia, yet there is no proper documentation about their visits. Many of the respondents clearly mentioned that they do not usually go to these hospitals due to several reasons and complications. This holds true for all foreign workers in other countries when there is fewer number of visits to the hospitals and less utilization of health care services by foreign nationals (see Baglio et al., 2010).

Since the workers do not visit hospitals regularly, Bangladeshi workers bring along with them a few emergency medicines for precaution. Among the 200 respondents, 141 (70.5%) admitted that they brought some medicine from their own country; others procure these from their friends who have brought extra. We have identified at least ten different types of medicine which they bring from their country. These are: (i) napa, (ii) paracetamol, (iii) histacin, (iv) diclofenac, (v) gepan, (vi) seclor, (vii) ranitidine, (viii) filmet, (ix) orsaline (x) flazil and amodis. Since the workers do not have any pharmaceutical knowledge as such, it is quite likely that they apply these medicines based on their intuition which may often seem to be unreliable. They are fully ignorant about the after-effects of those self-applied medicine as they would often keep using them without having any proper medical check-up or consultation. This research does not however, blame the use of such medicine, but what concerns us most is that these workers remain uncared for and unprotected from health point of view.

### *5.1 Difficulties Faced by the Bangladeshi Migrant Workers in Regard to Their health Care*

Although access to primary health care is a basic right of all categories of people in the world, its utilization is not however, the same for all. A study on utilization of hospital services in Italy asserts that the immigrants in Italy are availing less health care facilities than the locals (Baglio et al., 2010). Rahman (2012) in his study on Bangladeshi migrant workers in the Gulf countries documents that the migrant workers there are not registered under the State Medical Schemes in which case they are clearly denied any medical facilities. It is reported that even at times of emergency, the foreign workers are not allowed easy access to the hospitals. In regard to Malaysia, Zain (2002) mentions that migrant workers in Malaysia have well access to the government hospitals and private clinics. Yet, the Bangladeshi workers are facing a lot of problems which usually discourage them from using the health care services in Malaysia and these are outlined below.

#### *5.1.1 Lack of Familiarity with the Malaysian Health Care System*

Most of the respondents in our research mentioned that they do not have easy access to the hospitals in Malaysia though, from a legal point of view, they are allowed to visit the government hospitals by paying a nominal fee. A few workers reported to us that as foreign nationals, they have to pay more fees than the locals but after careful cross-checking, we have not found this as fully true. But there is no denying the fact that the workers are very much unfamiliar with the health care system of Malaysia and they do not have any procedural acquaintance with it. Conversely in Bangladesh, a patient may be admitted into a hospital free of charge and also they can personally consult any physician outside on their own by paying a very nominal amount of money without having to go through any complicated procedures. For that reason, when the workers need to see a doctor or get admitted into a hospital in Malaysia due to severe ailment, they are often asked many questions about their jobs and authenticity making them very frustrated about their treatment. From Malaysian point of view, this is not however, very illogical as many Bangladeshi workers in the past did not have a legal stay permit. Due to this reason, many workers often prefer to go to a private clinic avoiding hassles at the government hospitals.

### 5.1.2 Traumatic Experience and Social Exclusion

Many workers narrated their stressful experience about health care and being sick. A few of them mentioned that as workers, they are often looked down upon for which they do not feel like seeking health care services. Since the workers come from a very poor socio-economic background, they are often neglected in the hospitals and clinics. Even having very modern health care services in Malaysia, there is a kind socio-psychological distance which keeps the workers far from utilizing these medicare facilities very smoothly. In urban communities, migrant workers are frequently marginalized socially by being blamed for the crowded cities, creating social disorder and increasing crime rates (see Hesketh, 2008). Such accusations are also found appropriate for the Bangladeshi migrant workers in Malaysia in the past, when the local people felt outraged about the presence of foreign workers in this country (see Karim et al., 1999). But in the case of Bangladeshi migrant workers, the number at present is very negligible compared to other foreign workers coming from Indonesia and the Philippines (see The Royal Department of Malaysia as quoted in Kanapathy, 2006).

### 5.1.3 Unclear Etiological Explanation about the Disease and Hazy Symptomatic Expression

Unclear etiological explanation and hazy symptomatic clarification have been identified as important barriers in communicating with the doctors and nurses which creates an impediment to getting proper treatment for many foreign nationals including migrant workers (see Woloshin et al., 1995). While mentioning about health care accessibility, Collins et.al (2002), clearly described the communication problem of the diverse minority groups of people in the United States. Although Bangladeshi migrant workers have acceptable levels of proficiency in Malay in broken Malay language, it is far different than expressing them in proper symptomatic narration about the etiology of a disease. The type of symptoms and the suffering expressed by the patients are the major determinants of health seeking behavior and it is also crucial for a physician to understand the disease. In the case of Bangladeshi workers, a similar situation has been observed where they cannot properly explain the etiology and symptoms of the disease making them often very reluctant to visit the hospitals in Malaysia. When these workers are unable to explain their problems, they then simply blame the Malaysian doctors saying that their treatment is not proper. Anderson (2003) identifies cultural and linguistic competence as the most congruent behavior needed which may make the health care system successful (Note 3).

### 5.1.4 Economic Problems Faced by the Workers Regarding Health Care

It is postulated that economic crisis and poverty always exclude migrant workers from receiving health care benefits and also restricting them from utilizing the benefit of most modern technology in the hospitals and clinics. As the migrant workers are not covered by any insurance and since their employers also do not provide them with any medical support, these Bangladeshi workers have to incur all expenses for their treatment. For that reason, many workers face severe financial burden in making full payment for their treatment. Among a few examples, we can mention here the case of Ali Ilyas, who after breaking his legs, was admitted to Sungai Pusu Hospital, staying there for two months. Being out of the work, he remained unpaid for the period facing difficulties in payments of repeated x-rays and other expenses in the hospital. In another incident, Md. Mozibur Hossain broke his hand for which he stayed in Sungai Pusu Hospital for a few days facing tremendous financial problem. While conducting the FGDs with the migrant workers, one Bangladeshi named Md. Ahmed Hossain had severe back pain spending around RM330 ringgit so far, but could not fully recover from it. Writing about foreign workers in general, Kanapathy (2006) hints that recent fee hike by medical practitioners deny many foreign workers in Malaysia to get proper access to health care facilities and especially those who do not have legal status and are working in the lowest paying jobs; they are most at risk in this context.

## 6. Conclusions and Recommendations

This paper is an outcome of a field-based empirical investigation into the lives of Bangladeshi migrant workers in Malaysia, recording a substantial amount of demographic information about their socio-economic and cultural traits. Especially significant from the health care perspective, the research relates the socio-economic and cultural understanding of Bangladeshi migrant workers through their own narratives in the form of qualitative investigation on health seeking behavior and thus identified the problems encountered by them in this context.

Due to not having any specific and clear agreements on health care issues between Bangladesh and Malaysia, it directs us to conclude that despite their human rights, the health care aspects of foreign workers are partially ignored. Although foreign workers in Malaysia are formally accorded equal rights *at par* with the locals making their legal access to public hospitals and clinics by paying a nominal consultation charge, due to absence of any precise specification on health aspects, these workers are seldom able to get benefits from the system. They face plenty of barriers and constraints that often discourage them from seeking such health care services. "There is anecdotal evidence of migrants having limited access to preventive care and seeking treatment late, *which*

*evidentially comes to be true in the case of Bangladeshi migrant workers who have been living in Malaysia temporarily*" (Zain, 2002, p. 3; italics are added by the authors). But it has been pointed out in our preceding discussion that the migrant workers feel quite strongly that they should receive some kind of medical support either from the work-organizations of the host country or some kind of medical support from their own country.

1) Based on the above, we may paradoxically conclude with a specific recommendation that since Malaysia is providing placement for a huge number of Bangladeshi workers, it is therefore the government of Bangladesh who should provide their workers with the initial primary health care support to its own people through a team of Bangladeshi medical professionals being deployed at their foreign mission located here in Malaysia. In phases, this innovative strategy may also be adopted in a similar way in other countries through bilateral agreements, where Bangladeshi workers are enormous in number. This strategy may allow the Bangladeshi workers to have a culturally competent health care system, having acquaintance of their own physicians who will be able to grasp the etiology of the diseases, thoughts and communicative actions, beliefs and pain in very effective and meaningful ways expressed in their own language.

2) The second recommendation which prompted us to assume that, since the foreign workers mostly live in congested accommodations with unhealthy atmosphere and poor quality of life facing dangerous and hazardous working conditions, it is therefore quite obvious that they require some kind of security-assurance in terms of their safety and protection. Many nations of the world, for that reason, allow the foreign workers to get their health-coverage from insurance companies (see Joshi et al., 2011; Hu, 2011). In their recent research on health care issues of Nepalese migrant workers in three Gulf countries, Joshi et al. (2011) mention that Nepalese migrants are covered by insurance during the first year of their stay in those countries and the companies there later, cover any accidents and deaths whatsoever that occur while they are at work. Although Joshi et al. (2011) did not mention clearly as to whether all other migrant nationals are also getting similar benefits, inquisitively it requires some further exploration as to whether it was the initiative of the Nepalese government itself to make such agreement with the Gulf countries or it was volunteered by the receiving countries themselves. As recently as in the year 2001, Thailand introduced a universal health coverage system through a scheme of health insurance for the registered foreign workers. We suggest that following Thailand and other Gulf countries, Malaysia also innovate such scheme for all foreign workers employed here making it suitable for the structural situation of this country.

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## Notes

Note 1. There are numerous models for the study of health care and health seeking behavior which may broadly be classified into three principal types: (a) The social psychological model (b) the network model and (c) the health behavioral model (see Young, 2005). The health behavioral model is based on the ideas of Aday and Anderson (1974) and Anderson and Aday (1978) which has been identified as the most reliable conceptual model having been used for the last 30 years in assessing health care situation in diversified cultural settings. This model has been widely used on various cultural groups in different parts of the world and most popularly, it is known as Anderson and Aday model. This model was first developed by Ronald Anderson in the 1960s, and later it was collaborated with Lee Ann Aday and they subsequently worked together for many years scrutinizing the theoretical parts of this model. In recent years, this model has also been dealt with and analyzed by others like Laurie. M. Anderson and a few other medical scientists in regard to their studies on health care disparities (see Anderson et al., 2003).

Note 2. The behavior model of Anderson and Aday has also been used at the empirical level in different cultures. Jian Hu (2010) tested this model in his study on Thai ethnic minorities and Subedi (1989) applied it in Nepal. Based on this model, as recently as in 2005, Young and a few other colleagues of him from the Institute of Behavioral Sciences and Department of Sociology of the University of Colorado at Boulders, USA conducted an extensive field based research on adult use of health services in rural Bangladesh which uncovered the situation of Bangladeshi health care users in the country.

Note 3. Anderson et al. (2003) define culturally competent health care system as that ‘type of behavior which is congruent for health services acceptable from linguistic and cultural perspectives’. US Department of Health and Human Services in a final report in 2001 contextually defines culture as an “integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Competence implies the capacity to function effectively as an individual and an organization within the context of cultural beliefs, behaviors, and needs presented by consumers and their communities” (US Department of Health and Human Services: A Final Report, 2001 as quoted in Anderson et al., 2003).

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