Main author: Dr Pratima Sambajee

Co-authors: Prof Dora Scholarios, Dr Imteaz Mohamadhossen, Miss Naila Maherally

Title: Health and well-being of south-south migrants

Abstract

The movement of workers from Bangladesh to Mauritius is exemplary of a south-south migration trajectory. Bangladesh is a low income country that relies heavily on remittance from migrant workers. Mauritius is a middle income country that has become an attractive work destination for Bangladeshi workers due to its industrial and cultural similarities. Using a qualitative exploratory method and a postcolonial sociological perspective, the paper presents findings from a study on health and well-being of Bangladeshi workers in Mauritius. The analysis shows that the discourse of health and well-being is absent in the labour migration model of both countries.

Keywords: South-south migration, postcolonialism, structuration theory, health and well-being.

Introduction

Labour migrants are the backbone of the migration-development nexus. The International labour organisation (hereafter ILO) defines the labour migrant as ' a person who migrates from one country to another with a view of being employed otherwise than on his own account and includes any person regularly admitted as a migrant for employment (ILO Convention No 143 (1975), Article 11). Common trajectories were movements from less developed/developing countries (South) to developed countries (North) mainly for economic reasons. The three corridors of movement are Asia-North America, Latin America/Carribean-North America and Asia-Europe (UN Migration report, 2017). The last two decades have also seen many developing countries become destinations to more than one-third of international migrants in the world (OECD/ILO, 2018). Unlike south-north migration where avenues for settling permanently in the destination country exists, south-south migration involves international labour migration for a certain period of time under contractual arrangements (ILO, 2018). South-south migration further reinforces the migration-development link as both destination and migrant economies are likely to benefit.

However in a recent report on ' How Migrants Contribute to Developing Countries', immigrants were found to have poorer working conditions than native-born workers despite

performing better in the labour market; they were proportionately more often employed but in lower skilled jobs; they were more subject to discrimination due to their non-standard employment, lack of bargaining power and easy-to-replace characteristics and they were not integrated in their destination countries (OECD/ILO, 2018). To date, studies on south-south migration have focused more on the developmental impacts on labour sending and receiving countries in terms of monetary aspects and remittances. The discourse of health and well-being in the south-south movement is relatively recent. The World Health Organization (WHO) defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (World Health Organization 1948). Migration health thus addresses the state of physical, mental and social well-being of migrants and mobile populations (Davies et al, 2009). However, the structural inequalities present in developing countries have a significant impact on overall health and well-being of migrant workers. Migration health in the south-south context goes beyond the traditional management of diseases among mobile populations and is intrinsically linked with the broader social determinants of health and unequal distribution of such determinants. Davies et al (2006) noted that in general migrants experience specific health challenges due to the nature of being a migrant, their legal status as well as the conditions surrounding the migration process. Zimmerman et al (2011) pointed at policy-making on migration and health as a key culprit claiming that the process is conducted within sector silos that frequently have different goals. Overall the locus of responsibility for the health and well-being of migrant workers, their rights to health; access to socially, culturally and language appropriate health and social care is under-explored in the south-south migration context. This paper addresses this by looking at the case of Bangladeshi workers in Mauritius.

Analytical framework

The impact of migration in migrant sending and receiving countries has been subject to continuous debate, opposing views of the "migration optimists" and "migration pessimists" (De Haas, 2010). This further reflects the deeper paradigmatic divisions in social theory and development theory. The discourse of health and well-being in the context of south-south migration carries a similar burden and leads to the questioning of where the locus of responsibility and accountability should lie, that is, who is responsible for the health and well-being of the migrant worker? Existing studies on health and well-being have often drawn on intersections of culture, structure, and agency (see for example Dutta (2017); Rütten and Gelius (2011); Williams (2003)). Although theoretical choices are many, in the context of

migration, any analysis of the issue shows that the actions and/or inactions of migrants (agents) and the structural processes within health and well-being that exist in the host and home countries have significant impact on the discourse. This further requires the development of an explicit approach to the relation between structure, in terms of what drives the process and produces distinctive patterns, and agency, in terms of the way individual agents (migrant workers) develop and pursue their strategies.

Gidden's structuration theory

Sociologist Anthony Giddens' structuration theory argues for a relational approach between structure and agency in which `structure' is established by the way agents operate : deploying, acknowledging, challenging and potentially transforming resources, rules and ideas as they frame and pursue their own strategies (Giddens, 1984) . Structure which refers to the framework within which individual agents make their choices, may be seen to inhere in the various resources to which agents may have access, the rules which they consider govern their behaviour, and the ideas which they draw upon in developing their strategies. Giddens attributes power to particular agents but also posits that power can be both oppressive and productive. Structuration sheds light on the dialectics between individual actions and social structure. Human agency is capable of making a difference and also readjust to turn 'structural properties' to its advantage. Structure and agency cannot be separated.

In south-south migration, the duality between agency and structure is complex and widely challenged. In a critique of classical Sociology, Go (2012) argued that the latter's tendency to portray non-Western societies as homogenous, a 'generalised other', static and backward, poses questions to its application in understanding non-Western societies and the relations between them (Bhambra, 2007). In general Sociology fails to acknowledge the socially-situated experiences of migrants workers who come from non-Western societies to work in non-Western contexts. It overlooks relations, overlaps and intertwines that exist between territories, entities, actors and histories in the migration process. However this should not dismiss the relevance of structuration theory to our understanding of health and well-being inequalities in south-south migration. Instead attention should also be paid to 'connected histories' between contexts under scrutiny (Go, 2012). This means recognising that the duality between structure and agent can also be entangled in dimensions that had been seen in separation and held severally apart (Dewey and Bentley, 1949). This relational ontology lies at the foundation of postcolonial sociology which postulates for a necessary strategy of

connections or interactions that helps mitigate the bifurcation effect of structuration theory (Go, 2012).

The postcolonial sociological perspective

Mauritius and Bangladesh are both postcolonial countries. An application of structuration theory could lead to binary thinking by failing to acknowledge the embodied incomplete or 'ambivalent' characters of knowledge (Bhabha, 1994, Bhambra, 2007) that exists in these contexts. Instead a) an interrogation into the agency of colonised actors and the voices of subaltern people, and b) a recognition that the migration relationship between the two countries is not easily disentangled (Bhambra, 2007) should form a fundamental theoretical grounding. Jackson (2012) identified a postcolonial perspective as useful in understanding the more subtle implications of power in postcolonial contexts. Its discourse whereby colonial practices and ideologies are viewed as still influencing the way ex-colonies are managed (Ahluwalia, 2001; Wood and Brewster, 2007) provides the relevant grounding to theorise non-binary and non-western models of thought. In the same vein, Spivak focussed on the position of those who were cut off from the lines of social mobility whom she called the subalterns (1985). As a deconstructionist, Spivak strongly criticised the tendency of equivocating the subaltern with the oppressed. For her, the subaltern is not only oppressed but is denied access to communication and democratic systems. While in the case of the oppressed, it is possible to force orthodoxy to recognise their oppression, for the subaltern, there is no recognition that these oppressions are taking place. Marginalisation, domination and subordination weakens if not silences the voice of the subaltern.

With a view to gaining a more overarching picture of the dynamics of health and well-being of south-south migrants, this paper brings together the 'structuration' and 'postcolonial' notions, capitalising on their common orientation with regards to power, structure and agency. While structuration elucidates how agents respond to both limitations and opportunities that emerge in the structure, the postcolonial perspective addresses the dimension of power that pertains to different structures embedded in postcolonial societies like Bangladesh and Mauritius. Thus, adopting a postcolonial sociological perspective, and with a relational ontology, this paper also seeks to capture historical and cultural relations that permeate the relationship between the structure and the agent within the contexts of study. To achieve this, the paper reflects on the socioeconomic condition of Bangladesh, its bureaucracy of

migration, the diplomatic arrangements with Mauritius, intersections in cultural and religious values and infrastructures on health and well-being of workers in both contexts. This allows for a postcolonial analysis of how the structure-agency relationship in the dialogue on health and well-being is constantly challenged by established ideologies of governance that also perpetuate structural inequality in relation to provision and access to decent work and health in south-south migration. Against this backdrop, the objectives of this paper are to:

- explore the relevance of health and well-being in the movement of workers between the two countries
- understand how relations beyond the structure-agent of both countries influence the above with particular emphasis on their connected histories and postcolonial present.
- reassess the locus of responsibility, accountability and inequality with regards to health and well-being in this context of study.

Setting the context

Bangladesh

Formerly known as East Pakistan, and before that as the East Bengal region of British India, Bangladesh gained its independence from Pakistan in 1971 following a civil war that included military intervention by India. Post-independence the then government adopted socialism as the economic and political framework to ensure the so called 'economic justice' or 'distributive justice'. Socialism was constitutionally accepted as one of the four fundamental principles of the state. Government of Bangladesh in an order (the Government of Bangladesh Nationalization Order, 1972) nationalized all large and medium sized industries including the banking and insurance sectors. These industries were most commonly known as the State Owned Enterprises (SOEs) As a result, there was no provision for growing the private sector enterprises. The economy was similar to that of a socialist country making Bangladesh one of the poorest countries and its economy one of the slowest growing economies in the world. The World Bank (1995, p 89) stated that the biggest public failure in Bangladesh was due to the SOE sectors in Bangladesh. The socialist experience only lasted until a change of regime in 1975 when Socialism was then omitted and the market economy policy was adopted. Since independence to the present day, there have been numerous changes in political leaderships and forms of government in Bangladesh. Through, the Mujib regime which started its journey with a parliamentary form of government and to a presidential form in 1974. Within five

years of its independence, Bangladesh had succumbed to successive military coup that resulted in the emergence of Army Chief of Staff General Ziaur Rahman as the head of state. Military rule continued for 15 years during which the constitution was suspended citing pervasive corruption, ineffectual government, and economic mismanagement. Parliamentary democracy was born again in Bangladesh in 1991 by the twelfth amendment of Bangladesh constitution. Though, parliamentary system of government was reintroduced, fluctuations of multiparty politics continued and real democratic practice is still absent in Bangladesh.

After more than two centuries of British and Pakistani rule, the administrative structure of Bangladesh exhibits all the cardinal features of colonial bureaucracies (Zafarullah, 1987). The Bangladeshi bureaucracy maintains itself as a subsystem with pronounced autonomy, shielding itself from other functional groups. Its members occupy key positions in the governmental structure and wield tremendous power and authority over policy making (Zafarullah, 2007). This incongruity between bureaucracy and society has serious implications for the perpetuation of various administrative, political, economic and cultural problems in societies (Haque, 1997). Today, Bangladesh is classified as a least developed country with Bengali (Bangla) as its national language. It is highly dependent on foreign aid with 22 million people living in poverty thus making job creation a top development priority (BDU, 2017). As part of this strategy, Bangladesh has become one of the top five migrant-sending countries in the world. It is one of the top ten remittance recipient countries– equivalent to roughly 13 per cent of its GDP (BDU, 2017). According to Bureau of Manpower Employment and Training (BMET), the total number of Bangladeshi labour migrants is about 11.46 million of which Saudi Arabia alone receives 29 percent. Female workers constituted around 12 percent of the total migrants in 2017. Despite the obvious contribution of expatriates to the country's economy, the government of Bangladesh has invested little in the protection and welfare of migrant workers. The budgetary allocation for the Ministry of Expatriate Welfare and Overseas Employment (MoEWOE) was the third lowest of all government ministries in Financial year 2018-19 (Ovibashi Karmi Unnayan Program (OKUP), 2019). Moreover migrant workers pay extremely high migration fee. OKUP research shows that 76 percent take out loans for migration, and many others are forced to resort to selling land. The lack of safe and orderly recruitment practices as well as adequate protection and welfare services abroad result in thousands of migrant workers becoming victims of trafficking, abuse, exploitation, and other rights violations. The research also pointed at the absence of official data on how many migrant workers face critical health

conditions abroad and how many of them are forced to return or deported annually without access to healthcare services in host destinations. The healthcare system in Bangladesh relies heavily on State funding. According to the WHO (2010) only about 3% of the Gross Domestic Product (GDP) is spent on health services. However, government expenditure on health is only about 34% of the total health expenditure (THE), the rest (66%) being out-of-pocket (OOP) expenses. Inequity, therefore, is a serious problem affecting the health care system (Anwar & Tuhin, 2014). A fact sheet from OKUP report based on a database of 215 returnee migrants shows that 19% become lame and sick due to employer's torture; 16% suffer from sickness due to excessive workload; 10% infected with different types of Sexual and Reproductive Health (SRH) infections; 7% found with trauma and mental imbalance; 6% with accidental injuries and physical distortion; 30% identified as HIV+ in 2015; 5% diagnosed with Hepatitis and 3000 dead bodies of migrants annually (OKUP, 2019). This situation poses questions of health and well-being for the migrant worker pre-departure, in destination countries as well as on their return to Bangladesh.

Mauritius

Mauritius is a developing country located in the Eastern African region. The local dialect is Kreol. French colonisation commenced in 1767 and ended in 1810 when France lost Mauritius to Britain who colonised the country until 1968 when it gained its independence. The Mauritian society is built on regimes of migration. It was first a major destination for slaves who were brought from Madagascar and Mozambique to work on the island. Following the abolition of slavery in 1833, British colonisers brought indentured labourers from India to work on the sugar cane plantations followed by Chinese petty merchants. Between 1842 and 1912, it was estimated that nearly half a million indentured immigrants came to Mauritius (Sohodeb, 2009). According to the most recent 2011 Census report, the population of Mauritius is approximately 1.2 million with two-thirds of Indian origin (Indo-Mauritian), followed by one-third of African descent (Creoles) and the remainder of Chinese (Sino-Mauritian) and French (Franco-Mauritian) origin. Despite 158 years of British rule, English never became the language of the land. During the handing over of the island to the British, the 1810 Act of Capitulation and the 1814 Treaty of Paris stated that the inhabitants could retain their religion, customs, property, laws and language which existed under French rule. English was only to be used within judiciary matters. This resulted in the continuation of

both French and Kreol under British rule. According to the most recent 2011 Census report, the population of Mauritius is approximately 1.2 million with two-thirds of Indian origin (Indo-Mauritian), followed by one-third of African descent (Creoles) and the remainder of Chinese (Sino-Mauritian) and French (Franco-Mauritian) origin. Miles (2000: 217) described the case of Mauritius as *'a four-part harmony of Mauritian languages'*: a context where Kreol is the lingua franca of the nation, French is the language of social and cultural prestige, English is the language of education, law and administration and a mixture of Asian languages dominated by Bhojpuri. On the global economic scale, the country was ranked first for 15 years on the Index of African Governance (Mo Ibrahim Index of African Governance, 2015). Overall the country rates highest in sub-Saharan Africa for good governance and political stability (Africa Economic Outlook, 2016) and for ease of doing business (Doing Business, 2018).The country's social and human capital development has also been ranked in the top tier of the continent and it has been described as a middle income country. It has a constitution whereby elections are decided by the First-Past-the-Post System (FPTP) but with elements that promote a power-sharing democracy such as a multi-member constituency, electoral districts and the Best Loser System for underrepresented minorities..

The 1970's saw the implementation of the Export Processing Zone (EPZ). Since then the country has encouraged both foreign labour and capital. The mid-1980s, saw many large and medium companies in the EPZ sector started importing labour and the Mauritian economy subsequently became heavily dependent on migrant labour, particularly within the textile sector. By year 2000, there were over 30,000 migrant workers in Mauritius, of which more than 80 per cent were made up of those from India, Bangladesh and China (Kothari, 2012). Due to their high productivity and low cost, there is a strong preference for foreign workers especially those from Bangladesh and India (Tandrayen-Ragoobur, 2014). Year 2016 recorded 21,157 registered Bangladeshi workers in Mauritius (Survey of Employment and Earnings in large Establishments, 2017) making Mauritius one of their top 5 destinations (ILO, 2014). Kothari (2012) compared the indentured labour system with the 1980's wave of Chinese migration to Mauritius. Points of congruence were found in systems of labour recruitment and control. Key commonalities were: deception in the overall process, unregulated recruitment, abuse and exploitation, discouragement from rebellion and unionisation, confiscation of passports, confinement to the workplace and lodging provided by the employer and general restrictions on mobility. While these finding pertain to Chinese migrant workers in Mauritius, it certainly depicts the political-economic imperatives of

colonialism and the plantation economy that brought indentured labourers from India under the colonial labour regime. The Bangladeshi government has renewed its bilateral agreement with Mauritius since 2010 and has recently concluded agreements to send more workers to Mauritius. Given the ethnic, cultural and religious demography of Mauritius, that is, two-thirds being of Indian origin and sixteen percent being Muslim, issues of Bangladeshi migrant integration are presumably less likely. However evidence of poor housing, little social interaction, xenophobic sentiments, poor working conditions including poor worker rights, low pay, exploitation and discrimination (Acbarally, 2016; Hamuth, 2016; Suntoo, 2012; Suntoo and Chittoo (2011); Lincoln, 2009; Sookrajowa and Joson, 2017) were also found for Bangladeshi migrant workers. The health and well-being of migrant workers in Mauritius has not been investigated despite the claims made by Kothari on the case of Chinese migrant workers. This paper explores this for the case of Bangladeshi migrants workers. The interest on this particular group of migrants arose from existing evidence of maltreatment mentioned above and also as a response to achieving decent work for all.

Methodology

Findings in this paper are from the first fieldwork conducted in Mauritius in November 2018. A qualitative exploratory approach was adopted to provide a richer understanding of the phenomenon in question (Ghauri and Gronhaug, 2010). Bangladeshi participants were recruited via their employers with the assistance of the Confederation of Private Sector Workers (CTSP). Twenty-three came from the garments industry and seven came from food processing and manufacturing. Five of the latter were females. The table below summaries this:

Participant	**Method**	**Number**
Factory managers	In-depth interviews	2
Bangladeshi workers	Story-telling, in-depth interviews	30
Trade union leader	In-depth interview	1
Bangladeshi workers' market	Focussed ethnography over half a day	n/a
Health profession	In-depth interview	1
Owner/Manager of small firm (less than 10 employees)	In-depth interview	2

Table 1: Details of participants

Fieldwork themes:

Employees

Health : Safety at work; access to healthcare at work and outside work, exercise and food consumption .

Well-being: Leisure and recreational activities, contact with family members, adaptation with Mauritian culture, integration in Mauritian society, religious and cultural freedom, workplace culture, working with Mauritians, conflict resolution and work emotions.

Employers

Management practices, orientation for migrant workers, promotion of leisure for workers, occupational health, access to basic health services, health and safety at work and compounds, facilities for freedom of religion and cultural practices and rewards.

Health professional

Nature of health issues of Bangladeshi workers and challenges in treatment.

Trade union leader

Nature of work issues of Bangladeshi workers

Other stakeholders

A workshop was also conducted with representatives of the Ministry of Labour, Ministry of Health, the Bangladeshi High Commission, the National Productivity and Competitiveness Council, CTSP and Mauritius Council of Social Service..

Context of research field:

Bangladeshi workers came to work on a initial contract of 4 years which can be renewed for up to eight years. However the sample also consisted of those who came under the old model which had no restrictions on the renewals. They lived in compounds located on their worksites. Rooms were arranged like dormitories with up to sixteen people in each. They had shared kitchen and toilets. Men and women lived separately. Factories had curfews for all workers. They spoke Bangla and Hindi and had little mastery of the local dialect, Kreol, English and French. Two Mauritian interpreters were used throughout the fieldwork to

maintain consistency but on most instances, each employer provided a Bangladeshi migrant worker who would interpret during the interview. In many interviews, a member of the management team was also present.

Findings

Pre-departure procedures

Migrant workers were recruited by agents despite claims by employers that workers do not require the assistance of an agent in Bangladesh to obtain a work permit. A considerable and varying amount of money (a minimum of 1 Lakh (100000) Bangladeshi Takas) was paid to an agent. In some cases the employer would send a key member of management to

> Interpreter (also a respondent)*: It is obligatory to have agents over there. The company will send the description of job vacancies they have to these agents. These agents will start looking for interviewees then someone from here will go over there for testing purpose. Each agent has their own fees.*
>
> Interviewer*: There is no control for the fees?*
>
> Interpreter*: We do have control. The company and the country Law over there already told everyone not to pay more than 22,000 Bangladeshi Takas to any agent. Even the agent has been made aware. In exception where someone has less chances of being chosen, he will pay more. We also have some people who came here without paying any fee to the Agent. But the company will pay the agent for their facilities such as collecting the passport or helping the employees with their medical check – ups. This will depend on the employees how much they are able to pay.*

This highly unregulated recruitment process involves unofficial middlemen, who despite bringing recruiters and rural workers together, often give false promises about jobs and pay to entice workers then charge high fees that trap them in debt bondage. Many participants sold land, borrowed money from family, friends or banks, or mortgaged their house to obtain the funds. Agents held information about jobs abroad and conducted interviews and practical tests on potential workers before deciding on the rate to charge.

> Res*: Yes, I am the one who went to see him first. He said that there are good companies in Mauritius, so I gave my interview and got selected by this company*
>
> *Interviewer:Ask her about the things he asked her in the interview?*

Interpreter: what were the things/questions they asked you in your interview?

Res: They asked me to make a collar. Which I did well. After completing the collar they said am good.

Interpreter: So you gave a sample first?

Res: Yes, they were analysing the time I took to complete the task they gave me.

The importance of pre-departure medical examination of the departing migrant worker was first adopted in the Code of Conduct of Recruiting Agencies and License Rules (2002 stating that recruitment agents must arrange medical examination for the potential migrant. In 2008, the Ministry of Expatriate Welfare and Overseas Employment (MoEWOE) adopted the "Health Check up Policy for potential Bangladeshi Migrant Workers" which states that the quality of medical testing should be in line with international standard (WHO). Despite these reinforcements in the law, from our respondents the focus of the recruitment process was mainly of the worker's ability and efficiency to perform the tasks of the job. The concept of health rarely mentioned.

On-site procedures

Participating employers had heterogeneous and ad-hoc practices with regards to how they treated their employees. The garments industry is under close scrutiny of the Ethical Trading Initiative (ETI) and international clients. Both demand that employers acts responsibility and provide decent work for employees. In this respect and acknowledging 'pressure from clients', participating factories had established some form of occupational health structure that revolved around a weekly visit of a doctor on site, a first-aid clinic operated by a trained member of staff on a needs-basis and provision of transport and a translator in case a visit to the hospital is required. These were considered adequate and decent:

Res (Manager): They used oriental toilets not European ones, we had to remove and put oriental ones..we gave them their facility. Their ways of eating, they were all 'anaemic' at first, then we started to teach them how to eat and cook. Everytime we do not let them cook in their house. We provide them breakfast and meal here. You would go to many companies and see that they give money. They give you Rs1500 to eat for one month by your choice. We provide them food. There are cooks everytime which I go to bring and they cook as per their choice and of course we buy and we check the food before we serve to know what we are buying. Now we are also working

on balanced diet, we are seeing how much calories they are eating, how much food wastage there is per person. We see all that. Many companies will not do it. We are not doing it for economic purposes but to see if that person is eating or not?

The most critical barrier to accessing free healthcare outside work is language. Workers were only provided interpreter assistance and transport when ill on normal working days during the week. The role of the interpreter also called the 'team leader' is crucial to access available services:

> Interviewer*: That is your family and wife were able to come, now you are a Team Leader, you look after the problems, food, health regarding the workers from Bangladesh who come to see you, Do you take them to the hospital ?*
> *Res: Yes anytime no problem either during the day or night if I get a call someone is ill then I must go to the hospital then I phone..to arrange for the transport.*
> Interviewer*: How much people are you looking now?*
> *Res:87*
> Interviewer *: That is only you look after workers from Bangladesh, did it ever happened that 2 or 3 people are ill at the same time?*
> Res*:Yes*
> Interviewer *: Then what do you do?*
> Res *: We bring together in the same transport.*
> Interviewer *: Then there how do you do because because everyone is going to see a different doctor because of different disease?*
> Res*: No problem, we wait a little and I bring one by one.*
> Interviewer *: What is the procedure ?*
> Res *: Illness can come anytime, if during work somebody is ill then I take permission with the foreman as I need to bring the latter to the hospital, I arrange for the transport, I inform that someone is ill I need to go to the hospital..no problem then I can go, if someone is at home he phones and tells that he has a problem.*
> Res *: If somebody gets cough or fever, I bring him to the dispensary which is near, the doctor look after him and if can get medicines here, if there is a need to go to the hospital in case of emergency, the doctor tells to bring the latter to the hospital then we bring him to the hospital.*

Interviewer *: The dispensary is not in the factory, it is a branch of the hospital in Mauritius which is near the factory, you all go there first and if the doctor says that there is a need to go to the hospital ?*

Res *: Yes, if there is a need the doctor gives a paper then we go to the hospital.*

Interviewer *: In the factory is there First Aiders.*

Res *: Yes first treatment first aid..anyone's hand is cut or head pain a little, we bring the first aid first, there is a nurse there who sees, if there is a need to go to the hospital, if it is a bit normal cut she can do the dressing, if there is a need to bring the latter to the hospital then we bring.*

Interviewer : When you go to the dispensary or hospital, suppose it is not a small injury, as if stomach problem or vomiting, how do you understand and make the doctor understand what happened to the person because you too you are not a Mauritian, some words you do not know how to tell in Kreol, how are you able to explain to the doctor about the person?

Res *: No the person talk to me then I explain to the doctor.*

Interviewer *: But when you are explaining to the doctor, sometimes are there some words that you are not sure about, what to tell, does it happened or all always get the same disease.*

Res *: No I always go and come, I understand the disease.*

Res *: Yes, sometimes one may be allergic with medicines such as panadol*

Interviewer : You need to know all that?

Res *: Yes*

Interviewer *: Now to go and take the medicines and explain to the person how much to take, you do it by yourself ?*

Res *: In the hospital they write on a paper, that to drink before eating after eating, all is written, then on coming home I explain one by one.*

Workers make other arrangements if they need care during the weekend which often involves seeking private healthcare as public hospitals refuse to see patients without the team leader. The health professional narrated a number of cases when Bangladeshi workers were unable to explain their symptoms and took longer to be diagnosed. Currently the Mauritian government does not provide any interpreter facility in its hospitals. Workers who required longer treatment often did not turn up to their appointments due to fear of the employer and/or loss

of income. This resulted in a number of the workers self-medicating causing major problems in future treatment.

> Interviewer *: Is it true, make as if in weekdays someone (worker) came alone, nobody accompanied him/her. Some workers mentioned that they were refused treatment and were asked to go back to work and that they must ask someone to come with them.*
> Res (general practitioner)*: It depends on the doctor if he/she can speak a bit of Hindi and Urdu they can manage because some doctors say no they do not understand anything then it becomes very difficult for them to speak in any language. Once I got a patient who does not know Hindi or Urdu. I was stuck, language of sign do not work well too because there is the limit of accuracy. There is language barrier. Otherwise we put in folder that there is language barrier only or no interpreter available. Then it becomes difficult because if the patient cannot explain or diagnosis is not done then one must rely much in investigation.*

Common health issues identified by the practitioner were muscular pain, symptoms of over tiredness and also chronic fatigue syndrome. However as discussed in the conversation below, 'homesickness' was also a common diagnostic. It is also noted in this quote how the Ministry of Health plays a passive role in preparing its service providers about the nature of care required by Bangladeshi migrant workers:

> Res (general practitioner): *No... There was a notice which came stating that they cannot use mixer.. then another stated that they can use that's all I do not see any other notice which is specific to them.*
> Interviewer *: Is it a need?*
> Res (general practitioner)*: I think for them there need something for communication, perhaps an aspect of medicine which adhere to them because may be the question is of physical component and mental well-being that should be assessed because regarding the mental well-being even when you have finished talking to them, they tell you that another thing, belly pains or this pains. Eventually when you realise the biggest thing is that they are home sick.*

The meaning of well-being: Religion, Food and Family

Leisure and recreational activities were minimal. Employers organised an annual outing to the beach and a special holiday was granted on Eid, a special festival celebrated by Muslims. A fundamental dimension of this study was also to define the meaning of well-being for these

migrant workers. Findings showed that the practice of their religion was an important dimension of well-being for Bangladeshi workers. Given the significant Muslim community in Mauritius, mosques were located in almost all towns and villages. However this study found that prayer time was negotiated with line managers especially on Fridays and during the fasting month of Ramadan. Factories had no dedicated payer facilities while dormitories had limited space due to the large number of occupants in each.

> Interpreter : *And during Ramadan?Can you repeat what you just said about Namaz ?*
> Res : *In the Canteen.*
> Interpreter: *In the 45 minutes break*
> Res : *Yes, I read Namaz[1] there and later when I am released at 9 0'clock, I go home then I read Namaz and on Friday I go to the mosque.*
> Interpreter : *So you do not take your first break of 15 minutes, you take your long lunch break of 45 minutes so that you can lunch and do Namaz?*
> Res : *Yes for Namaz, that is why I take more time here as I am a Muslim and read Namaz.*

Gender differences were also noted in the frequency and nature of leisure and recreational activities. Male workers frequently ventured out of compounds, to the beach, to the capital city and also to play football and cricket. None of the female respondents engaged in outdoor leisure activities. Reading of the Quran was a quintessential part of how they spent their leisure time. This

> Interpreter: *What do you do in your leisure time during holidays?*
>
> Res: *I stay in the hostel, prepare my favourite foods such as biryani or vegetables. Read Namaz or Quran.*
>
> Interpreter: Y*ou don't go out with friends?*
>
> Res: *No I don't like. I prefer to read Quran at home instead.*
>
> Interpreter: Are you able to do your prayers well in the hostel? Do you have enough privacy?
>
> Res: *Yes I face some difficulties, we have a TV room there which is on rarely. So we use the TV room to pray but some girls will walk around, talk on the phone*

[1] Religious reading of verses of the Quran, a Holy book for Muslims.

Food was also a quintessential part of the Bangladeshi migrants life. Most respondents described their holidays as one where they would cook their favourite foods, different to what is provided to them by their employer. The contractual arrangements state that the national minimum wage also includes the housing and food allowance up to the value of £2500 (Ministry of Labour, 2019). The findings reveal ad-hoc practices with regards to how this allowance is calculated and distributed, leaving some workers worse off than others. Some employers gave their employees a cash allowance from their allocation each month to spend as they wish while others deducted the whole amount from the worker's salary.

Retaining contact with their family back in Bangladesh was an essential aspect of the workers' well-being, especially female workers, many of whom had left their children and husbands back home. The Mauritian government has refused to adopt the ICRMW (The international convention on the protection of the rights of all migrant workers and members of their families) whereby migrants would be allowed to bring their families (Sookrajowa and Joson, 2017). This means that many spent years without seeing their children and family. Findings revealed a number of narratives where there was strong emotional distress of being disconnected with 'home' and family. The use of mobile technologies and applications that enable long-distance communication are the most common ways of keeping in touch. Only one of the factories has free internet access in dormitories. Workers spent a considerable amount of money to buy data to talk and see their close family. A significant finding from the study was that married couples who lived and worked in Mauritius were not allowed to live together. Instead they had to spend on a weekend accommodation to see each other.

> Res: *No, it's only in weekends that he comes to stay. He comes on Saturday evening then return back on Sunday evening.*
>
> Interpreter: *Why your husband doesn't stay with you all the time?*
>
> Res: *No, he is allowed to go out after 6pm. Am the one who is not allowed to leave the hostel that's why I have taken room on rent.*
>
> Interpreter : *Her husband stays in the hostel provided by the company whereas she stays in a personal house. Her husband is not allowed to leave hostel on weekdays. that's why they meet only in weekends.*

Restrictions on mobility of workers including curfews strongly affect family life for married couples together with incurring additional expenses. This form of unfreedom (Kothari, 2012) based on a combination of manipulated mobility and enforced confinement could have lead to the lack of integration of Bangladeshi workers in Mauritius despite the large Muslim population and multicultural demography. Overall they are overtly marginalised. They live in designated areas, do not interact with local people, rarely consume local products (especially females) and are unaware of Mauritian culture. They only socialise with in-groups and do not join trade unions. Despite sharing religious beliefs with many Muslim Mauritians, they happily perform festivities and religious practices in their own enclaves. Their focus on sending money to their families in Bangladesh makes them more prone to working long hours and tiredness. Yet the workers displayed a general satisfaction with their current life in Mauritius.

Discussions

Bureaucracy of migration

Four public and private institutions offer services to migrant workers from Bangladesh – the BMET (Bureau of Manpower, Employment and Training), Bangladesh Overseas Employment Services Limited (BOESL), recruiting agencies and migrant networks (Siddiqui, 2005; Rahman, 2012). The Bangladeshi government's most prominent structure regulating migration is the BMET, established in 1976. The BMET issues and renews the licenses of recruiting agencies, grants permission to agencies to recruit, provides immigration clearances after verifying visa papers and employment contracts, looks after the welfare of Bangladeshi workers abroad and manages many other functions related to training of workers and promotion of migration overseas. The BMET is under the administrative control of the Ministry of Expatriates' Welfare and Overseas Employment. Private recruiting agencies emerged in response to the growing demand for labour overseas in the late 1970s. They perform under the Bangladesh Association International Recruiting Agencies (BAIRA), formed in 1984 with the purpose of catering to the needs of the licensed recruiting agencies.

BAIRA is also involved in the welfare of the migrants overseas. They have launched two insurance schemes: one is for the workers before their departure and the other is for their families left behind, through BAIRA Life Insurance Company Limited (www.baira.org.bd). However a recent search on BAIRA Life Insurance Company Limited shows that they have been accused of corruption in 2018. It's plan to set up a medical test centre since 2013 ha not

concretised yet. The reality based on this paper's findings is that the government of Bangladesh and its bureaucracy of migration has failed to deliver the demands of a transparent labour migration regime. Instead the system is marked by a well established agent recruitment structure that is largely unregulated and informal. Agents have control over the processing of pre-departure information. Experiences with this bureaucracy are characterised by exorbitant fees under total control of the agent. Despite the company's and the country's regulations of a maximun payment of 22,000 Bangladeshi Takas, there is ample evidence of an overuse of power by agents. Rahman (2012) highlighted that the actual recruitment procedures are much more complex and multilayered with both formal and informal recruiting agents. With the most prospective migrants coming from rural Bangladesh and recruitment agencies based in the capital city of Dhaka, sub-agents who act as middlemen between a prospective migrant and a licensed recruiting agent are very common. Sub-agents help prospective migrants find jobs and help agencies find prospective workers. Therefore the sub-agent is a critical actor whose agency is able to influence the demand for specific labour and the supply of such labour. This informal system fails the formal structure and bureaucracy of migrant recruitment in Bangladesh. It also underlines the incongruity between bureaucracy and the actual postcolonial Bangladeshi society which has a large rural population.

Diplomatic arrangements between Bangladesh and Mauritius regarding migrant worker recruitment have revolved around the 2009 signing of the convention for the avoidance of double taxation and fiscal evasion with respect to taxes on income in Mauritius (Tax-News, 2010); the use of BOESL to recruit on behalf of Mauritian employers to avoid abuse by sub-agents (Business Mega, 2011); the signing of the memorandum of understanding on manpower export which was due in April 2011 (Business Mega, 2011) and the more recent discussions about the direct air links (Govmu.org, 2018). None except the double taxation treaty have concretised to date. An important remark is the total absence of mention of health and well-being of migrants in these government discourses. Overall the two countries are unresponsive to the health and well-being needs of workers focusing more on economic gains for each. Political actors in both contexts align in their manipulation of the state apparatus illustrating the potency of the latter as powerful in camouflaging the real problems of migrant workers.

Health and well-being inequalities

Following colonisation of Mauritius by Britain, it was in the mid1930s that the colonial government took steps towards broad-based social welfare system. This was strongly influences by the economic conditions of the 1930s which inspired unorganised labour from the sugar plantations to rebel against the colonial government's neglect of terrible poverty leading to severe decline in the standards of living for the Indo-Mauritian majority and the lack of comprehensive assistance programmes to cater for the livelihoods of the poor. The second influencer was the formation of the Indo-Mauritian dominated Mauritian Labour Party (MLP) in 1936 which represented the emergence of nationalist platform to pressure the colonial government to provide services to Mauritians. Thereafter, since its independence in 1968, Mauritius has held a robust welfare state providing free universal healthcare. Successive governments have strived to improve the universal healthcare system by making it an essential of their annual budgeting priority areas. While this illustrates concern for health and well-being for all, a significant feature of the Mauritian healthcare systems is the dominance and continuation of imperial languages in its delivery. This means practitioners in the public health sector are mostly conversant in French, English and Kreol thereby alienating the language of the 'Other'. In this case the 'Other' language is Bangla. Although many workers also spoke Hindi and Urdu, the Western-centric training of practitioners did not allow them to diagnose against descriptions given in 'Other' languages. Previously Miles (2000: 215) argued that colonial languages are valued as they are 'foreign and ostensibly neutral tongues'. In this study they have contributed to inequality. As informed by the findings, the 'team leader' is one who masters at least one of the imperial languages and/or Kreol. Language therefore becomes a key barrier to access universal healthcare. Colonial imposition of French and English is a clear example of how language acquisition became part of the process of imperialism–in this case linguistic imperialism (Phillipson, 1996). In his theorisation Phillipson refers to Western countries of the centre as using language as one of the tools employed for the purposes of domination over the developing countries of the periphery. Through postcolonialism, linguistic imperialism has been perpetuated by political structures and also culturally sustained by ideologies that French and English are higher status languages and where the two colonial languages have been privileged at the cost of others (Muhlhausler, 1986) as in the case of Mauritius (Sambajee, 2015). Given the increasing number of Bangladeshi workers in Mauritius, infrastructures of health and well-being with zero consideration for languages other than French, English and Kreol should be questioned in terms of the country's readiness as a foreign labour receiving country. Therefore the lack of

access to healthcare in Mauritius reinforces the existing limited access in Bangladesh, making the Bangladeshi migrant worker a victim of both structures.

The subaltern

The Mauritius Decent Work Programme (MDWP) 2012-2014 claimed that migrant workers enjoy the same terms and conditions of employment as Mauritian workers and they have the same rights as local workers in terms of trade union activity (MDWP, 2012). This is reinforced by a section in the contract stating that union membership is permitted. From our findings none of the workers are members of a trade union. According to Spivak (1985) the subaltern is not only oppressed but is denied access to communication and democratic systems. This denial may not be overtly visible but is ongoing to silence the voice of the subaltern. In this study, the inability to express their own health and well-being needs due to language deficiencies, is a major denial of access to communication and information. All documentations, health and well-being related information is written in imperial languages with a few written in Kreol. This places the migrant workers in a weak position to develop and pursue their strategies towards an improved health and well-being situation. The loss of agency here is structural and lead by the ongoing postcolonial state of Mauritius. Kothari's concept of unfree labour is evident in the case of Bangladeshi workers. The treatment they received on coming to Mauritius is symbolic and synonymous to the indentured labour system including rationing of commodities, reduced mobility and confinement to specific spaces and places. Overall migrant workers believe that there is an improvement in life due to higher income earning capacities. However they oversee the health and well-being consequences of the process. Their docility and silence is to a great extent structural.

Conclusions

There is no concern for the migrant worker's health and well-being in either Bangladesh or Mauritius. As a labour sending country, Bangladesh has failed to protect and educate its workers before they venture out to work. The locus of responsibility is passed on to the worker, the employer and the health infrastructure of the destination country. The study shows that the agency of migrant workers is lost when structures in the destination country raise significant barriers to accessing information and services that are resourceful to make structural changes. As long as the migrant worker is silenced, the health and well-being situation will always be compromised. Channels of communication have to open to allow better access to health and social care services. This may include making information

available in forms that are accessible by the migrant worker, local language training, educating health practitioners on the medical tendencies of migrant workers and lifestyle back in Bangladesh, making medical care more culturally appropriate, promoting non-unionised forms of voicing out in the workplace, promoting the notion of well-being and counselling thereafter to the needy and finally moving away from the (im)mobility practices subjected by the employer. Commitments to these proposed changes are required from both governments for the sustainability of this south-south labour regime.

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