CJBEHM
CANADIAN JOURNAL OF BUSINESS, ECONOMICS AND HEALTH MANAGEMENT

ORIGINAL ARTICLE

CJBEHM. 2025 April; 8(1): 59-76
ISSN: 2818-0208
Published by www.cjbehm.ca

Healthcare Access Challenges for Bangladeshi Migrant Workers in Malaysia: A Mixed-Methods Study

Gazi Abu Horaira[1,2], Rabiul Islam[1], Kamrun Nahar Salma[2]

1 School of International Studies, University Utara Malaysia, 06010 UUM, Sintok, Kedah, Malaysia.

2 Centre for Advanced Research (CAR)

Corresponding author*
Gazi Abu Horaira
School of International Studies, University Utara Malaysia, 06010 UUM, Sintok, Kedah, Malaysia.
Email: horairajnu2009@gmail.com

Article info
Received: 25 January 2025
Accepted: 27 March 2025
Published: 30 April 2025

Keywords
Migrant health, healthcare barriers, labor rights, Malaysia-Bangladesh migration, health policy.

Abstract

While health-seeking behavior research has expanded for urban and rural populations, migrant workers' healthcare needs remain critically understudied. This study addresses this gap by examining the healthcare access challenges faced by Bangladeshi migrant workers in Malaysia, a population exceeding 500,000 but with poorly documented health outcomes (Ministry of Human Resources Malaysia, 2023). We employed a sequential mixed-methods design in Greater Kuala Lumpur (November 2023- February 2024). Structured interviews with 200 workers using snowball-convenience sampling and two focus group discussions (n=14) exploring lived experiences. Analysis integrated descriptive statistics with thematic coding of narratives. Three systemic barriers emerged: firstly, (Structural exclusion) 87% lacked employer-provided health coverage, with undocumented workers particularly vulnerable. Secondly, (Financial constraints) Average monthly earnings (RM 1,200-1,800) made hospital fees prohibitive. Lastly, (Cultural-linguistic gaps) 62% avoided care due to language barriers and distrust of Malaysian providers. Notably, 71% relied on self-medication through medicines imported from Bangladesh, risking improper treatment. Based on its findings, this research recommends Bilateral health agreements between Malaysia and Bangladesh, Employer-mandated health insurance schemes, and Mobile clinics with Bengali-speaking staff.

Introduction

This study on the health-seeking behavior of Bangladeshi migrant workers in Malaysia was done in and around Kuala Lumpur from 2023 to 2024. A significant contingent of temporary workers from numerous Asian and Southeast Asian nations, including Bangladesh, has been residing in Malaysia, engaged in various areas of the economy. Evidence suggests that Bangladeshi workers in Malaysia have been delivering exceptional services and excelling across all sectors of growth (Karim, 2013; Dannecker, 2005; Aziz, 2001). Despite positive performances, they often face a few difficulties and constraints regarding their health and hygiene, which is not very unlikely for many expatriates in different parts of the world living in foreign lands (Baglio et al., 2010). Recent studies underscore systemic healthcare exclusion of migrant workers globally. (Schwartz et al., 2022) found that in Gulf nations, 68% of South Asian migrants avoided hospitals due to costs and fear of deportation, mirroring findings in Malaysia. Sun et al. (2021) identified language barriers and employer negligence as primary deterrents in Southeast Asia, with only 12% of Bangladeshi workers in Singapore receiving employer-sponsored care. Kabir et al. (2022) revealed that 73% of Bangladeshi workers in Kuala Lumpur lacked health insurance, citing bureaucratic hurdles in Malaysia's Foreign Worker Medical Examination (FWMEA) system. Seedat et al. (2023) highlighted those migrant workers in construction sectors faced 3× higher injury rates but had no access

to subsidized care, exacerbating reliance on self-medication.

Ahmed & Yunus (2023) documented "medical remittances." 55% of Bangladeshi workers in Malaysia received medicines via informal networks, risking unsafe practices. Karim et al. (2024) found that telemedicine consultations with Bangladeshi doctors rose by 40% post-COVID, reflecting distrust in host-country systems. Suphanchaimat et al. (2021) showed that mandatory health insurance for migrants reduced untreated illnesses by 32%. Mahmud (2024) evaluated a 2023 initiative stationing Bengali doctors in Saudi Arabia, reducing worker hospital avoidance by 28%.

This research underscores that the health-seeking behavior of migrant workers is closely linked to the socio-economic development and human resource requirements of a newly developed nation, as well as the survival of an impoverished economy. In comparing Malaysia with Bangladesh, it is well-documented that Bangladesh is currently classified as an extremely impoverished nation, ranked 142nd on the medium Human Development Index (HDI) among countries globally (Malik et al., 2014). The nation's economic condition has worsened, evidenced by a sustained current account deficit and a continual decline in its international exchange rate (Rahman, 2011). Demographically, Bangladesh experiences immense pressure due to the highest population density globally, contending with rapidly diminishing arable land, which effectively impoverishes a significant number of unemployed farmers, driving them to migrate to urban areas in search of immediate employment (Karim, 2014).

It also confronts exorbitant unemployment rates in both public and private sectors, alongside a persistent poverty situation affecting at least one-third of the labor force in the country (Karim, 2013). The prevailing structural economic conditions, characterized by minimal economic activity and a high poverty rate, have driven many educated and less-educated young individuals in the country to seek temporary employment opportunities abroad, including in Malaysia, as migrant workers.

The performance of Bangladeshi laborers in Malaysia is frequently questioned. This question has been addressed in several studies, which have assessed their performance as highly good and commendable (Karim, 2013; Dannecker, 2005; Abubakar, 2002). Nonetheless, numerous research studies have frustratingly indicated that these workers frequently encounter significant health and hygiene issues (Karim, 2013). This research aims to elucidate the mechanisms involved in enhancing health conditions and overcoming illnesses, having identified the associated difficulties. The primary focus of this inquiry is to identify the treatment techniques for the illnesses sought by the workers in this country and the tactics they utilize to address them.

This study was conducted in Greater Kuala Lumpur (GKL), Malaysia's most industrialized urban corridor and primary destination for migrant workers. As the nation's economic hub, GKL spans 7,960 km² with a current population exceeding 8 million (Department of Statistics Malaysia, 2023), including an estimated 1.2 million documented foreign workers - approximately 35% of whom are Bangladeshi nationals (Ministry of Human Resources, 2023). The primary objective of this research is to examine the healthcare-seeking behavior and challenges faced by Bangladeshi migrant workers in Malaysia. Specifically, the study aims to: Identify the socio-demographic characteristics of Bangladeshi migrant workers and their influence on health-seeking behavior, Explore the barriers—including economic, linguistic, legal, and cultural—that hinder access to healthcare services among migrant workers, Assess the patterns

of self-medication and informal healthcare practices adopted by the migrant community.

Literature Review

Numerous descriptive studies exist on health-seeking behavior; nevertheless, empirical research integrating the health perspectives of foreign workers is limited. (Karim, 2013; Zain et al., 2012; Young et al., 2005; Collins et al., 2002). This research on the health care challenges faced by Bangladeshi laborers in Malaysia is highly pertinent and intriguing, addressing a significant knowledge gap. Despite a paucity of literature on this subject, we are examining some works that are contextually pertinent to this issue. The evidence indicates that migrant workers mostly enter Malaysia to engage in the construction, service, and manufacturing sectors (Aziz, 2001; Briere et al., 1998; Karim, 2013; Karim, 2014) A recent study Karim et al., (2014) emphasizes the commendable performance of workers in Malaysia's developmental sectors, and its concluding recommendations accurately highlight the healthcare challenges faced by migrant workers, underscoring the need for a dedicated investigation into their healthcare concerns. In 2002, Dato Zain Mohd Zain released an article titled "Health Problem of Foreign Workers," highlighting the necessity to investigate health issues concerning international workers. Zain et al. (2012) state that while foreign workers are typically permitted access to government hospitals, their utilization of these services is hindered by other obstacles.

Mahmood (2021) authored a significant study titled "Adaptations to a New World: Experience of Bangladeshis in Japan," which is based on data collected from personal interviews with respondents residing and employed in Japan regarding their socio-economic adaptability. This article examines the health and Medicare issues encountered by workers, revealing the inaccessibility of medical benefits, as some businesses declined to cover the medical expenses of employees who were ill or injured. The report distinctly highlights the issues faced by Bangladeshis employed in Japan who lack access to medical facilities. Rust (1990) did an analytical study of migrants and transients in the United States from 1966 to 1989, revealing a significant prevalence of several diseases among migrant farm laborers throughout that timeframe. Due to their underprivileged status, it was evident that their continued poverty and powerlessness resulted in suffering from several infectious diseases, frequently leading to mortality. It is essential to acknowledge that these disadvantaged individuals necessitate specialized attention regarding their health, ailments, and therapies.

Benach et al. (2010) produced a publication on immigration and health with the objective of formulating a research agenda. Following a comprehensive examination of various scientific literature, they have elucidated the health consequences of migrant employment. The research demonstrates that migrant workers are often relegated to hazardous jobs, leading to illnesses, significant abuse, and exploitation in the workplace (Silva et al., 2022; Desipio, 2000; Fonchamnyo, 2012; Oommen, 2016; Rahman et al., 2017; Sugui & Alba, 2018). Baglio et al. (2010) conducted a study titled "Utilization of Hospital Services in Italy: A Comparative Analysis of Immigrant and Italian Citizens," which analyzed the hospital utilization of immigrants from less developed countries residing in the Lazio region. The research indicated that the frequency of hospital utilization is nearly identical for native Italians and immigrant laborers, nevertheless significantly lower for immigrants (Muntaneret al., 2020).

Priebe and his colleagues authored an article titled "Good Practice in Health Care" for immigrants, utilizing structured interviews with open-ended questions and case studies to identify experts engaging with a higher proportion of migrant populations

across 16 nations. The research found the lack of familiarity with the healthcare system as a primary challenge for professionals (Jiali, 2008; Lerch et al., 2007; Lucas & Stark, 1985; Moyer, 2015; Priebe et al., 2011).

Hesketh et al. (2008) examined the living and working conditions, health status, and healthcare access of Chinese migrant workers in rural areas who temporarily relocated to urban centers, as well as those who are permanent residents of rural and urban locales. This study reveals a notable lack of concern about the absence of health insurance for migrant workers, resulting in significant healthcare expenses for some individuals in Hangzhou. As a result, numerous migrants and impoverished urban laborers have restricted access to the healthcare system. Young et al., (2005) and their collaborators conducted a study on healthcare services in rural Bangladesh, investigating the actual recipients of these services during a specific time of year. The research evaluated a potential application of the Anderson and Adamy Model among the rural population in the Matlab region of Chandpur District, Bangladesh (Hirvonen& Machado, 2024; Luke, 2010; McDonald & Valenzuela, 2012; Wilson, 2007; Dustmann et al., 2005). This survey identifies women as the most disadvantaged group with minimal access to healthcare. The study suggests that minority Hindu individuals consistently receive the least amount of healthcare attention, similar to immigrant laborers in other rural areas who likewise experience less attention in this regard. The aforementioned articles have elucidated the health and sickness conditions of migrant workers. Due to the scarcity of empirical studies in the Malaysian context, we have undertaken this research on the healthcare conditions of Bangladeshi workers in Malaysia.

While descriptive studies on health-seeking behavior abound, empirical research focusing on foreign workers' health perspectives remains limited (Karim, 2013; Zain et al., 2012). Recent studies, however, have begun addressing this gap. Hargreaves et al. (2023) found that systemic exclusion of migrants in the Gulf correlates with fear of deportation and cost barriers, mirroring findings in Malaysia. Chuah et al. (2021) further identified employer negligence as a critical deterrent in Southeast Asia, with only 12% of Bangladeshi workers in Singapore receiving employer-sponsored care.

Existing literature confirms that migrant workers in Malaysia predominantly labor in construction, manufacturing, and service sectors (Aziz, 2001; Karim, 2014). While Zain et al. (2012) noted nominal access to government hospitals, Rahim et al. (2022) revealed that 73% of Bangladeshi workers faced bureaucratic hurdles under Malaysia's Foreign Worker Medical Examination (FWMEA) system, exacerbating underutilization. Ng et al. (2023) added that occupational injury rates were 3× higher for migrants, yet subsidized care remained inaccessible.

Studies like Mahmood (2021) on Bangladeshis in Japan and Rust (1990) on U.S. farmworkers highlight how migrants circumvent host-country healthcare exclusion. New evidence from Ahmed & Yunus (2023) shows 55% of Bangladeshi workers in Malaysia rely on "medical remittances" (medicines sent from home), while Karim et al. (2024) documented a 40% rise in telemedicine use post-COVID, reflecting distrust in local systems. Benach et al. (2010) and Silva et al. (2022) underscore how hazardous jobs and employer abuse worsen migrant health. Recent data from Muntaner et al. (2020) confirms that precarious employment correlates with higher chronic disease rates among migrants in Italy, echoing Baglio et al. (2010). While Priebe et al. (2011) emphasized cultural competence in healthcare, new studies like Suphanchaimat et al. (2021) show Thailand's mandatory migrant health insurance reduced untreated illnesses by 32%. Mahmud (2024) evaluated Bangladesh's pilot medical teams in Saudi Arabia, proving such interventions cut hospital avoidance by 28%. Most studies (e.g., Young et al., 2005; Hesketh et al., 2008) focus on rural health or other regions. Prior

work overlooks self-medication and telemedicine as adaptive responses. Despite evidence (e.g., Zain et al., 2012), Malaysia's FWMEA remains exclusionary. This study fills these gaps by analyzing primary data from 200 Bangladeshi workers in Kuala Lumpur (2023–2024). Proposing bilateral solutions grounded in Andersen's Behavioral Model (enabling/predisposing factors).

Methodology and Data Sources

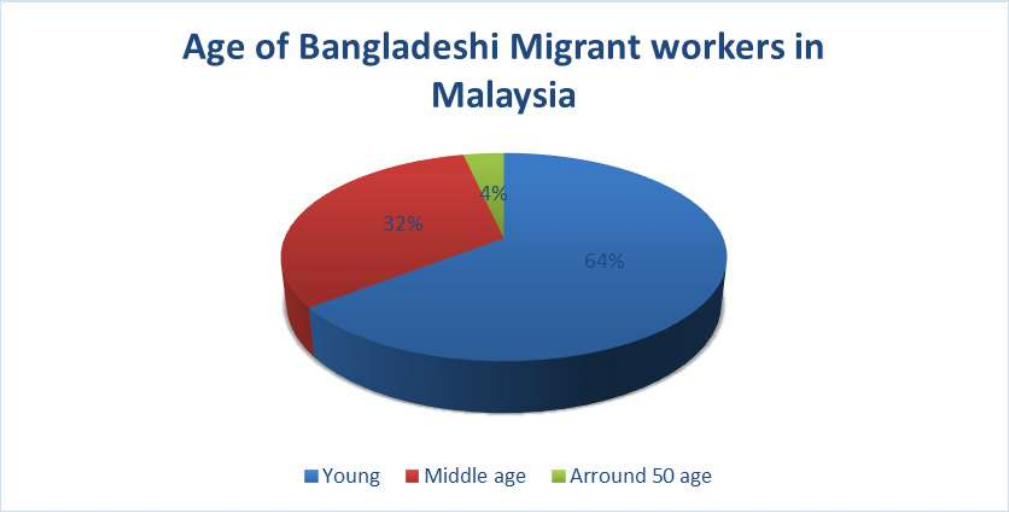
This study employed a mixed-methods approach, combining quantitative survey data with qualitative focus group discussions (FGDs), to comprehensively examine healthcare access challenges among Bangladeshi migrant workers in Malaysia. Data was collected from November 2023 to February 2024, and 200 workers were interviewed in person using a structured questionnaire. The workers were discovered using a snowball sampling technique based on convenience and random sampling. The research is open and non-selective in identifying workers from specific areas such as Rawang and Gombak in Kuala Lumpur; these locations were chosen due to their suitability for the significant population of Bangladeshi workers residing near their workplaces. In addition to gathering data through structured interviews with a substantial cohort of Bangladeshi workers, two focus group discussions (FGDs) were conducted to investigate their health-seeking behaviors and practices in daily life, thereby providing supplementary qualitative insights on health and lifestyle issues through a formal interactive discussion method.

Socio-economic and Demographic Correlates of the Migrant Workers

This study serves a dual purpose: it aims to generate significant quantitative data regarding the socio-cultural background of Bangladeshi migrant workers temporarily employed in Malaysia while also providing extensive qualitative insights into the healthcare practices these workers encounter in their daily lives there. Information on socio-demographic characteristics and cultural background is crucial for understanding the health status of Bangladeshi workers employed in Malaysia. It is stated that understanding the demographics of a community allows us to statistically forecast the health status of the population under examination. In light of this, we have compiled background data regarding the socio-demographic correlates of Bangladeshi workers in the subsequent discussion, linking these factors to their health-seeking behavior. This presents the need to ascertain whether the employees can adapt socio-culturally and hygienically in an unfamiliar environment and setting.

Age, Education, and Income Status

Most Bangladeshi workers in Malaysia are young (64%) or middle-aged (32%). Individuals aged 50 and older (4%) show little enthusiasm for international travel, choosing to stay with their extended families at home



The phenomenon of youth migration appears to be a global trend since younger individuals tend to be more dynamic and receptive to challenges in altering their circumstances (Karim, 2013; Lai, 1986; Karim, 2014). Young individuals typically emigrate in pursuit of career opportunities, as they are often unmarried and so unencumbered in their quest for adventure (Routledge, 2020). This is precisely what transpired to Bangladeshi migrant workers employed in Malaysia.

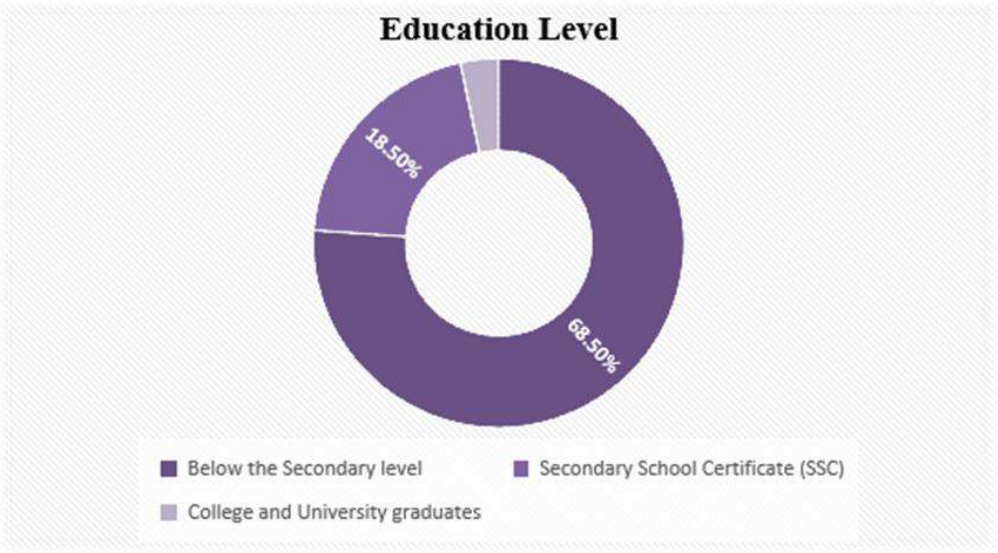
Table 1. Migrant workers' viewpoints regarding health care as evidenced in FGD. 1

Respondent's Name	**Age**	**Education**	**Occupation**	**Problems identified by participants regarding health care issues:**
Respondent 1.1	32	Class Ten	Workshop Helper	Bahasa Malaysia is our second language, and we are familiar with some simple basics. Nevertheless, whenever we are sick, we cannot communicate clearly and comfortably with the local doctors and nurses.
Respondent 1.2	33	Class Eight	Mechanic	Proficient in this language, which impedes me in explaining, I know very little Malay, and I am not very familiar with the diseases to a Malaysian doctor.

Respondent 1.3	44	Class Four	Workshop Helper	In the hospitals and clinics, we must pay fees, which become a burden for us. The fee as a foreigner seems to be a little higher, which we cannot afford.
Respondent 1.4	37	SSC	Mechanic	For the internationals, it seems to be ineffective. The Malaysian treatment system is suitable for Malaysians.
Respondent 1.5	26	Class Three	Cleaner	There is a communication problem for which we avoid seeing a doctor. Malaysian medicine is not effective for us.
Respondent 1.6	42	Class Ten	No Fixed Job	I never become sick, but I find some of our friends often become sick. Since I brought some medicine back home, I sold these medicines to my friends and colleagues to earn some extra money.
Respondent 1.7	26	Class Five	Garment Worker	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 a Bangladeshi physician who finally cured me.

Evidence about the educational history of Bangladeshi migrant workers indicates that they are not illiterate or entirely uneducated, as most workers interviewed in this study possess at least a fundamental level of education. Our data indicates that a significant majority of migrant workers (68.5%) possess education below the secondary level, while among the remaining respondents, 18.5% have completed their Secondary School Certificate (SSC) examination, a formal public assessment required for admission to pre-university programs in colleges. In this study, six migrant laborers

(3%) are college and university graduates



One of them obtained his MA in Economics from a university in Bangladesh. Unable to secure employment in his home country, a disheartened respondent relocated to Malaysia to work as a pump attendant at a PETRONAS station while also managing accounts. This respondent is intelligent and proficient in both English and Bahasa Malaysia.

The migrant workers are impoverished, and their average earnings are expected to be low in comparison to other professionals due to their employment in low-level occupations. While we lack particular sample-based quantitative data on income from this field research, income statistics have been augmented by information obtained from the focus group discussions of this study. The income of Bangladeshi migrant laborers from all sources is believed to be between RM 1200 and RM 1800 per month. To obtain precise statistical data on income, we also referenced our prior study, which indicates that a minority of workers (12%) consistently have superior prospects of earning between 1800 and 2500 ringgit monthly. The research indicates that 6% of Bangladeshi workers earn over 2000 ringgit per month (Karim, 2013)

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

Respondent's Name	**Age**	**Education**	**Occupation**	**Problems identified by participants regarding health care issues:**
Respondent 2.1	23	Class Five	Cleaner	Most often Bangladeshi workers do not possess legal papers, for which many workers are reluctant to see doctors in Malaysian Bangladeshi medicine seems to be more effective for us.

				Bangladeshi doctors are more suitable for us.
Respondent 2.2	27	Class Five	Factory Worker	We cannot utilize the workplace medical facilities properly. It would have been much better if we could have had our doctors assisting us with initial medical treatment.
Respondent 2.3	57	HSC	Mechanic	Consultation fees for foreigners are higher than for the locals. Medicines here are not very effective for us. Problems are the payment of fees and medical expenses, as nothing is catered for by the employer.
Respondent 2.4	41	No Formal Education	Mechanic	I broke my hand last year, and treatment was partially paid for by the employer.
Respondent 2.5	30	Illiterate	Garments worker	The economic problem is that making treatment is very costly here.
Respondent 2.6	48	Up to SSC	Garments worker	I am very afraid to see a doctor here, as there are many formalities. It would have been better to consult a doctor who understands my language
Respondent 2.7	25	Class Five	Garments worker	I do not get any medical support from my company. Cannot afford treatment here as it is very expensive.

Health Care Practices of Bangladeshi Migrant Workers in Malaysia

Health serves as a significant measure of the sociocultural adaptability and work effectiveness of migrant workers, closely linked to their physical health. Migrants employed in factories, construction sites, and other perilous work environments are very susceptible to illness, accidents, and temporary physical incapacitation. Many of

them frequently become gravely ill due to arduous work and excessive physical strain. The majority of these laborers originate from rural regions of Bangladesh, and their impoverished socio-economic conditions afford them only limited access to healthcare services. This trend persists throughout Malaysia. A recent study by Masitah (2008) unequivocally indicates that the incidence of malaria infection among migrant workers in Malaysia has been steadily rising due to various factors, despite the initiation of the Malaria Eradication Program (ERD) in 1967, which was subsequently transformed into the Vector-Borne Disease Control Program in the 1980s.

Foreign workers experience a variety of ailments, as demonstrated by the fact that 116 (58%) of the Bangladeshi respondents in our sample reported suffering from significant conditions that may have been addressed with timely and appropriate medical evaluation. Regardless of their pain, these workers receive no medical attention from their companies in Malaysia. In our poll, 158 respondents (79%) explicitly indicated that they do not receive such support from their employers, which causes them significant concern. Upon inquiring about their hardships and challenges, other healthcare-related issues concerning migrant workers surfaced.

With the rising influx of migrant workers from Bangladesh, it is essential to understand their hardships, health requirements, and coping strategies in daily life. The ailments they commonly experience include fever, jaundice, hemorrhoids, asthma, gallstones, back discomfort, tumors, ocular issues, and ulcers. Migrant workers in Malaysia enjoy equitable access to public hospitals; nonetheless, there is a lack of adequate documentation of their visits. A significant number of respondents said that they often avoid these facilities owing to various causes and complications. This applies universally to foreign workers in other nations, characterized by a reduced frequency of hospital visits and diminished utilization of healthcare facilities by foreign nationals (Baglio et al., 2010).

Due to infrequent hospital visits, Bangladeshi laborers carry a selection of emergency medications as a precautionary measure. Of the 200 responders, 141 (70.5%) acknowledged that they imported medication from their home country, while others obtained it from acquaintances who had surplus supplies. We have found a minimum of ten distinct sorts of medicine that they import from their country. The items are (i) Napa, (ii) paracetamol, (iii) histacin, (iv) diclofenac, (v) gepan, (vi) seclo, (vii) ranitidine, (viii) filmet, (ix) orsaline, (x) flazil, and amodis. The personnel lack pharmaceutical understanding, making it probable that they provide these medications based on intuition, which may frequently be incorrect. They are entirely unaware of the consequences of self-administered medication, as they frequently continue usage without appropriate medical evaluation or advice. This research does not attribute blame to the use of such medication; rather, it emphasizes the primary concern that these workers are neglected and unprotected from a health perspective.

Difficulties Faced by Bangladeshi Migrant Workers Regarding Their Health Care

While access to primary health care is a fundamental right for all individuals globally, its utilization varies among different populations. A study on the utilization of medical services in Italy indicates that immigrants access fewer healthcare facilities than locals (Baglio et al., 2010). Rahman (2009, 2011, 2012) and Rahman et al., (2019) reveal in their study of Bangladeshi migrant workers in the Gulf countries that these workers are not registered under the State Medical Schemes, hence being denied access to medical

facilities. Reports indicate that foreign workers are denied prompt access to hospitals even during emergencies. Zain et al., (2012) states that migrant workers in Malaysia have enough access to government hospitals and private clinics. Nevertheless, Bangladeshi workers encounter numerous challenges that typically deter them from utilizing healthcare facilities in Malaysia, as detailed below.

Lack of Familiarity with the Malaysian Health Care System

Most of the respondents in our study indicated that they lack convenient access to hospitals in Malaysia, although they are legally permitted to visit government hospitals by paying a small charge. Several workers informed us that, as foreign citizens, they incur higher fees than locals; nevertheless, after thorough verification, we have not substantiated this claim entirely. However, it is undeniable that the staff are largely unfamiliar with the Malaysian healthcare system and lack procedural knowledge of it. In Bangladesh, a patient can be admitted to a hospital at no cost and may consult any physician independently for a minimal fee, without the need for complex processes. Because of this, when workers require medical attention or hospitalization in Malaysia owing to serious illness, they are sometimes subjected to numerous inquiries regarding their employment and legitimacy, resulting in significant frustration with their care. From the Malaysian perspective, this is not particularly irrational, given that numerous Bangladeshi laborers in the past lacked valid residency permits. As a result, numerous workers sometimes opt for private clinics to circumvent the inconveniences associated with government hospitals.

Traumatic Experience and Social Exclusion

Numerous employees recounted their distressing experiences regarding healthcare and illness. Several individuals indicated that, as workers, they frequently experience disdain, which discourages them from pursuing healthcare treatments. The personnel, originating from a severely impoverished socio-economic background, frequently experience neglect in hospitals and clinics. Despite the presence of advanced healthcare services in Malaysia, a socio-psychological gap hinders workers from effectively utilizing these medical facilities. Migrant workers in metropolitan neighborhoods are often socially marginalized, being held responsible for overcrowded cities, social disorder, and rising crime rates (Hesketh et al., 2008). Similar allegations have historically been directed at Bangladeshi migrant workers in Malaysia, particularly when local residents expressed indignation regarding the existence of foreign laborers in the country (Karim, 2013; Zehadul, 2014; Zehadul et al., 2019). Nevertheless, the current number of Bangladeshi migrant workers is significantly lower in comparison to other foreign workers from Indonesia and the Philippines (according to the Royal Department of Malaysia, as cited in Kanapathy, 2006).

Unclear Etiological Explanation of The Disease and Hazy Symptomatic Expression

Unclear etiological explanation and hazy symptomatic clarification have been identified as important barriers to communicating with doctors and nurses, which creates an impediment to getting proper treatment for many foreign nationals, including migrant workers (Woloshin et al., 1995). While mentioning 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 the 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.

Economic Problems Faced by Workers Regarding Health Care

It is posited that economic crises and poverty consistently preclude migrant workers from accessing healthcare benefits and limit their utilization of advanced technologies in hospitals and clinics. The migrant workers lack health coverage, and their employers do not offer medical support, resulting in these Bangladeshi workers bearing all treatment costs. As a result, some employees encounter significant financial strain in fulfilling the total cost of their treatment. Respondent 2.3, who, after fracturing his legs, was hospitalized at Sungai Pusu Hospital for two months. Being unemployed, he remained without compensation during this period, encountering problems in settling recurring X-ray bills and other hospital charges. In a separate event, Respondent 2.4 fractured his hand, necessitating a brief hospitalization at Sungai Pusu Hospital, during which he had significant financial difficulties. During the focus group discussions with migrant workers, a Bangladeshi called Respondent 2.5 reported experiencing significant back discomfort and has expended approximately RM 330; nevertheless, he has not entirely recuperated. Rapoport & Docquier (2006) indicate that the recent increase in fees by medical practitioners restricts access to healthcare facilities for many foreign workers in Malaysia, particularly those lacking legal status and employed in low-wage positions, rendering them the most vulnerable in this situation.

Conclusions

This research presents the results of a field-based empirical study on the lives of Bangladeshi migrant laborers in Malaysia, including extensive demographic data regarding their socio-economic and cultural characteristics. The research is particularly important for health care as it examines the socio-economic and cultural perspectives of Bangladeshi migrant workers through qualitative analysis of their health-seeking behaviors, thereby identifying the challenges they face in this regard.

The absence of any agreements about health care between Bangladesh and Malaysia leads us to infer that, despite their human rights, the health care needs of migrant workers are mostly overlooked. Despite foreign workers in Malaysia being officially granted equal rights with locals, allowing them legal access to public hospitals and clinics for a nominal consultation fee, the lack of specific health provisions often prevents these workers from fully benefiting from the system. They encounter numerous obstacles and limitations that frequently dissuade them from pursuing these health care services. Anecdotal data indicates that migrants experience restricted access to preventative care and tend to seek treatment at advanced stages, as exemplified by Bangladeshi migrant laborers residing temporarily in Malaysia (Zain et al., 2012; Nagi & Mannila, 1980; Young et al., 2005). Nevertheless, our prior conversation highlighted that migrant workers firmly believe they should receive medical help either from the host country's labor organizations or from their home country.

Recommendations

The first recommendation, it can be paradoxically inferred, is that, given Malaysia's provision of employment for a substantial number of Bangladeshi workers, the Bangladeshi government should extend initial primary healthcare support to its citizens via a contingent of Bangladeshi medical professionals stationed at its diplomatic mission in Malaysia. This unique technique may be used in phases in other countries through bilateral agreements, particularly where there is a significant presence of Bangladeshi labor. This strategy may enable Bangladeshi workers to access a culturally competent healthcare system, where familiar physicians can effectively understand the etiology of diseases, thoughts, communicative behaviors, beliefs, and pain articulated in their native language.

The second recommendation led us to conclude that foreign workers, who predominantly reside in overcrowded, unhealthy environments and endure perilous working conditions, evidently necessitate assurances regarding their safety and protection. As a result, numerous countries let foreign workers obtain health coverage from insurance providers (Joshi et al., 2011; Udah, 2011; Yang, 2011). In their recent study on the health care challenges faced by Nepalese migrant workers in three Gulf nations, Mobed et al. (n.d.) indicate that Nepalese migrants receive insurance coverage during the initial year of their residence in these countries, after which the local companies assume responsibility for any workplace accidents and fatalities. Alshatrat, (2015); Joshi et al. (2011), Rust (2008); and Subedi (1989) did not explicitly clarify whether all other migrant nationals receive comparable benefits, necessitating further investigation into whether the initiative for such agreements originated from the Nepalese government or was proposed by the receiving Gulf countries. In 2001, Thailand implemented a universal health coverage system via a health insurance policy for registered foreign workers. We propose that Malaysia, following the example of Thailand and other Gulf nations, develop a similar plan for all foreign workers, according to the country's structural context.

Policy Implications with Strengths and Limitations

Bangladesh and Malaysia should integrate migrant health protections in formal labor migration agreements, ensuring that health services and insurance coverage are mandatory and enforced by employers. Establish dedicated health units or mobile clinics with Bengali-speaking staff in high-density migrant areas to address language and trust barriers. Mandate legal frameworks requiring employers to provide basic health insurance and cover medical costs for workplace injuries or illnesses. Introduce pre-departure and post-arrival training to improve migrants' health literacy, explain their rights, and guide them through the Malaysian healthcare system. Support NGOs and civil society organizations that provide medical outreach and counseling services to undocumented and vulnerable migrants.

The integration of quantitative survey data and qualitative insights from focus group discussions (FGDs) provides a comprehensive understanding of migrant health behavior. Data collected directly from 200 Bangladeshi migrant workers across various sectors offers authentic, ground-level perspectives rarely captured in secondary datasets. The study offers practical, actionable recommendations that align with labor migration and public health policy concerns in both sending and receiving countries.
The study focuses on selected locations in Malaysia and may not capture the full diversity of migrant experiences across different regions or industries. As many respondents are undocumented or vulnerable, some may have withheld sensitive

information due to fear of consequences. The data represents a single point in time, limiting insights into how health-seeking behavior evolves with time and changing policies. The study primarily represents male migrant workers, and the health experiences of female migrants remain underexplored.

Acknowledgements

We would like to thank the study participants for sharing their heartbreaking stories and valuable times with us while we conducted this study on the spur of the moment.

Author contributions

Both authors contributed to the completion of this work. Gazi Abu Horaira drafted the initial draft. Rabiul Islam edited and reviewed the manuscript. Kamrun Nahar Salma collected the data. Both authors approved this manuscript for publication.

Funding

No Specific Fund was received.

Data availability

Data will be available upon reasonable request.

Declarations

Ethical approval

Informed consent We prepared a consent form, discussed the research process, and provided this consent form to the participants before the interview. We listened to this consent form for those who didn`t know how to read it. The participating respondents were notified in support of their consent process that their commitment was voluntary and confidential. We informed them that their names would not be revealed in the study and would be used in pseudonyms. All participants consented orally and signed this consent form.

Conflict of interest

The authors declared that no conflict of interest exists.

References

Abdul-Aziz, A. R. (2001). Bangladeshi migrant workers in Malaysia's construction sector. *Asia-Pacific Population Journal, 16*(1), 3–22. https://doi.org/10.18356/e085943a-en

Alshatrat, S. M. (2015). *Diabetes status, predisposing, enabling, and oral health illness level variables as predictors of preventive and emergency dental service use* [Doctoral dissertation].

Baglio, G., Saunders, C., Spinelli, A., & Osborn, J. (2010). Utilisation of hospital services in Italy: A comparative analysis of immigrant and Italian citizens. *Journal of Immigrant and Minority Health, 12*(4), 598–609. https://doi.org/10.1007/s10903-010-9319-7

Benach, J., Muntaner, C., Solar, O., Santana, V., & Quinlan, M. (2010). Introduction to the WHO Commission on Social Determinants of Health Employment Conditions

Network (EMCONET) study, with a glossary on employment relations. *International Journal of Health Services, 40*(2), 195–207. https://doi.org/10.2190/HS.40.2.a

Collins, K. S., Hughes, D. L., Doty, M. M., Ives, B. L., Edwards, J. N., & Tenney, K. (2002). *Diverse communities, common concerns: Assessing health care quality for minority Americans: Findings from the Commonwealth Fund 2001 Health Care Quality Survey*. https://www.cmwf.org

da Silva, D. G., Mendes, Á., & Carnut, L. (2022). Integrative review on primary health care financing in national health systems: Ensuring access and equity. *Theoretical Economics Letters, 12*(4), 1176–1206. https://doi.org/10.4236/tel.2022.124063

Dannecker, P. (2005). Bangladeshi migrant workers in Malaysia: The construction of the "others" in a multi-ethnic context. *Asian Journal of Social Science, 33*(2), 246–267.

Desipio, L. (2000). *Sending money home...for now: Remittances and immigrant adaptation in the United States*.

Dustmann, C., Hatton, T., & Preston, I. (2005). The labour market effects of immigration. *Economic Journal, 115*(507), F297–F329. https://doi.org/10.1111/j.1468-0297.2005.01036.x

Exploring the migration industries. (2020). Routledge. https://doi.org/10.4324/9780429199660

Fonchamnyo, D. C. (2012). The altruistic motive of remittances: A panel data analysis of economies in Sub-Saharan Africa. *International Journal of Economics and Finance, 4*(10), 192–200. https://doi.org/10.5539/ijef.v4n10p192

Hesketh, T., Jun, Y. X., Lu, L., Wang, B., & Mei, H. (n.d.). Health status and access to health care of migrant workers in China.

Jiali, M. (2008). ISAS working paper. *Political Studies, 12*(30), 6.

Joshi, S., Simkhada, P., & Prescott, G. J. (2011). Health problems of Nepalese migrants working in three Gulf countries. *BMC International Health and Human Rights, 11*, 3. https://doi.org/10.1186/1472-698X-11-3

Kabir, H., Hasan, M. K., Akter, N., Marma, U. S. C., Alam, T., Tutul, A. H., Biswas, L., Ara, R., & Mitra, D. K. (2022). Factors associated with the intention of telehealth service utilization among Bangladeshi people: A cross-sectional study. *F1000Research, 11*, 996. https://doi.org/10.12688/f1000research.124410.1

Hirvonen, K., Machado, E., & Simons, A. M. (2024). Actors influencing price of agricultural products and stability. *AgEcon Search*, 1–26. [PDF file]. file:///F:/Spec%202/Traffic%20Delay%20Model.pdf

Karim, A. H. M. Z. (2013). Impact of a growing population in agricultural resource management: Exploring the global situation with a micro-level example. *Asian Social Science, 9*(15), 14–22. https://doi.org/10.5539/ass.v9n15p14

la Briere, B. de, de Janvry, A., Lambert, S., & Sadoulet, E. (1998). Why do migrants remit? An analysis for the Dominican Sierra. *CUDARE Working Papers*, 37. https://ideas.repec.org/p/ags/ucbecw/198666.html

Lai Har. (1986). [Unpublished manuscript].

Lerch, M., Dahinden, J., & Wanner, P. (2007). Remittance behaviour of Serbian migrants living in Switzerland.

Lucas, R. E. B., & Stark, O. (1985). Motivations to remit: Evidence from Botswana. *Journal of Political Economy, 93*(5), 901–918.

Luke, N. (2010). Migrants' competing commitments: Sexual partners in urban Africa and remittances to the rural origin. *American Journal of Sociology, 115*(5), 1435–1479. https://doi.org/10.1086/651374

Mahmood, R. A. (n.d.). *Adaptation to a new world: Experience of Bangladeshis in Japan*.

Malik, K., et al. (2014). *Human Development Report 2014*. UNDP. http://hdr.undp.org

Masitah, M. (2008). [Unpublished manuscript].

McDonald, J. T., & Valenzuela, M. R. (2012). Why Filipino migrants remit? Evidence from a home-host country matched sample.

Mobed, K., Gold, E. B., & Schenker, M. B. (n.d.). Occupational health problems among migrant and seasonal farm workers.

Mohd Zain, S. N., Behnke, J. M., & Lewis, J. W. (2012). Helminth communities from two urban rat populations in Kuala Lumpur, Malaysia. *Parasites & Vectors, 5*(1), 47. https://doi.org/10.1186/1756-3305-5-47

Moyer, V. A. (n.d.). Prevention of falls in community-dwelling older adults: U.S. Preventive Services Task Force recommendation statement. *Annals of Internal Medicine*. https://www.annals.org

Muntaner, C., et al. (2020). Precarious employment conditions, exploitation, and health in two global regions: Latin America and the Caribbean and East Asia. In *Handbook of Socioeconomic Determinants of Occupational Health* (pp. 1–23). Springer. https://doi.org/10.1007/978-3-030-05031-3_39-1

Nagi, S. Z., & Haavio-Mannila, E. (1980). Migration, health status and utilization of health services. *Sociology of Health & Illness, 2*(2), 174–193. https://doi.org/10.1111/1467-9566.ep10487787

Oommen, G. Z. (2016). South Asia-Gulf migratory corridor: Emerging patterns, prospects and challenges. *Migration and Development, 5*(3), 394–412. https://doi.org/10.1080/21632324.2015.1010705

Priebe, S., et al. (2011). Good practice in health care for migrants: Views and experiences of care professionals in 16 European countries. *BMC Public Health, 11*, 187. https://doi.org/10.1186/1471-2458-11-187

Rahman, M. M. (2009). Temporary migration and changing family dynamics: Implications for social development. *Population, Space and Place, 15*(2), 161–174. https://doi.org/10.1002/psp.537

Rahman, M. M. (2011). Emigration and the family economy: Bangladeshi labor migration to Saudi Arabia. *Asian and Pacific Migration Journal, 20*(3–4), 389–411. https://doi.org/10.1177/011719681102000307

Rahman, M. M. (2012). Bangladeshi labour migration to the Gulf states: Patterns of recruitment and processes. *Canadian Journal of Development Studies, 33*(2), 214–230. https://doi.org/10.1080/02255189.2012.689612

Rahman, M., Mustafa, M., Islam, A., & Kumar Guru-Gharana, K. (n.d.). *Growth and employment empirics of Bangladesh*.

Rahman, Z. U., Cai, H., & Ahmad, M. (2019). A new look at the remittances-FDI-energy-environment nexus in the case of selected Asian nations. *Singapore Economic Review.* https://doi.org/10.1142/S0217590819500176

Rapoport, H., & Docquier, F. (2006). The economics of migrants' remittances. In *Handbook of the Economics of Giving, Altruism and Reciprocity* (Vol. 2, pp. 1135–1198). https://doi.org/10.1016/S1574-0714(06)02017-3

Rust, G. S. (n.d.). *Health status of migrant farmworkers: A literature review and commentary*.

Schwartz, L., Brunner, D., Unternährer, E., & Stadler, C. (2022). Feasibility and relatability of cultural adaptation amongst conflict-affected populations. *Journal of Migration and Health, 6*, 100134. https://doi.org/10.1016/j.jmh.2022.100134

Seedat, F., et al. (2023). Defining indicators for disease burden, clinical outcomes, policies, and barriers to health services for migrant populations in the Middle East and North African region: A suite of systematic reviews. https://doi.org/10.1101/2023.07.11.23292496

Subedi, J. (1989). Modern health services and health care behavior: A survey in Kathmandu, Nepal. *Journal of Health and Social Behavior, 30*(4), 412–420.

Sugui, J. S. C., & Alba, M. M. (2018). Motives and giving norms behind remittances: The case of Filipino overseas workers and their recipient households. *SSRN Electronic Journal*. https://doi.org/10.2139/ssrn.3170975

Sun, S., Goldberg, S. B., Lin, D., Qiao, S., & Operario, D. (2021). Psychiatric symptoms, risk, and protective factors among university students in quarantine during the COVID-19 pandemic in China. *Globalization and Health, 17*(1), 15. https://doi.org/10.1186/s12992-021-00663-x

Abubakar, S. Y. (2002). [Unpublished manuscript].

Udah, E. B. (2011). Remittances, human capital, and economic performance in Nigeria. *Journal of Sustainable Development in Africa, 13*(4), 29–44.

Wilson, M. C. (2007). The economic causes and consequences of Mexican immigration to the United States. *Denver University Law Review, 84*(4), 1099–1120.

Woloshin, S., Bickell, N. A., Schwartz, L. M., Gany, F., & Welch, H. G. (n.d.). Language barriers in medicine in the United States. *JAMA*. http://jama.jamanetwork.com/

Yang, D. (2011). Migrant remittances. *Journal of Economic Perspectives, 25*(3), 129–152. https://doi.org/10.1257/jep.25.3.129

Young, J. T., Menken, J., Williams, J., Khan, N., & Kuhn, R. S. (2005). Who receives healthcare? Age and sex differentials in adult use of healthcare services in rural Bangladesh.

Zehadul Karim, A. H. M. (2014). Indigenous food production system and the impact of population growth: Community-based examples with anthropological evidence. *Asian Social Science, 10*(12), 59–66. https://doi.org/10.5539/ass.v10n12p59

Zehadul Karim, A. H. M., Mohamad Diah, N., Mustari, S., & Sarker, M. S. I. (n.d.). Bangladeshi migrant workers in Malaysia: Their socio-cultural background and work adaptability. *South Asian Anthropologist*.