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TRANSNATIONAL HEALTH SEEKING BEHAVIOR OF BANGLADESHI PEOPLE  
LIVING IN ATLANTA

by

MD TANVEER HASSAN

Under the Direction of Cassandra White, PhD.

ABSTRACT

The health care setting and available health resources impact the health seeking behavior of people. The transnational migrants from Bangladesh find the health care system of the U.S. fundamentally different from that of their place of origin. This study aims to explore the health seeking behavior of Bangladeshi transnational migrants living in Atlanta, USA. Through analyzing data obtained from interviews, participant observation, and autoethnography, this research explains how their transnational status impacts their perception of health and health seeking behavior.

INDEX WORDS: Transnationalism, Consciousness of Health, Transnational Therapy Network, Support Group, Lay Diagnosis, Anxiety of Illness

TRANSNATIONAL HEALTH SEEKING BEHAVIOR OF BANGLADESHI PEOPLE  
LIVING IN ATLANTA

by

MD TANVEER HASSAN

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

in the College of Arts and Sciences

Georgia State University

2016

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2016

TRANSNATIONAL HEALTH SEEKING BEHAVIOR OF BANGLADESHI PEOPLE  
LIVING IN ATLANTA

by

MD TANVEER HASSAN

Committee Chair: Cassandra White

Committee: Steven Black

Bethany Turner-Livermore

Electronic Version Approved:

Office of Graduate Studies

College of Arts and Sciences

Georgia State University

May 2016

## **DEDICATION**

To my wife, all my family members, and informants of this study.

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I would like to show my gratitude to a number of people without whom the research would not be possible. I want to thank my family members first who are the main support of life. I am here only because of them. Next, I would like to express my thankfulness to my committee chair, Cassandra White, without whom this journey could be incomplete. She helped in every single steps of this thesis and the MA program. She is undoubtedly the best person I met in the U.S. I would also like to thank all other committee members and faculties of this department whose help and guideline pushed me forward. I don't know how to express my gratitude to Kevin McGuire (Gandalf the Grey), who has been a great friend and support in the whole journey of my graduation.

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## 1 INTRODUCTION

“My both arms were broken. One broke in Bangladesh and other in US. One costs me \$150 and other \$1300.” Nadim, a 27 years old international student studying at a prestigious university in Atlanta, was showing me his arms while explaining grouchily about the insurance policy stipulated due to his documentation status. He is a passionate man and was incapable of hiding his anger. During our conversation, I saw his face redden several times. We were ensconced in a Bangladeshi restaurant eating Biryani—a Bangladeshi popular rice made with meat and spices—while discussing his health condition (Nadim complained a lot about the Biryani too). The consequences of his last accident is not physically visible, nonetheless his eyes, body language and words demonstrated his agony and anxiety. Despite the physical damage being over, the repercussion of the damage can be numerous and long term. Nadim was struggling to find a way to pay his \$1300 medical bill. I realized his anger is just an expression of his frustration with the challenges induced by the U.S. healthcare system for international migrants to the U.S., which is one of the themes of this thesis on the health and illness experiences of Bangladeshis in the U.S.

The Bangladeshi community in Atlanta is considerable, nonetheless there are only few hubs for Bangladeshi people to hangout. This allows people get to know each other quickly. Nadim’s injury is well known, and during our conversation, five Bangladeshi migrants asked him about his physical condition. Nadim appreciates the help and support of diasporic Bangladeshis. According to him, at times they are more than family members—a feeling I share too. People who live without their family abroad develop a strong bond to each other, which is a way to fill the void of family. Nadim’s friends, especially his roommate, helped him not only in recovering from his injury but also in managing school works and other daily issues. Yet, Nadim

characterized his life in Atlanta not just as a blessing; he also had a sense of helplessness. It is a blessing because of his generous and supportive social networks, but he has a feeling of helplessness because of the financial burden in part created by his experience with U.S. healthcare.

When we shook hands at the end of the conversation, he chuckled and said, “Be careful man.” I am not sure what he meant. Probably it was just an expression, but I felt I needed to be very wary about my health. I felt that for the first time in my life. But why did I feel that? Is it because I want to live strong? Or is it the apprehension of financial encumbrance? I am still dealing with those questions. My other informants (especially those who are international students) share that feeling too. I never felt that way when I was in Bangladesh.

### **1.1 Research questions and objectives**

The aim of this research is to understand the health-seeking behavior of transnational Bangladeshi people living in Atlanta, U.S.A. Through qualitative anthropological research, this study intends to investigate how “health” issues are negotiated by transnational Bangladeshi people living in Bangladeshi diaspora. Broadly, this research involves two research questions: How do transnational Bangladeshi people living in Atlanta perceive health? And how does their transnational status influence their health-seeking behavior? Necessary data was gleaned through ethnographic methods, including participant observation, interviews, and autoethnography. I conducted interviews with 12 people for at least one session and participant observation in different cultural and religious festivals and social gatherings. As I belong to the transnational status, my own feelings, thoughts, and experience are part of this thesis as well.

In order to address my research questions, I established few research objectives. One of the main objectives of this research is to investigate how differently they perceive their health in

a new social settings. Understandably, the socio-cultural, socio-economic, and socio-political context of U.S. life is significantly distinguished from that of Bangladesh. Thus, exploring the impact of the components of a new society, especially a new health care system, on their perceptions of health is a key issue of interest in this thesis. There are a few fundamental differences between Bangladeshi and U.S. healthcare system, from the importance of health insurance to methods of seeing a doctor and getting medicine. These differences may shape the way they perceive their health. One of the most significant research objective is to look into the decision-making process regarding health-care treatment, and who is involved in this process of treatment. Health-care treatment is initiated and managed by a group of people, termed as a “therapy management group” by Janzen (1987), in many societies. Their roles are diverse and crucial in the whole procedures; such as diagnosis, selection of a/multiple therapeutic option/s, post-treatment supports and other important steps necessitated by that particular culture. Understanding the role of therapy management group in the health-care treatment is one of the central aim of this research. However, due to their migration and transnational status, the study population’s social network extends from their place of origin to diaspora. Understanding the influence of extended social network in the formation of a therapy management group and in health-seeking behaviors is also a part of this study. However, in a society with a pluralistic medical system- like Bangladesh, seeking alternative medicine is very common. Another significant objective of this research is to examine their seeking of alternative medicine in the U.S. where medical pluralism may not be the same as they had in their country.

## **1.2 The study population**

One of the fundamental changes that globalization generates is high mobility of human beings within and across national boundaries. Advancement in technology and communication is

largely responsible for this. Leaving a place is not leaving everything behind; rather, in the present era, maintaining ties with old places is very common. Transnationalism is an emerging issue with the advent of globalization. Maintaining socio-cultural, socio-economic and socio-political connections across the national boundaries is more evident in this world. First generation migrants are, thus, more likely to be transnational because of their ties with place of origin. In my research, I focused on the first generation transnational people from Bangladesh who have been living here for a while and maintaining connections with their place of origin. People living in Bangladeshi diaspora belong to diverse groups in terms of documentation status and their different purposes in coming to the U.S. My research centers to only those people who belong to transnational status, the first generation migrants who maintain ties with their place of origin. “Transnational”, according to Lamb (2002, 303), is social, cultural, political, and economic forces that extend across multiple nations. International migrants, moving from one place to another, forge and maintain social, political, cultural, and economic ties that cross international borders. Transnational people maintain strong ties to their home country which enable reciprocity of beliefs, norms, customs, and knowledge between home country and new country. They live in a new social reality where their life is dictated by a fluid culture, which is a product of their constant attempt of holding on to their old culture and struggle related to acculturating to the new culture.

Their identity can be recognized as what Victor Turner (1987) characterized as “liminal”. In the rites of passage as people enter into a new group or status, people move through different stages. At first they separate themselves from the old status and move to a liminal period where they learn the new way of life for their future stage. After successfully finishing their liminal period, they are incorporated into a new position in the society. Anthropologist Leo Chavez

(2013) discusses migration process in the light of rite of passage. In the migration process, people separate themselves from their origin by leaving their home country. After stepping into a new place, they go through a liminal period where they learn new practices that enable them to adapt or acculturate to a new way of life. They are incorporated into the new society only when they learn the new way of life (Chavez 2013). However, all migrants are not necessarily become part of the new place. Sometimes migrants do not consider themselves as members of the new society and sometimes other members of the society may not accept them as U.S. people.

Transnational people may continue to exist in a liminal state as they maintain social, political and economic ties with country of origin. Their ties impact their behavior and on the other hand, a new place, new surroundings and system influence their behavior too. In this way, they belong to a position where their practice, belief, and behavior are neither Bangladeshi nor American.

The number of Bangladeshi people is increasing in the U.S. Currently, according to a 2014 Rockefeller Foundation-Aspect Diaspora Program profile, the number is 277,000, including first and second generation Bangladeshi people. Though the number constitutes only 0.5 percent of the foreign born population of the U.S., the Bangladeshi population is growing, especially after 2000. In fact, 48 percent of the population arrived at the U.S. after 2000 (RAD diaspora profile 2014). However, little scholarly work has been conducted about the health-seeking behavior of Bangladeshi people living in the U.S. Thus, this research will contribute significantly in minimizing the knowledge gap of understanding the health-seeking behavior of Bangladeshi people living in Diaspora.

### **1.3 Health practices in Bangladesh**

Bangladesh is a Southeast Asian country with a population of over 160 million, a densely populated country with limited access to health resources. Baer (2004) argued that the

stratification of the society mirrors the stratification of medical systems. This statement is fully applicable to Bangladesh. The health care system in Bangladesh is stratified with diverse healing methods, knowledge, beliefs and practices. Health care is provided in different levels in Bangladesh; self-care, care from non-practitioner who has some medical knowledge, paid and unpaid practitioners without license, and care from professional practitioner in formal settings (Homlan and O' Connor 2004). Biomedicine, Allopathy, Homeopathy, Ayurveda, and Unani are prominent medical systems in mostly urban areas (Sarder and Chen, 1981). However, other different folk and religious healing methods are also practiced, especially in rural area. Among them totka, a combination of Ayurveda, Unani, and indigenous shamanic traditions, is practiced in rural Bangladesh. Every cause of illness is supernatural according to this healing system. Most of the practitioners in this system are women with no formal education in healing (Sarder and Chen, 1981). There is another popular traditional healing method, boneji, practiced in rural areas, especially by elderly women. It is an art of concocting medicine from herbs and other substances such as honey and fruit juice (Mushtaque, Chowdhury, and Kabir, 1991). Apart from that, mystic healer (Fakir) and magic healers (Ojha) are also popular practitioners in rural Bangladesh (Maloney et al. 1981).

The health care provision of Bangladesh is pluralistic with plethora of options available for patients in both rural and urban areas. The health care service is provided by both government and non-government entities, though non-government services dominates (Vaughan et al 2000; 6). Biomedical option is available in both sectors. However, there are subdivisions among the services provided by both sectors. The facilities, quality of doctors and officials, access to and quality of medicine, and medical costs are not same within all sectors. There are multiple options within the private or non-governmental sections. There are low budget health



clinics with limited facilities and sometimes poor treatment quality, and on the other hand, highly expensive private hospitals with international standards facilities visible in Bangladesh. And at the same times, the quality and features of government hospitals vary from place to place. The urban government hospital and rural hospital do not provide the same facilities and neither cost the same. However, undoubtedly, the medical cost in government hospital is way less than a non-government or private health providing organizations. The selection of therapeutic options is convoluted and a number of factors influence their decision making; symptoms, socio-economic, socio-cultural, socio-political position of patients, gender, geographical location, etc. More than 80 percent people seek biomedicine, especially in severe cases, though in few cases, especially in minor issues, majority of the health care treatment are sought form alternative medicine which includes various local, regional, and indigenous healing methods (Vaughan et al. 2000;6).

The idea of health insurance is still in its nascent stage in Bangladesh. There are few private insurance companies and NGOs that provides health insurance in Bangladesh. Government employees also have health facilities but with very limited scope. “Out of the pocket” payment is the dominant method of paying medical bills in Bangladesh. Few private companies provide health insurance for their employee. Micro-insurance for health is an emerging, though limited to only a few place in Bangladesh, initiative taken by NGOs for disadvantaged people in especially in the rural areas (Werner 2009).

The payment regarding medical costs can be devastating or very affordable, contingent on what types of facilities a patient seeks and what is the health condition, and of course the socio-economic condition of the patient. Typically a visit to doctor costs 50 cent to \$15 in private settings, depending on the types of hospital or clinics a patient selects. In the government hospital, it cost less than 50 cents. A coronary angiogram costs around \$200 in Ibrahim Cardiac

Hospital and Research Institute (public hospital), and typically a Coronary artery bypass grafting (CABG), a common surgery in Bangladesh, costs around \$3500, which includes every possible cost in the same hospital.

#### **1.4 Transnationalism and health seeking behavior**

The health seeking behavior of a person is highly shaped by the system surrounding him/her. The socio-cultural, socio-economic, socio-political context of the U.S. is significantly dissimilar to that of Bangladesh; thus, a transnational Bangladeshi's health seeking behavior tends to be different from that of a Bangladeshi (in Bangladesh). As I argued previously transnationalism is a liminal state which separates (not completely as they maintain ties with home) a person from their place of origin but does not incorporate her/him into the host society, the health seeking behavior of the transnational Bangladeshi is not similar to that of a U.S. citizen either.

In the era of globalization with high mobility of people within and across borders and advancement of communication system, people have more opportunity to maintain ties with place of origin which contributes to the exchange of knowledge, belief, customs, and rituals among nations. In the health sector, though biomedicine becomes hegemonic all over the world, the exchange of medical knowledge and belief is not one way (west to other parts of the world). In fact, the presence of Yoga center, Unani centers, and Ayurvedic stores in the U.S. implies the "both way" notion of the exchange. Hence, the presence of medical pluralism in the U.S., with few options similar to Bangladesh- like Homeopathy and Ayurveda- makes the selection of options more flexible for transnational Bangladeshis.

Another consequence of globalization is seeking treatment across national borders. Approximately one to six million US citizens traveled abroad for health care in 2010, partially in

response to increasing local health costs. The main destination is Asia and Latin America (Reed 2010). The United States accounts for the \$3.3 trillion spent annually for health care around the world (US Senate Special Committee on Aging 2006). The movement between country of origin and host country is now common than ever. Thus, seeking treatment across the border amongst transnational communities is now higher than ever.

### **1.5 Researcher's identity**

The distinction between the “native”/ “indigenous” / “insider” and “real” anthropologist stems during the colonial period when native was deemed genuine native and anthropologists’ objectivity of “other” was not challenged as much (Narayan 1993). However, after the advent of decolonization, civil right movements, and involvement of “third world” scholars into anthropology, the polarization started to break down. The readjustment and, in some cases, overthrow of ethnocentric ideas due to the engagement of minority anthropologist in academic arena of first world (Gwaltney 1981; Jones 1970; Limon 1991), the destabilization of the “self and other” dichotomy ((Abu-Lughod 1990; Alarcon 1990; Lauretis 1986; Mani 1990; Mohanty and Russo 1991; Strathern 1987), the flexibility of the concept of field (Narayan 1993), and the increasing acceptance of putting first world society under the anthropological microscope contributed to subsuming of polarization. In this thesis, I do not want to inscribe my professional identity as Native or insider anthropologist; in fact I hold a strong stance against this polarization. I do echo the voice of Kirin Narayan (1993), “how native is a native anthropologist?”

The idea of authentic insider is very problematic because of the fragmentation of society and heterogeneity of culture/ “beautiful mess”, and thus, the identity of Anthropologists, who could be a member of the society, creates at least to some extent distance between them and the

society. Even if someone claims to be an experienced insider, it is impossible for him to grasp everything of his own society due to diversity in the cultural domain and in the small groups within the society (Aguilar 1981). The whole world and social reality are in flux due to rapid globalization, development of global trade, migration, communicational improvement etc. The identity of people and culture are not in a stagnant form. There are multiple and flexible ways anthropologists can align with or distinguish themselves from their study people; gender, ethnicity, class, race, education and so on (Narayan 1993; 671-672). My preexisting experience in Bangladesh and subsequent experience in Atlanta, undoubtedly, place me in the Bangladeshi diaspora, but the power dynamics and nuanced difference between me and my informants will be questioned if I claim myself a true insider.

Another question is, am I an insider to insiders? My access to the diaspora as a member is different from that of as a researcher. My interaction with other people in the diaspora in daily life is different from that of as a researcher. I felt a distance between my informants and me while conducting my interview. I suppressed some of my usual casual behavior to behave with appropriate decorum in few cases and that went other way too.

Undoubtedly, my position in the diaspora and my social networks place me in an advantageous position in my research, but I do not want to label my work as native ethnography. Of course, my interviews and participant observation were more comfortable for me and my informants because of our few similarities, and interestingly because of our dissimilarities. In addition, autoethnographic analysis is also very pertinent in this thesis. I want to stress radical empiricism here which underscores the subject's experience and relation to others in order to understand the social phenomena (Jackson 1989).

## 1.6 Following chapters

This thesis is divided into six chapters with separate, yet overlapping discussion issues. The second chapter engages discussion about the theoretical concepts that I ponder throughout the thesis. I discuss some theoretical concepts pertinent to migration-such as diaspora and transnationalism- to elucidate the identity of my study group. Subsequently I take into account concepts like health/body, illness, and disease to discuss perceptions of health. Next I move forward to discuss “therapy management groups” and “transnational therapy management networks” to explain health seeking behavior.

In chapter three, I start with a discussion about the researcher’s identity and relationship with the study population. Later, I describe sampling and data collecting strategies. This chapter illuminates all methods that this thesis engaged during fieldwork; interview, participant observation, and autoethnography. The limitation of this research is also discussed in this chapter. Chapter four examines the perception of health of transnational Bangladeshis. The discussion includes how their perspective regarding their health changed after migration due to the new social structure. In this chapter, I discuss what accounts for their changing perception of health and what are the consequences. Chapter five explores the health seeking procedure of transnational Bangladeshis. I attempt to examine every single steps they take during seeking treatment, from understanding symptom to post treatment care. In this chapter, I also discuss the decision making regarding health care treatment and influential factors that shape the decision making. The final chapter is about recapitulation of the findings of the thesis and also a discussion of the scope and significance of this thesis.

## 2 LITERATURE REVIEW

This chapter discusses the theoretical framework that I employ in my study. I start with a discussion about the transnationalism and the notion of transnational health. After that I move to the discussion of perception of health and how it is influenced by the available health care settings and available resources. Last part of the discussion focuses on the health seeking behavior of transnational people and the role of their therapy management network in the process of treatment.

### 2.1 Migration, diaspora, and transnationalism

Migration is the horizontal mobility, movement from one place to another—specifically from place of origin to other places, of people in an expectation of vertical mobility (betterment of life). Aspiration for a better life is the core reason that underlies the movement of people. Sometimes conditions force people to be displaced, and sometimes voluntary choice explains why people to move. Among the motivations or forces behind the migration, economic factors are the most significant, though other factors like natural disaster, war, and persecution are also leading forces (Willis 2008, 212).

The migration of human populations is as old as the emergence of hominids (Brettell 2003), though the emergence of migration in human history can be a matter of debate as scholars are at odd in determining the inception. However, the recent era is undoubtedly experiencing the highest incidence of migration all around the world. From 1970 to 2010, international migrations doubled and the number of people who migrated internationally is estimated to be 213.9 million in 2010 (Willis 2008, 212). This pattern is certainly applicable for Bangladeshi migrants as well.

According to Migration Policy Institute's report 2014, nearly half of the total Bangladeshi migrants living in the United States came here after 2000.

Globally the reasons for leaving one place and moving to other places can be diverse; for instance, aspiration of higher education, job opportunity, business opportunity, and religious and political persecution are some examples. However, the underlying motivations tend to be the aspiration of a better life. Chavez (2013, 4) categorizes these people into two groups: migrant and settler. Migrants are those people who come to a place for whatever reason, and then go back to the origin. His contention about migrant is problematic in as sense that people don't necessarily go or want to go back to their birth place. On the other hand, settlers have the intention to be settled in the new place. The decision over whether to go back to the place of origin or to permanently stay in the host place is not always premeditated. Rather, in many cases, people decide after arriving. Financial opportunities, environment, ties with home, and other factors shape the decision making. The distinction between migrants and settlers is very fluid. In fact, it takes time for people to decide whether they want to settle themselves in a new place, to move back, or to go elsewhere. Most of my informants, chiefly students, expressed their ambivalence in deciding what they would do.

High mobility within and across national boundaries is very evident in this interconnected world. The spread of advancement in the technology, transport, and communication systems makes the migration easier. My informant Jamil, a 44 years old man migrated here 6 years back, mentioned access to information and inexpensive communication cost are the most important factors behind the increasing number of Bangladeshi migrants in USA. In recent years especially after 2000, Bangladeshi international students increased significantly. The emergence of the internet played a major role as students no longer have to go to consultancy firms, university

agents, and organizations in order to study abroad. Students now directly communicate with universities, faculties and other Bangladeshi students studying abroad for information. In this way they save some money and time that they would have spent for third parties.

Globalization or the interconnectedness of the world has impacted migrants' way of life as well. Leaving a country is not leaving everything behind, in fact, globalization exposes people to their own culture (may not be in the same way that they used to see in their place of origin) in the new place. Within the diaspora, organizations, festivals, rituals and other cultural activities generate a sense of home. Availability of resources from their home is one of the factors that help people to create this sense even in a foreign world. The accessibility of grocery stores, clothes stores, restaurants, and organizations that focus on a national culture play a major role in bringing home abroad. Jean Gottmann (1952) emphasizes the importance of iconography in consolidating diasporic groups. He contends that some visible or palpable symbols with cultural/political/religious significance contribute to the formation of the identity of diasporic peoples. At the same time, iconography singularizes a group of people from other groups who are attached to other symbols.

Diaspora, as a theoretical concept, has been discussed for a long time in the fields of social science. The old concept of diaspora implies only religious or national groups dispersed forcefully in other countries, maintaining their identity without assimilating into the host society (Faist 2010). It's a group that desires to return home but is unable to go back because of political, religious, ethnic, and other issues (Safran 1991). A classic example would be the Jewish diaspora. However, the theoretical discussion of diaspora has undergone dramatic changes, chiefly in the 1970s when it underwent enormous experimentation and application (Faist 2010). The post- 1970s debate of diaspora includes all possible types of migration of people as people



migrate due to diverse reasons (Cohen 1997), and adds discussion of dense and continuous connections across national borders (Faist 2008). The discussion of diasporic cultural hybridity (Bhabal 1994) and cultural innovation along with cultural preservation is a new topic in the intersection of migration and diaspora.

However, transnationalism has emerged as a dominant issue in the discussion of migration in last few decades. Anthropologists, in the 1990s, incorporated this concept in order to discuss the persistent home connection and frequent mobility between home and host country of migrants (Waldinger 2008, Kelley 2010). In some ways transnationalism as a concept complements and in other ways, opposes the idea of diaspora. Both have similarities; such as connection to homeland, unity on the basis of nationalism, religion or other symbols, maintenance of identity, difficulty or unwillingness to assimilate in the host society and so on. Yet, Michel Bruneau (2010) distinguishes diaspora from transnational community. In his characterization, diaspora is sedentary and more static and conversely, a transnational community is nomadic and dynamic. Transnationalism can also be understood in contrast to assimilation, which refers to blending in the host society and entails weak or no connection with place of origin. (Bradatan et al 2010, 177). In my discussion of transnationalism, I emphasize three notions of transnationalism: connection with place of origin and host countries, mobility between place of departure and place of arrival, liminality of their identity.

First, the connection with home and host is one of the significant notions of transnationalism. In the host countries, transnational people may identify themselves or be identified by others based on their origin. A common inclination of human beings is to assume a social identity by recognizing themselves in connection to a certain group, whether it is a national, ethnic, family or work-related social group (Tajfel & Turner 1986). Place of origin is a

very common symbol that connects transnational people into one group, and at the same time their attachment to host country is also very important to their identity. In the home country, transnationalism shapes their local identity as well. Dual citizenship and foreign visa play as symbolic capital (Bourdieu 1977) which heightens people's position in the society.

Second, mobility between home and host country is another characteristic of transnationalism. Due to advancement in transportation and communication the movement of people around the world has increased dramatically, especially in the last few decades. However, the pattern of migration is mostly unidirectional as we observe an exodus of migrants or refugees crossing their border and moving especially to Europe and North America every year, whereas, very few expatriate ( interestingly these term is assigned to people who migrate from west to other part of the world) from developed countries to developing and underdeveloped countries. This circulatory movement between home and host countries is another notion that deemed as a characteristic of transnationalism (Massey 1997, Sandu 2001).

Third, another significant notion of transnationalism is the liminality of their identity. Leo Chavez (2013) discusses the incorporation process of migrants in the host country where they go through a process very similar to what Victor Turner characterizes as the phases of "rites of passage". Like the ritual process, migrants also separate themselves from their previous stage by moving away from their country and in this way they place themselves into a liminal period where they learn new code and conduct of host country. After successful learning, they are acculturated into the host society. However, incorporation is not that simple of a process, in fact, there are a lot of factors associated with the incorporation process; such as the context of the migration, relationship between two countries, proximity of their culture, and so on. Transnationalism, which does not include total assimilation into the host society (Bradatan et al

2010, 177), can be described as liminal period because transnational people do not belong fully to the host society. Contemporary migrants are more transnational in the sense that they are not forced to integrate into the new society as they have access to maintain connections with their family and friends in both diaspora and home due to advancement in communication (Schiller et al 1995), though for refugees this scenario may not be similar as they have limited access to resources sometimes. On the other hand, transnationalism can be helpful for migrants to assimilate themselves into the host society since contemporary migrants are more skilled and open to the host society, and have less language barrier than people who moved previously (Faist 2000, Vertovec 2001; 2002). However, transnational people or contemporary migrants have more access to human and social capital in their home, diaspora and host society than before which enable them to hold flexible identity rather than a rigid diasporic identity of isolation from host society. They can claim themselves as part of one nations or both nations or even as people without nations (Waldinger & Fitzgerald 2004).

The relationship between migration and health is a central paradigm in this research. Migration positions a person in a new places with, sometimes fundamentally, different socio-economic, socio-cultural, and socio-political context. Thus, the health orientation which is largely determined by those factors is expected to be different in the new place. Migration, thus, generates two changes: their position in the society, which may be different from their previous position in the place of origin, due to difference in the social structure of both nations, and their surrounding settings which is the product of the historical process.

However, recent advancement in technology and communication stimulates higher mobility and more connections around the world. Thus, when people leave a country, he physically separates himself but there are ample opportunities, in most cases except unfortunate

refugees, for people to maintain ties by visiting in a regular basis or communicating via any technological medium. For transnational people, both host country and place of origin become territories of actions as they forge and maintain social, cultural, economic and political ties across the border (Lamb 2002; 303). Hence, when a migrant leaves for a new place, he carries his country with him through bringing belief, customs, rituals, and other cultural aspects with him. In this way the perception of health, illness, sufferings, treatment procedure are may not be in accordance with the cultural reality of new places since they are shaped by cultural factors of a society (Chavez 2003; 198-199).

## **2.2 Health, illness, and disease**

According to WHO (1948), “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. This essentialist definition is ambiguous with multiple opportunities for problematization, especially for anthropologists. The complete state of well-being of physical, mental, and social condition is really hard to define, considering the cultural diversity and its associate differing knowledge and belief system around the world. People’s perceptions of health and health seeking behavior are largely controlled by the episteme surrounding the local health care system, knowledge, and belief. However, in the era of globalization, with flow of knowledge, “how local is a local?” is a valid question.

The classic categorization of body by Nancy Scheper-Hughes and Margaret M. Lock (1987) would be a good point of start of this discussion. In their seminal work “The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology”, they proposed three level of analysis of body: the individual body, the social body, and the body politic. The individual body is the phenomenological sense of body-self through lived experience. Human beings have some individual intuitive senses of self which exists apart from other individual (Mauss 1985). These

intuitive senses encompasses body image, awareness/consciousness of self body and mind, and sixth sense or in neurological term proprioceptive. These senses differ from individual to individual though all human being share these senses (Scheper-Hughes and Lock 1987; 14). These intuitive sense are predispositions that are naturally placed into human body (Winnicott 1971; 48). Reasonably, the feeling of unwell and the degree of unwell is subjective as Scheper and Lock (1987;7) say “However, the constituent parts of the body-mind, matter, psyche, soul, self, etc.-and their relations to each other, and the ways in which the body is received and experienced in health and sickness are, of course, highly variable.” The social body discusses how body is understood in the cultural meaning system. The representation of body and what is socially accepted are culturally defined. The body is not an independent entity rather an inseparable part of meaning system. As Mary Douglas (1966; 122) maintains everything in the cultural meaning system symbolizes the body, and body, reciprocally, represents everything as well. The culturally produced meaning or symbol of body is a useful tool in maintaining the social relation and ideology of the society (Scheper-Hughes and lock 1987; 19). In this way, whatever the subjective feeling of individual body, it is only culturally meaningful when connected to the web of cultural symbols. Thus, subjective feelings or perception has a name and importance when attributed by culture. The third body, the body politic, is “...the regulation, surveillance, and control of bodies (individual and collective) in reproduction and sexuality, in work and in leisure, in sickness and other forms of deviance and human difference” (Scheper-Hughes and Lock 1987; 7-8). The body politic is practiced through state systems whose aim is to regulate social body and discipline individual body. These regulations and controls are not limited to the period of crisis; rather according to the needs of the society the body politic is reproduced and retained (Scheper-Hughes and Lock 1987). The ideal body concept is an

ephemeral idea as the way the perfect body is perceived in the U.S. is quite different from what people used to think probably hundred years back. The modern and liberated American women are depicted as fun loving, sensual, thin, lovely, hardworking, and self-disciplined. The plethora of cases of eating disorder among young American women is a result of such aspiration to have the perfect body, and death due to eating disorder is also not unusual news (Crawford 1985).

For migrants, the notion of body is very significant in a sense that migrants in most cases, especially when moving from a developing country to developed country-where the health care system, and belief and knowledge regarding health are fundamentally different- are oriented in the host society with different construction of social body and body politic. Understanding the new perception of individual body is an objective of this study. A new health orientation with its regulation and controlling must have an impact on people's individual perception of self-body.

The perception of illness varies from society to society as illness and experience of illness are culturally constructed idea. Illness is a feeling of unwell but the experience and expression/narrative are culturally structured. Illness may include somatic, social, cognitive, and emotional troubles etc. Whereas disease denotes objectively and biomedically measurable lesion or symptom of anatomical or physiological disorder (Soho 2004; 3). Here the symptoms, measures, and treatment are biomedically defined without acknowledging the cultural, social and political issues, which may substantially shape the sufferings of the afflicted. The cultural construction of illness in the U.S. tends to different from that of Bangladesh so as the disease. Disease varies because of change of climate, geography, environmental, and organic nature. At the same time the organization and distribution of resources are different which impacts their work life, production, reproduction, living condition and so on (Singer 2004; 26). The distribution and outcome of disease are not same everywhere due to structural issues like

inequality and structural violence (Farmer 2001). In addition, the notion and perception of disease are not same as well. Though disease is biomedically defined, the perception of disease is variable because the advancement of biomedicine is not similar everywhere and the hegemony of biopower is not same either.

### **2.3 Health seeking behavior**

Health seeking behavior, like the perception of health and body that I discussed above, is also variable. Political economy and cultural belief system largely determine the health care system of a country. Health seeking behavior is guided according to the options available in the health care system. A number of therapeutic options may consist a health providing system in a given society-such as Biomedicine, Ayurveda, Homeopathy, and other traditional/local/indigenous healing practices. The dominance of a healing system within a society is contingent on state's interest, political economy, and cultural belief system. Thus, dominance of a particular option and availability of a particular options differ from society to society. Therefore, the health care system and health seeking behavior of Bangladeshi people must be different from that of the U.S.

However, people within a society not necessarily manage their health care treatment in the same way, especially when there are more than one healing system available in the society. People's position in a society, as Bourdieu (1986) argued, is determined by their economic, social, cultural and symbolic capital. These capitals not only defines their position but also their association and orientation. Their association and orientation, or in Bourdieu's (1977) term "habitus", shapes their perception of health and health seeking behavior. The health knowledge, belief and practice of a person is also shaped by habitus. The experience due to a disease is also forged by society as well. As Paul Farmer (2001) argued, structural violence results in people of

different socio-economic groups having different health experience. According to him, inequality impacts not only the distribution of infectious diseases but also the outcomes of disease. The pathogenic force created by social inequality has an unequal biological expression in the society and that is why a particular population group suffers the epidemic. He contends that the access to resources is key to ensure proper health. He forthrightly claims that lack of access to resources and infrastructural barriers create the obstacle for the afflicted people to seek treatment for diseases that are completely treatable. Both the perception and experience of health are, thus, determined by one's position in a society where access to resources is unequally distributed.

For transnational Bangladeshi community, the U.S. health care system should be a different experience due to differences in the health care system and different orientation and association. At the same time their position in the U.S. class is different from what they used to have in Bangladesh. This is how they place themselves in different health orientation where their decision making regarding health care treatment are distinguished from that of Bangladeshi people and the U.S. people.

#### **2.4 Medical pluralism**

Medical pluralism is widely debated and discussed in medical anthropology. A significant amount of scholarly work is dedicated to this field of study, which covers a variety of societies; traditional, complex, industrial, postindustrial, etc. Medical pluralism refers to the array of different medical systems within a society; mostly stratified society (Baer 2004; 109). Dunn (1976) discussed three types of medical systems: local, regional, and cosmopolitan. Local medical systems are traditional and folk medical systems found in foraging, pastoral, and horticultural societies and peasant communities in state societies. Regional medical systems, such as Ayurveda, a widely used healing method in Southeast Asian countries, are prevalent in



larger areas. Cosmopolitan medical system, such as biomedicine, is available worldwide, though accessible to certain population of a society due to unequal distribution of resources. My research incorporates the idea of medical pluralism, primarily, for two reasons; first, medical pluralism exists in Bangladesh and health seeking behavior of Bangladeshi people is influenced by its presence, and second, though biomedicine dominates the medical system in the US, medical systems from all over the world are imported to the US through the transnational network. Leslie (1976, p. 9) notes that “even in the United States, the medical system is composed of physicians, dentists, druggists, clinical psychologists, chiropractors, social workers, health food experts, masseurs, yoga teachers, spirit teachers, Chinese herbalists, and so on.” People have access to different therapeutic options across the world. Besides their own traditional multiple healing systems, societies incorporate healing systems from other societies as well. Globalization triggers the dissemination of traditional healing systems across the border. Different medical systems coexist in a society and the relationship among them can be cooperative or competitive, depends on the context of the society (Baer 2004; 109). In a capitalist society, the hegemonic and discursive nature of biomedicine may suppress other traditional methods of healing. However, sometimes biomedicine co-opts local or regional medical systems when, particularly, later systems obtain increasing legitimacy (Baer 2004; 110). Medical pluralism in Diasporas within the U.S. is an issue of interest in my study. Medical pluralism is visible in the U.S. due to its demographic and cultural diversity. In fact the use of alternative medicine is increasing in current era. In a national survey conducted by the Journal of Women’s Health, over half of the respondents used complementary and alternative medicine as a supplement to conventional medicine, especially in instances of chronic illness (Wade et al. 2008). However decision making over health-care treatment is a complex issue in a society

where medical pluralism flourishes. For transnational Bangladeshi people, their pre-migration knowledge and belief in certain medical systems, and their social reality in the new place play a major role in the decision making process.

Bangladesh has a pluralistic medical system where biomedicine dominates all other medical systems from colonial period. Diverse traditional and regional medical systems are also available here. Folk healer, religious healer, Unani, Ayurveda, homeopathy, and biomedicine are prominent medical systems here. However, different ethnic communities living in Bangladesh also have their own distinguish medical system (Bhardwaj and Bimal 1986). Frankenberg (1980, p. 198) observes, “The societies in which medical pluralism flourishes are invariably class divided.” In other word, the stratification of a society based on class, race, caste, and other categories also mirrors the hierarchical relationship among the medical systems (Baer 2004; 111). The choice of therapeutic options in medical pluralism is problematic. Folk healers and religious healers are very popular among poor people in rural Bangladesh, though the desire to seek biomedicine is not limited to only urban and upper class people. The reason behind the popularity of folk healing and religious healing is not simple. Lack of access to biomedicine is one of the primary reasons (Bhardwaj and Bimal 1986). Thus, people’s class orientation largely defines their choice. In other word people’s choice of medical system defines their position in the society. As Crandon-Malamud (1991) argues, in the context of her research in Andean mountains of Bolivia, individuals use the “primary resource” of medicine to gain access to secondary resources. Secondary resources can be social mobility and material resource. However, health can be secondary resource as well. As biomedicine is perquisite to upper/middle class people in Bangladesh, seeking biomedical system can be seen as an attempt to mobilize their social position.

Bangladeshi people living in Atlanta don't live in a geographically separate area, rather in a place of demographic and cultural diversity, where they are exposed to different medical systems which may not be available in Bangladesh. Besides, the treatment procedure of biomedicine is also different. Together the health resources, therapeutic options, treatment procedures, and the environment may impact, heavily, the health seeking behavior of Bangladeshi people living in Atlanta.

## **2.5 Therapy management group (network)**

“Therapy management group” is a central theoretical tool for my research. John M. Janzen (1987) introduced this idea in his famous work “The Quest for Therapy in the Lower Zaire.” This theoretical framework has been widely used in medical anthropology and in other researches that engages health seeking behavior. One of the significances of this theoretical frame work is its wide applicability. According to Janzen,

[w]henver an individual or set of individuals becomes ill or is confronted with overwhelming problems. Various maternal and paternal kinsmen, and occasionally their friends and associates, rally for the purpose of sifting information, lending moral support, making decisions, and arranging details of therapeutic consultation. The therapy managing group thus exercises a brokerage function between the sufferer and the specialist (1987:4).

A group of people plays active role in the whole procedure. Genest (1985; 345) discussed basic features of the therapy management group. The group can be divided in two parts; one is engaged in consultation and other is involved in actions taken in the whole. First group's aim is to discuss possible diagnosis, to select therapeutic options, and to evaluate the treatment procedure. Second group takes all necessary steps, and support the sufferer during and after the treatment. Therapy management group works in many societies, though size of the group may vary. The responsibility and amount of work to be done by the group also contingent on the

society and the options one select. Biomedical system may require more people than Ayurveda or homeopathy.

The relationship among cultural assumption and values, behavioral process, and social and economic forces that influence the treatment procedure is very pivotal in understanding the therapy management group (Janzen 1987; 68). Cultural norms and values determine the interaction among people, and to what extent one influences others' decision making. In some societies, reciprocity among people is customary, and people in those societies tend to be more supportive and cooperative. Thus, therapy management group is formed on the basis of whether a society fosters support and cooperation among the member of the community.

## **2.6 Transnational network**

Globalization, undoubtedly, is responsible for the dominance of biomedicine but it also increases the accessibility of transnational communication, which in turn facilitates the exchange of medical knowledge and beliefs among nations (Koser 2003). Health knowledge, resources, belief, and support are exchanged through a transnational network (Thomas 2010). This network plays a major role in the health seeking behavior of transnational people. Transnational people maintain ties with home country which provide them access to knowledge and resources of their home country. In addition, transnational people maintain a strong bond with diaspora community. Their social capital is very crucial in the health seeking behavior. This social network within the diaspora helps people understand health care system of the new place.

Krause (2008; 245) used the term transnational therapy network, borrowing idea of Janzen's therapy management group and Portes's idea of social capital. Portes (1995), building on Bourdieu, argues that social capital is the capacity of people to gain access to resources which are scarce through the help of people they know. And, therapy management groups, according to

Janzen (1987), include the people who involve in the procedure of treatment. A transnational therapy network can engage people from more than two countries. Krause (2008: 245) discusses a case where a person from Amsterdam seeking treatment from Ghana with the help of a friend from London. A transnational therapy network is created through personal contacts which crosses several national boundaries. Unlike the network within the diaspora and that extended to home, this transnational therapy network can be ephemeral. The network may be active only during the period of sickness and treatment, and dormant in other time. Therefore, transnational status may render a web of network which connects people to their diaspora, their home, and to people from other countries.

### **3 METHOD**

In this chapter, I discuss my field experience, which included observing, experiencing, talking, interviewing, and documenting through field notes. I start with discussing my position and relation to the people who were the focus of my study. Then I move to the discussion of my access to the society as a researcher, which is different from my access as a community member. Next, I focus on main strategies of recruiting and sampling. After that I move to discussing data collecting methods: participant observation, interview, and autoethnography. Last, I talk about limitation of my methods.

### **3.1 My transnational identity, and position in the diaspora**

In the last chapter, I discuss the main components of transnationalism, connection to country of origin, diaspora and host society, mobility between home and host countries, and liminal stage. I would like to characterize myself as a transnational Bangladeshi, as I believe I possess all these aspects. However, this is a theoretical identity, and like my other informants, I introduce myself as a Bangladeshi rather than a transnational Bangladeshi if somebody asks my identity. This is the difference between what a researcher attributes to others and how people define themselves.

I believe I have been a part of the Bangladeshi diaspora, in fact, before I entered the U.S. I was in communication with few Bangladeshi students who helped me in renting an apartment, getting information that I needed to know before I moved and things to do before arriving in Atlanta. These people are the gateway to the Bangladeshi diaspora in Atlanta. After I arrived here, my social network expanded through these people. I realized that the more my network extends, the more my connection with diaspora consolidates. At the same time, my connection with Bangladesh is also strong, though I lost verbal or physical contact with a number of people whom I used to see around frequently when I was in Bangladesh. Pavel, one of my informants living here for more than seven years, made a very interesting point regarding connection to place of origin. According to him, in one way his ties weakened as he used to hang out with plenty of friends when he was in Dhaka (the capital of Bangladesh), and it is not possible to contact them all frequently. In his point of view, living abroad has less to do with that, and if he were in Bangladesh now, the situation would be the same. Time or context of life is a more important factor than place. On the other hand, connection with family is stronger than ever as he mentioned he talks to his mother every day and he never did that regularly before he migrated.

Due to social media, online newspapers, and access to a Bangladeshi TV channel, people are aware of what is happening in Bangladesh. The difference is, according to him, we don't experience what is happening there, but we are aware of that. We feel the same ecstasy that people living there do when Bangladeshi cricket team wins any match, and we are as disappointed, sad and furious as they are when we find out news of big corruption of political leaders. I observed that people are more aware of the Bangladesh Awami league (ruling political party in Bangladesh) and the Bangladesh National Party than the U.S. Democrat and Republican parties, though they have been living here for several years. In my case, I think I am more concerned and aware of what happening in Bangladesh than in the U.S. However, this does not mean I am closed to the host society; in fact I am interested in learning new customs and behavior. To some extent I succeeded because when I visited Bangladesh after ten months staying here, some of my friends playfully pointed out some tiny difference in my behavior which is, I realized, spontaneous. I don't try hard to refrain myself from assimilating into the host culture and I don't worry about whether they accept me as a member of their society, but acceptance in the diaspora matters to me since diaspora works as a safety net for me. However, people who have been helping in my everyday life do not include diasporic people only; my American friends, professors, and classmates support and help me enormously. Being a university student exposes me to more American people and provides me more opportunities for learning American lifestyle. It may not be the same for other diasporic people.

The position of researcher in the society, especially when he is studying own society, is very crucial because access to people and the relationship between researcher and study people are highly shaped by researcher's position in the society. The way people define their position in Bangladesh is different from that of the U.S. people. "Middle class" is a widely used term which

covers a range of people with different income, social status and prestige. In diaspora, there is an invisible, yet strong wall, between people who have formal higher education, jobs or own businesses, and people who works for stores, gas stations or other jobs that are deemed inferior in Bangladesh. Students' position is hard to place as their cultural capital may position them above second group but they earn less money. Yet, their position is not similar to the first group as students earn less money than them. While conducting my field work I experienced this dilemma.

### **3.2 Gaining access as a researcher**

Gaining access to the diasporic community as a member was, I would say, easier since I was in communication with several people before I moved here. These people introduced me to other Bangladeshis and guided me in terms of what to do and not to do as I am new to this country. I usually go to Bangladeshi grocery stores, restaurants, and mosques where usually people gather. These hubs really helped me to expand my social network. Like most other Bangladeshis, I try to fulfill to some extent the void of family, relatives and friends by spending time with Bangladeshi fellows living here. Overall, it is not a difficult experience to be a part of diaspora here.

However, as a researcher I had a slightly different experience. Undoubtedly, people living here usually have a very busy schedule on weekdays, and on weekend people have plans with family members or friends, and sometimes people work on weekends as well. But there are some other issues that I noticed that while conducting field work. Obviously, some of my informants are more willing than I expected to help me, but in some cases I noticed reluctance, unwillingness and an outright negative attitude from people. I asked more than fifty people to be part of my study and thirty five of them agreed to take part. Most of the people who refused to



take part did not like to expose their personal information, though I assured them about the confidentiality of their information. Later, I realized they did not want to provide their personal information to me. When I first started approaching people with an invitation and got refused several time, though I personally have good relationship with them, I thought there might a problem with my way of explaining my research to them. I worked on improving my clarity in explaining my research to them. However, I realized clarity is not the issue here. However, I somehow persuaded a few from that group to participate in interviews and for the most part, they did not want to talk about their jobs, but they were willing to talk about how much money they make and some of them asked me how much money I earn from my university. I felt their nuanced attempt of raising their position above me. I did not feel uncomfortable of their attempt; rather I helped them in doing so because I understood that would push them to be more open about themselves.

### **3.3 Recruitment and sampling**

The beauty of the U.S. is its diversity, which encompasses people from almost all part of the world. However, it is not necessarily implied that people from a certain country live closely and are bound to a particular area/neighborhood. Bangladeshi people living in Atlanta are connected through pre-migration and post-migration networks. These networks are created through organization, festivals, and other social activity. They are scattered all over Atlanta, rather than clustered in one neighborhood. Thus, there is no visible physical territory that accommodates them. In this circumstance, I employed chain referral or network methods to find potential informants. These methods are useful and effective when population group is small and dispersed in a large territory (Bernard 2006; 192). I used both snowball sampling and respondent-driven sampling methods to make a large sample frame. As a member of Bangladeshi

community, I have some contacts. These people were asked to take part and pass along my contact information to other potential informants. I also asked them to talk to other members of the community about my research agenda and asked them if they are interested to take part in my research. My contact information was provided to them so that they could contact me if they are interested.

On the basis of my contacts and other people in my network, I made a list of possible informants. From that list I selected only first generation Bangladeshi because the second generation tends to have fewer ties with place of origin. I contacted these selected people personally, by making phone calls/sending emails/meeting them, to inquire whether they would be interested in participating in my research. This list includes 25 people, but I was able to interview only 12 informants for this study due to time constraints; all of them were selected randomly for interview.

### **3.4 Research methods**

In gaining data for my research I conducted interviews, participant observation and autoethnography. In this case, my research field is not a classic Anthropological field where anthropologists go, wander, observe, and talk to people. The Bangladeshi diaspora here is dispersed, rather than sticking together in one neighborhood. However, I have been a participant observer in this community, however dispersed, since I arrived. My participation even in hanging out with friends in this community constitutes participant observation. Besides, my own experience, thoughts, feelings and narratives are also reflected in this thesis.

#### **3.4.1 Interviews**

In this research, interviews were the main method of obtaining information. My interviews included in-depth interviews and informal discussions. As I focus more on quality

rather than quantity of data and due to time constraints, I decided to interview 12 people. Among them 7 are male and 5 are female. The age range of my informants is 25 to 45. I have interviewed 7 of them multiple times. Interviewing informants more than once can be beneficial. First, it helps building good rapport and trust between researcher and study participants (O'Reilly 2005:112-114, Trotter & Schensul 1998:704). Second, it helps to find different angles to look at the experience of informants. Thirdly, multiple sessions of interview minimizes the gap which produces more information that may not be possible to get in first session. In addition, multiple sessions with informants allowed me to visit their homes. I had the opportunity to talk to other family members sometimes informally and sometimes formally. In a few cases, there were group discussion which produced more data.

Whenever I approached a person for interview, I invited him or her for multiple sessions of interview, though I always emphasized that their participation was voluntary. I interviewed five people for just one session, and in these interviews I had a guideline to direct my session though interviews were flexible enough to discuss whatever informants wanted to talk. In the first meeting, whether a one session interview or multiple session interview, I presented myself, my research goals, my academic affiliations, and other relevant information. In both types of interviews, I provided them my study prospectus and consent form in the beginning of the first meeting. I also took all of my informants' verbal consent before I started interview. I encouraged them ask me questions as well. In the one session interviews, I usually started with their life history and then with specific questions about perception of health and health-seeking behavior. I wanted to make these more discussion-oriented sessions rather than just typical interview where interviewers talk less and listen more. I encouraged a discussion where both the interviewer and interviewee were asking and answering questions. As I am also a transnational Bangladeshi like

my other informants, I never hesitated to share my experiences in the discussion, especially about the difficulty I had when I sick. I observed this method created a more friendly ground which connected informants more to the discussion and evoked more information. In fact, to make the interview session more comfortable for them I asked them choose place for interview. All of the female informants, except one, selected their home for interview. Out of 7 male informants, 3 preferred their home and rest of the interviews are taken either in parking lot or coffee shops.

I realized that multiple session interviews are more in-depth and informative than one session interviews. In multiple sessions interviews I selected second interviews as in-depth interview because it requires more trust and closeness to conduct an in-depth interview. In-depth interviews are appropriate for more nuanced and complicated questions that entail a space where informants can trust the interviewer and feel safe (Bernard 2005:256). In case of multiple interviews, the first meeting was usually a session of informal discussion about on the one hand, myself, my research, my personal life and any questions informant asked, and on the other hand, what they think about this research, suggestions, possible informants, general discussion about diasporic life, health care systems, and health-seeking behavior. The first session helped me shaping my second interview questions and pattern. In the second interview, I came with more nuanced and specific questions regarding their life, position, identity, health, decision making regarding health care treatment, social network, family ties, connection with Bangladesh and other relevant issues.

All of the interviews are conducted between December 2015 and February 2015. All these interviews are transcribed, and subsequently, these transcriptions and personal notes that I

took during interview were analyzed using thematic analysis methods for common patterns. Next these themes were coded, sorted and interpreted, which I will discuss in the following chapters.

### ***3.4.2 Participant observation***

What I experience as a transnational migrant is not different from, in fact in some cases similar to, what my informants experienced. Pierre Bourdieu (1990, 69-71) argued we are taught habitus or social order through practice which involves our body, and this is why Loïc Wacquant (2004) emphasizes a bodily commitment to research which means practicing or experiencing the local life rather than just observing what is happening. In my research, I would say I have the privilege to take part in the diaspora life spontaneously.

Participant observation is very useful to build trust and camaraderie between researcher and community, and at the same time, it places researcher in a position to observe reality and context more deeply. In my research, as a member of the community I take part in activity regularly though this is not a classic anthropological field where observed people maintain a geographical territory, as Bangladeshi people living in Atlanta are dispersed into a large territory, instead of concentrating on a particular neighborhood. Festivals, cultural events, and religious events (Eid ) are the occasions where I engaged myself as participant and observant, and as researcher and community member.

### ***3.4.3 Autoethnography***

Being a transnational Bangladeshi, my own experiences, feelings, and observations in Atlanta are inextricable in this research, thus, making autoethnography an integral part of this thesis. In this research, along with other informants, I will discuss my own experience and sufferings regarding health. My identity is really helpful to understand what my informants are dealing with every day. As a result, a good portion of the following chapters have excerpts from

my experience and feelings. Researchers retrospectively and selectively write about their epiphanies in their writing while doing their autoethnography; this is possible when researcher and study people possess the same identity (Ellis et al 2011, 276). However, an autoethnography should not be about presenting and analyzing one's own experiences or epiphanies only; rather a researcher should compare and contrast his own story with those of other members of the community in order to articulate cultural facets to both insiders and outsiders (Ellis et al 2011, 276). My experience in Atlanta is a real asset in this thesis. It provides me with resources to write about and at the same time it influences my interview questions, helps me comparing my perspectives with others, and makes me more empathetic to my informants.

Clifford Geertz (1983) emphasized the concept of “experience near” and “experience distant” in writing ethnography. The “experience near” concept is the way people perceive their surroundings, events, phenomena and so on which they explain in their own words that make sense to other people of the local community, whereas “experience distant” concepts are those such as the language that experts employ in the literature. The key challenge is to grasp the first concept and convert it into the second one while writing ethnography. Being a member of the community places me in a position to grasp (as least to some extent) “experience near” concept, and autoethnography is a valuable tool to articulate the understanding of my research issue with my experience and its reflection in my informants' experience.

Another characteristic of autoethnography is that it recognizes the presence of researcher in the study and emphasizes the identity of the ethnographer, which may impact the interaction between informants and researcher. It also acknowledges the power dynamics that may appear between them (Hernández 1995: 151-157). All these are important to provide the reader a better context of the study.

### 3.5 Limitations of the study

One of the difficulties that I faced during researching on secondary materials is the lack of reliable statistical data about Bangladeshi immigrants living in Atlanta. As scholarly work regarding Bangladeshi diaspora is scarce, it is difficult to gather relevant information Bangladeshi diaspora through secondary sources. However, on the other hand, this work will be a remarkable step to minimize the knowledge gap. Through ethnographic experience, this research present valuable information regarding the Bangladeshi diaspora as much as possible.

One of the significant problem of social research has to do with representation. Including the entire Bangladeshi diasporic population in the research may provide the bigger picture. However, this would not be a feasible task, even in the context of this community in Atlanta. Social researchers, through different sampling methods, do research with a subset of the population in a feasible size and consider how it may or may not be generalizable to the study population. According to Bernard (2006), snowball sampling and opportunistic sampling are not a random sampling method; thus it may not represent entire population. This research heavily relied on snowball and opportunistic sampling methods. However, I tried to make the sampling frame as vast as possible. From the sampling frame, I randomly selected 12 participants for my research.

I mentioned earlier that studying own society has both advantages and disadvantages. Familiarity with the culture, language and behavior is helpful for understanding any particular aspect of the society. Studying one's own society is also helpful for finding key informants and building rapport with informants. However, overfamiliarity with the culture and people can be an obstacle to anthropological research (Fedlman 1981; 236). In applying anthropological methods, such as participant observation, overfamiliarity may distract the insider-observer from noticing

crucial issues. What is strange to outsiders may not be the same to insiders. An anthropologist may not find a quintessential phenomenon of daily life interesting or crucial for research as, being a member of that society he may participate in that phenomenon every day. From outsider's point of view, this daily activity can be strange, interesting, and outstanding. In addition, sometimes, people don't feel comfortable sharing their personal/sensitive information with someone they know. "Strangeness" between the anthropologist and the observed people, in some cases, is required to set a comfortable settings for participant observation and interview (Fedlman 1981; 236).

Another problem, or I should say ethical dilemma, has to do with interviewing and presenting the experience of undocumented people. Many Bangladeshi people in the U.S. are staying without properly complying immigration laws; living with expired visas, working without work permit, and so on. These people would be reluctant, or afraid, to participate in my research. This research promises its informants to secure confidentiality of their personal information by taking some measures, such as using pseudonyms and protecting identities by eliminating identifiable information.

#### **4 THE PERCEPTION OF HEALTH**

Perceptions of health are highly shaped by people's surrounding environment and culture. In other words, the context of life is very important in creating health perceptions. A new place with a new system and environment places introduces a person to a different lifestyle with different perspectives. Bangladeshi transnational people's perception of health tends to be different from



that of their pre-migration perception since the health care system, health belief and knowledge system, facilities and other issues regarding health in most cases are fundamentally different in Atlanta. In this chapter I will look into their changing pattern of perceptions of health and what accounts for this change.

#### **4.1 Consciousness of food**

I can still remember the first day I went grocery shopping in Atlanta, right after the day I arrived in this city. Biplab- an informant of this study and also a friend of mine who has been helping me from the first day I moved in Atlanta- took me there. He is a 30 year old man living with his wife for last 3 years. He received me from the airport and took me to my apartment, and the next day we went to the farmers market, Walmart, and Bismillah (a Bangladeshi grocery store). I observed how strategic people are while selecting food items here. Of course, people are very selective while doing grocery shopping in Bangladesh, but the main concerns are the price, freshness of the food items, and taste. I hardly saw anyone bothered about how much fat a jar of milk contains in Bangladesh. But I observed a hint of difference, here in my first grocery shopping trip, when he insisted me to take 2% fat milk rather than the whole milk. I was not sure how to respond but I thought it would be nice to take something that he suggested as I consider him a well-wisher.

A custom of Bangladeshi families is to entertain guests with food, which includes light snacks, main meal, and desserts. However, who is visiting, what is the visiting time, and how long is guests staying determine the types of food they serve. The type of foods that I had during my visit to any informants' and friends' home in Atlanta are not always the same that I used to have in Bangladesh. I initially thought the difference could be due to lower availability of Bangladeshi food. The number of Bangladeshi grocery stores is few here but there are a number

of Indian stores where one can find familiar food items, especially spices. Bangladeshis share almost the same spices with Indian. It is very possible, in Atlanta, to cook or have Bangladeshi food if somebody wants, though the price of Bangladeshi food items--including Bangladeshi frozen fish, vegetables common in Bangladesh, and Halal meat (I will define that in the footnote later)--are high-priced and sometimes unaffordable for some people to include in their everyday meal. I do not contend there is a dramatic change in their food preference, but there are few changes that I observed.

I realized, in order to investigate the differences in the food habits between transnational Bangladeshi in Atlanta and Bangladeshi living in Bangladesh, I needed to ask them how frequently they consume their favorite Bangladeshi meal. Unless people have severe medical conditions, beef curry is an indispensable part of meal of for a Bangladeshi Muslim family, and as anticipated most of my informants listed beef curry at the top of their favorite food item during their life in Bangladesh. All of them informed me that beef can be a part of their meal once or twice a week whereas in Bangladesh they used to have at least 5 times a week. However, in the festivals, social gathering, potluck party, and in any family functions beef curry or beef Biryani is a must.

Their lowered consumption of traditional Bangladeshi food also has something to do with the time it takes to make. Popular Bangladeshi items like meat curry or Biryani take more than 2 hours and entail painstaking attention of every step: marinating meat, putting spices in order, and changing heat according to the stage of cooking. This is the reason people sometimes avoid making these items in the weekdays. Munna, my first informant in this study, invited my wife and me to conduct this interview. He asked me to have dinner at his home and I was expecting a Bangladeshi meal but it turned out to be Italian pasta and garlic bread. I was little bit

disheartened, but I understood the reason. Munnah, a 32 year old man, works full time at Georgia State University as an accountant and his wife also works for a school. They have little time for cooking except weekends which they spend mostly visiting relatives or friends. They invited us in on a weekday. I realized later that expecting biriyani was little bit unfair. Besides that, the price of beef and Bangladeshi fish, which is always old and frozen, are high comparing to chicken. Not all Bangladeshis can include these in their daily meal due to economic reasons.

There is an apparent change in the dietary pattern of transnational Bangladeshi people that I observed on the basis of my visits to their houses. I asked all my informants the same questions: What is the main difference in your eating habits? And most of them replied identical answers: less consumption of red meat, more vegetables in the menu, inclusion of fresh juice, and avoidance of fat as much as possible.

Maintaining health through proper diet is also a big concern among Bangladeshi transnationals. As Jamil, one of my key informants in this study said, “you better take care of yourself rather than spending money on treatment”. Jamil is an U.S. citizen who migrated six years back. He is 45 years old and living with his family, consisting of two sons and his wife. Jamil works for a NGO in Atlanta with a salary just enough for his family. He acknowledges how important it is to maintain your health sound because the cost of health care treatment, in spite of having insurance coverage, can be high. There are always co-payments, and it is difficult to anticipate the cost beforehand. He takes every possible step- including maintaining a proper diet and taking physical exercise- to keep his family healthy. Jamil explained:

You cannot prevent a medical cost when you have an injury due to accident because your insurance company will somehow manage a loopholes to send you a fat medical bill. I always encourage my family members and other people around me to keep themselves fit. There are ways to keep yourself fit. Follow diet according to your condition.

However, exposure to food habits of other people through the work place, educational institutions, and other places is also an influential factor in changing food habit. Jamil mentioned that a significant portion of his female co-workers usually take salad in the lunch which he never thought as main item in the lunch before he moved to the U.S. During the lunch break people talk mostly about food, and its ingredients and nutritional value which is a way of learning about new food and their usefulness. Jamil categorized foreign food into two parts: “good for health” and “delicious”. He is more open to the first one. The presence of avocado, passionfruit, and blueberries in his fruit basket in his kitchen table, where we were talking during the interview session, implies their adoption of new fruits because these fruits are rarely found in Bangladeshi markets. When it comes to restaurant food or delicious food, he prefers to go to Bangladeshi or any other restaurants that serves Halal food.

One of the reason that I do not usually miss the opportunity to visit a Bangladeshi home or a festivals is the opportunity to have delicious Bangladeshi authentic food. I must confess I am bad cook and I always messed up a traditional dish either by pouring more salt or pepper powder or something else. I do not consider the restaurant food authentic enough, and they frustrated me several times, but I always found homemade foods are very close enough to what I used to have in Bangladesh. In the festivals and social gathering in home or outside, talking about food for long period of time is nothing new here especially when people get nostalgic. It is understandable because the relationship between people and place is forged through some cultural practices, and food practices are one of them (Counihan and Van Esterik 2008). In the era of globalization with constant movement of people all around the world, food and drinks play a major role in maintaining relationship with place of origin, family, and culture (Fernández-Armesto 2002). Even food practices often very useful in alleviating nostalgia (Matt 2007).

Another interesting activity is making a list of items they will have when they will go to Bangladesh and that list includes food like Beef or mutton Biryani, beef or mutton curry and other food contains good amount of fat which they try to avoid here. However, discussing nutrition value of food and sharing knowledge about food nutrition are common discussion topic of gathering which I found slightly atypical.

Their openness to the U.S. culture is demonstrated in their preference of food and dietary pattern. Their social network in the U.S.-both diasporic and other U.S. people-plays a major role in the process of change in their food habit. Food preference is also a reflection of their higher consciousness of health, a way of keeping health fit and avoiding any unwanted medical cost. The social body, which is the product of cultural meaning system, impacts the individual body here as new social settings and the people around them influence their dietary pattern. At the same time, the fear of medical cost is result of U.S. health care system, which is shaped by the political economy (the body politic) of the U.S. society. Their connection to their place of origin is also reflected since most of the food item in the festivals and social gatherings are traditional Bangladeshi food.

#### **4.2 Health literacy and access to information**

I was talking to Munnah about the difference between seeing a doctor in the U.S. and in Bangladesh, while we just finished our dinner and took a cup of tea with milk and sugar. For me sugar is mandatory if I take tea or coffee as I don't like the bitterness of them. Munnah has given up sugar for more than one years and prefer tea without milk as well. He mentioned that the good aspect of seeing a doctor here is that you will be well aware of your health. They will help you understand your health condition. They will not only explain you your health problem, if there is any, but also what causes them and what to do. He thanked almighty for a good health but he

was very cautious of his health as well because his cholesterol level is quite borderline. He is one of the people among Bangladeshi community who is very eager to play sports like soccer or cricket which engage heavy physical activity. He blamed his sedentary job for his condition and that is why he never misses out any opportunity of playing these games. In fact I met him first time in the football ground of Georgia Institute of Technology where Bangladeshi people usually play on the weekends during the warmer months.

Bangladeshi doctors, according to Munnah, do not bother to explain one's health condition, and sometimes explain in such way that it becomes difficult for layperson to understand. People are more interested to know if there is any illness, what illness we are suffering, and what medicine we should take. The inner mechanisms are considered esoteric for layperson. However, Pavel, one of my key informants, contradicted this statement. He said it entirely depends on what kind of doctor you are seeing. If someone goes to Lab Aid Hospital or Square Hospital (two most expensive hospitals of Bangladesh), doctors are more friendly and eager to explain your situation in simple terms and discuss about your problem for long. These hospitals are expensive and facilities are good, at least better than other places. However, if somebody goes to a government hospital, which is saturated with patients, or an inexpensive private clinic, doctors usually do not have the luxury to spend time explain conditions. However, both Pavel and Munnah agreed that seeing a doctor is more comfortable here and it helps understand health situations quite well. If they do not understand anything in their report they can consult it with doctor back home to have a good idea. Having information about their health encourage them to know more about their health condition.

Both of them also mentioned that they spent hours of their time browsing information on medicine. They did not recognize medicine by their generic name when they were in

Bangladesh; the market name of medicine is more used by lay people, even by doctors as well. Thus, after migration they had a hard time finding medicine, which does not require a prescription, available in the drug store. For example, “Ace Plus” (made with paracetamol/acetaminophen and caffeine) is a common pain reliever in Bangladesh and used by a lot of people, including me, in Bangladesh. I carried a box of that with me while I was travelling. But it is not possible to bring all the required medicine in the luggage because it is not predictable what kind of medicine I would need in the future.

Familiarizing with medicine name is a part of familiarizing with health care system, and usually, social network play a good role in that. A box of useful medicine is a part of Bangladeshi home which is true for the Bangladeshi people living in Atlanta too. The main difference is the name of the medicine. I remember the first time I had a headache, which was excruciating, while I was in Jamil’s home. I was asking for an “Ace Plus” spontaneously. However, he gave me two “Advil PM” which was part of his medical box. He also explained me why this medicine is more effective. That medicine was really helpful and more effective than “Ace Plus”, I realized and next day bought Advil (both am and pm). His knowledge and familiarity with the U.S. medicine is very good, as one of his brothers is a doctor who lives in New York and has been practicing there.

All of my informants acknowledge that they are more curious and conscious about any information regarding health and medicine after they migrated here. In other words, their health literacy is much higher than what they used to have in Bangladesh. Health literacy and information about medicine and health care system are more required here in Atlanta because access to doctor and hospital are not so easy, at least comparing to Bangladesh. But in Bangladesh, though they were aware of their health (not as much as they now) and did not know

much about health information as much as they do now, the health care system is so flexible and in most cases, so accessible that they did not realize the importance of health information.

Both of them have doctors in their family. Both of them have already checked up their physical condition thoroughly as they have good insurance coverage. Their institutions provide their insurance which made it easier for them to have a checkup. I asked them if they have ever gone for a thorough checkup while they were in Bangladesh. Both of them said that they did that just before they move to the U.S. They knew that medical expenses are very high here and as international students they have to pay at least 20% of their expenses though they have insurance. They wanted to make sure that if there is something wrong they would carry medicine from Bangladesh if needed. But before that, they never had any thorough checkup. I asked Munnah, “Why did you do it here? His answer was simple “I don’t have to pay for that, and it’s good to know about yourself as well.” I was trying to dig thing up. “Why did not you consider doing that while you are in Bangladesh?”

“Well I was not concerned about that. I left Bangladesh when I was only 24 years old and just finished my bachelor. I was young—well, still I am young (with a laughter). I did not care about my health. I was solid.”

Me: “Don’t you feel solid now?”

Munnah: “Yes, I do but you know what, I don’t want to be sick here.”

Me: “Why? You have insurance here.”

Munnah: “Yes, I do. But it is not that simple to live here. You have to take care of yourself and your family as well. You can’t just get sick. Because there is no one to do your job and don’t make yourself burden to other people. Everyone is working here. If I were in Bangladesh, there were a lot of people to take care of you. I have an extended family there and



all of them live in the same building; my parents, my brother and his family. But here I have my wife only who is also working person. So I don't have the luxury to get sick.”

Jamil contends that health literacy is a part of American life style. Tons of information is available through the internet. The U.S. atmosphere regarding health is completely different from Bangladesh. People are more concerned about their health, and spent a significant portion of their time to keep themselves fit which is unlikely in Bangladesh where people, most of the time, only become serious about their health when inflicted with a sever health condition. But in the U.S., the way people perceive their health and the way they try to pursue or maintain a sound health condition is different.

The way people perceive health in Bangladesh is different from the way they do here. Health information is not the privy of the doctors only in the U.S., in fact knowing technical information about health from doctors and, subsequent attempt to learn more though internet and social network make them more knowledgeable of their own health, whereas in Bangladesh people, as my informants mentioned, are more concerned with medicine rather than the cause of disease. Gaining more technical knowledge about health and becoming more aware of their health is the reflection of their degree of consciousness of their health.

The health care system in the U.S. requires people to be more conscious of their health by every measures-which includes sound health literacy and access to information. For transnational Bangladeshis, gaining more information about health and medicine is very crucial as new health orientation and health care system do not offer an easy access to doctor and medicine that they used to have in Bangladesh. Besides, medical cost in the U.S. is very expensive comparing that of Bangladesh. The body politic, which is shaped by the neoliberalism-an ideology that encourages less government funding for welfare sector and makes people take their own

responsibility-is a determinant factor here. The higher consciousness of the health is, thus, a result of the new social settings-the body politic.

### **4.3 Support group and consciousness**

A few times, I had the opportunity visit few Bangladeshi people's home as a guest. Most of the time I would visit someone's home either for a potluck party or a celebration where a group of people gather. During my fieldwork, in few occasions, I conducted their interview in their homes as they preferred to talk in a place where they can maintain privacy. I offered them the flexibility to choose whatever place they felt comfortable. People who preferred their homes for interviews had families with at least three members, and I realized what accounts for their preference. Most of my informants acknowledged that significant portion of their free time are spent with family, whereas when they were in Bangladesh their friends and other relatives consumed a good portion of their free time. However, they also have social connections in Atlanta which encompass family, relatives and friends. In fact, sometimes a friend may be more than a family member here in abroad life. The reason they spent most of their free time with family is the constant consciousness about their family member. Jamil characterized this consciousness as the "fear of lack of support group". He continued:

"You don't have the support group here in Atlanta if you live primarily with you family and children. Of course your family is your support group but we used to have large family back home who were always there when you are in trouble. In terms of health problem I used to talk to my brother who is a doctor. In fact, I relied on his decision when it comes to my health issues or my children's health issues. But when you choose to live this life away from your family, there are certain consequences. One of them is the apprehension of sickness or injury. Sometimes it is unbearable to have that. And at some point you will be helpless. When I in Bangladesh I was carefree as I know that I don't have to be constantly worried while I am in my office about Arib (his eldest son) while he was sick though Taniya (his wife) was in her office because my parents were there. But what would I do if Arib or Adyan (his youngest son) get sick in the weekdays? Probably this is why I am constantly conscious of my health and my family health"

The atmosphere of constant consciousness about family members is also mentioned by my other informants who live here with their family. Understandably, support groups create a sense of strength among the member of the community which reduces the anxiety. The void created due to moving from an extended to small nuclear (in most cases) family creates a constant awareness of their family member and their health. This void is created because of the new social settings that shape their life.

#### **4.4 Complications in the system and financial burden**

Jamil emphasized lack of easy access to medicine and doctors as one of the significant differences between the Bangladeshi and the U.S. medical system. He contends that this factor accounts for the higher consciousness of health. In Bangladesh, access to doctors and medicine is not complicated; there are multiple layers of options people have, from highly expensive hospitals with world class facility to free government hospital with minimal facility. In case of medicine, drug stores usually do not ask for authorized prescription to provide medicine. In fact consulting a doctor over the phone and getting medicine from dispensary without a prescription are also common health seeking behavior. Getting medicine is not so simple in this country. Jamil said, “It’s a crucial decision to make whether you wait or see doctor immediately. If my son gets sick, I will immediately consult doctor because it takes time to get medicine”.

Another significant factor that forces people to be more aware of their health is the inclusion and complicated nature of the insurance in the health care system. None of my informants have a comprehensive idea about their insurance policy. There is always some concern about co-payments when it comes to decision making regarding health care treatment. Though all of my informants have health insurance, they are less enthusiastic to see doctors due to the cost it may cause. Calculating the treatment cost beforehand is also a very difficult thing to

do, whereas in Bangladesh, patients have a very clear idea about the cost before they start the treatment. The hospitals, clinics, or physicians provide information about the cost of the treatment, which helps patients selecting an options for treatment. On the other hand, in Atlanta the insurance policy significantly stipulates the decision making. Not all insurance allow its patients to seek treatment to any hospitals they want. There are convoluted rules and regulations that one has to follow regarding treatment. Within same insurance policy, in state and out of state rules are not the same. Even, within the state compliance with different hospitals may not be similar. As Munnah mentioned his insurance covers, not fully, if only he seeks treatment from only two particular hospitals in Atlanta.

The uncertainty of the financial cost causes an uneasiness among my informants. Biplob recommended me, when I first time come here in 2014, not to seek any treatment here. He argued, “whether someone has an insurance or not, the cost of the treatment is high. Yes, if you have coverage, the cost may be zero or high, if you don’t have any, it will be insanely high. In both cases it is better if you avoid seeking treatment as much as possible”.

This financial burden and lack of clarity of the insurance policy creates an atmosphere of anxiety among my informants. This anxiety encourages them to take care of their health as much as possible through good diet, physical activity, and other initiatives including routine checkup- if the insurance allow it with a manageable cost. Insurance and financial costs constitute the most prominent difference between the two countries, which largely define the difference of their awareness of health. In Bangladesh, people with insurance are rarely found, and the health care system is, what Jamil characterized as, “convenient” because of the easy access to doctor and medicine. But in the U.S., when a support group may not be available (or the way they used to have in Bangladesh), and with the lack of clarity of insurance policy and financial encumbrance

it produces, people tend to be more conscious about their health and try to keep it sound through various measures.

The insurance policy, expensive health care system, and complicity stipulated in the system are the characterization of the neoliberal system of the U.S. society which underpins less government funding for public sectors. The role of the body politic is apparent here, as it impacts both the social body and the individual body. The main aim of the body politic is to regulate the social body and discipline the individual body (Scheper-Hughes and Lock 1987). Internalizing state mandated policy into regular life is a way of adapting an aspect into their cultural life through practice, in other word the body politic shapes the social body. The higher consciousness of health and anxiety of illness are new component added to their individual body after their migration because the new social settings and political structure-the body politic- influences both the social and the individual body.

## **5 HEALTH SEEKING BEHAVIOR**

This chapter is the heart of this thesis as I address the main research questions here. In this chapter, I examine their approach to health care treatment in a changed health orientation. Discussion of this chapter encompasses their knowledge and attitude towards U.S. health care system, their learning of new health care system, and their decision making and treatment seeking.

## 5.1 Pre-migration preparation

All of my informants talked about some types of health-related preparation they took before they moved to the U.S. These include medical checkup, short/long term treatment, and stocking up medicine and other related resources. These preparations are not mandatory for them as Bangladeshi people are not mandated by the U.S. embassy for medical checkups before they move to The U.S. However, international students, including Bangladeshi students, have to provide proof of certain immunization to their school before they start school. Thus, most of the students I am in contact with, have taken necessary steps regarding immunization before their flight. But, taking preparation or precaution is common reported by all of my informants. Pavel, a 35 years old man living with his wife and daughter, put it in this way;

When I get the Fulbright scholarship to study in the U.S., I was pretty sure that I would get visa as I have never heard of anyone rejected for visa after getting Fulbright scholarship. I had plenty of time to prepare visa application and interview. I tried to talk to all my friends who were studying in U.S.A. All of them suggested me to go for a thorough medical checkup. A lot of hospitals and diagnostic centers offer this facility in Dhaka with very manageable price. I went to Medinova Hospital for my all medical examination, and I talked to a doctor after I received the report. He found nothing serious, and suggested me to take exercise to keep myself feet. This hospital also provides immunization vaccine and required documentation for the school as well. I was surprised to find out that you can get immunization record related document without even taking them. I knew corruption is everywhere but did not realize that much. However, I went for an extensive dental treatment which was really good for me. Some of my friends told me that most of the times insurance for international students does not cover dental care, and dental treatment is very expensive in the U.S.

All of my other informants also described their pre-migration medical preparation. A thorough checkup is a common activity before someone migrates. I did too, and it was really eye opening for me because my medical report showed that my cholesterol level was above the normal line. I was a little bit surprised. My father insisted me to go another diagnostic center because inaccuracy in the medical report is not a strange phenomenon in Bangladesh. However, I got a similar result in the diagnostic center. The doctor recommended me to reduce consumption

of red meat and sugar, and to take regular exercise. However, none of my informants were detected with any severe medical issues in their medical checkups and no one was ever diagnosed with any severe health problem. Still all of them and I decided to go for a thorough diagnostic examination. It was well known to everyone that the medical expenses are very high in the U.S. Getting a medical checkup was an attempt to minimize future medical expenses as much as possible, at least for my informants. I do agree with them too.

However, the most common and useful activity is dental treatment. I never observed any grownup around me in Bangladesh going to a dentist unless they had a serious dental issue, though children go to dentist frequently. One of the reason could be that there are some traditional way of treating minor dental problems, and access to medicine is very easy. Almost no medicine dispensary asks for a prescription from an authorized doctor to issue medicine; hence, all types of medicine including antibiotics are easily accessible to all. Though most of my informants never had to go to a dentist for severe condition before, all of them went to dentist for dental checkups. In fact they started their pre-migration health preparation with dental treatment because they were informed that in some cases treatment may require multiple appointments with doctor.

The last step of preparation is packing necessary medicine. Medication for long and short term health problems take up most of the of the medicine box people bring. Nabin, a 28 years old PhD student diagnosed with asthma, packed 15 inhalers in his luggage as his intension was to stay in the U.S. for at least one and half a year before he goes back home for a visit. He calculated that the price in Bangladesh is lesser than what probably he would have in the U.S. and seeing a doctor may result in additional charges. He used this particular inhaler for a long. However, he changed his inhaler and currently using an American one which he said more

effective. Usually antibiotics occupy a good portion the medicinal package. That includes Cefuroxime, Levofloxacin, Azithromycin, and some other antibiotics that are useful for sustained cold or fever problem. They knew that without prescription drug stores are not authorized provide antibiotics to their customers, thus packing up antibiotics as much as possible is an attempt to minimize medical cost in the U.S. as much as possible. Familiarity with the medicine also creates comfort and at the same time it is easier for them to consult Bangladeshi doctors over phone or skype if they have a variety of known medicine available with them. Some other common used medicine for minor issues like cold, fever, headache, toothache, gastronomical problem are also part of that. A couple of pairs of eye glasses are also necessary part in the list of health resources of those who have eye problem. It is understandable as the price of lenses and frames in the U.S. is far higher than that of Bangladesh.

However, economic considerations are not the only aspect underpinning their pre-migration health preparation. The fear of unknown place is also a major factor. Nabin mentioned that before coming to the U.S., no matter how much you brows about U.S. health care system or how much you are informed though other people living here, the unfamiliarity of the new place and system creates a kind of anxiety among migrants. Equipping themselves with necessary resources, especially medicine is an attempt to reduce health related anxiety, at least, until familiarizing with the U.S. health care system.

## **5.2 A new place, a new health setting**

The way we imagine or anticipate a new place with our imagination, with little or no information in hand, or the experience we expect in a new place before we moving there, is in some cases fundamentally and in some cases, superficially different from what we actually observe and face there. Attempting to know a place through secondary sources like, books,



pictures, motion pictures, or other media is always incomplete. I had some preconceived ideas about the U.S. through these types of sources, but when I re-explored the same ideas after coming here, I realized the difference of my understanding—like the difference between reading an ethnography and living in an ethnography.

Like my other informants, I found the health care setting fundamentally different from what people have in Bangladesh. The essence of health insurance and the complicity it incurs in understanding it and in seeking treatment, is utterly a unique experience for Bangladeshi people living here. Health insurance service is still in its incipient stage in Bangladesh, though it emerged a long time ago. Thus, the presence of a new system significantly influences the health seeking behavior of them after migration. The process of seeing a doctor and getting medicine is also very different here. As in Bangladesh, biomedicine is most dominant and prevalent therapeutic options, though unlike Bangladesh, the other treatment options are less apparent in the U.S.. Baer (2004) argued that the stratification of the society mirrors the stratification of medical systems. This statement is fully applicable to Bangladesh. The health care system in Bangladesh is pluralistic with diverse healing methods, knowledge, belief and practice. Health care is provided in different levels in Bangladesh; self-care, care from non-practitioner who has some medical knowledge, paid and unpaid practitioners without license, and care from professional practitioner in formal settings (Homlan and O' Connor 2004). People here go through a different procedure while pursuing a treatment in biomedical setting. Jamil characterized process of seeing doctor and access to medicine as the main difference in the health care setting of Bangladesh and the U.S. He explained:

The availability of doctors in different level is the biggest advantage of Bangladeshi health care systems. You can go to a government hospital though there is a dearth of doctor and proper facilities. If you have money you can go to private hospitals, health clinics, and medical centers. Every street, especially in cities, has medicine dispensary

with doctors, though most of the time you will see less qualified or unqualified doctor. For minor issues you don't have to go to a hospital. Hospitals are only for severe issues. People can consult a local doctor or sometimes they consult with the doctors within their social network over phone to consult a situation. You can go for other options as well like homeopathy, herbal medicine or other healer. Your socio economic condition sometimes define your selection. But here, if you have an insurance you must go to your primary doctor first unless there is a severe emergency. Access to medicine is also strictly maintained here, which has both negative and positive consequences. In Bangladesh, you can buy medicine even without prescription.

The access to medicine and doctors is the main difference between two health care system, and most of my informants consider the health care system of Bangladesh to be more convenient as people have more freedom to select options and seek treatment. However, the quality of treatment and facilities provided here are way better than what they received in Bangladesh. Jamil and Pavel stressed that if someone has good insurance coverage he should seek treatment in the U.S. because of the expertise and professionalism of doctors and other medical stuffs.

Familiarizing oneself with a new place and system is a prerequisite of new life, and social networks are the main guides in this procedure. I started communicating with people through social media, in fact, before moving here. I thought it would be better to befriend few people so that I can have some people to hangout. I did not realize the necessity of social networks until I came. People of the diaspora are the first teacher in the abroad life. They know what a new comer exactly needs in a new place. There are other ways of being familiarized with a new place, in fact browsing on the internet may provide tons of information; nonetheless talking to someone from one's own country is more helpful. Their teaching is not only about where you will get necessary things but also what you actually need. When I went to grocery for the first time here, my friend took me to all the places that he considered useful for getting basic things. He explained me what to buy and what not to buy. I was more eager to buy only Bangladeshi food

ingredients and later realized why he insisted me to mix my food items with other ingredients too. Bangladeshi foods are comparatively costly than some other available food.

The health care system of the U.S. is something that may baffle someone who comes to this country for the first time. When I first arrived, I gained some knowledge regarding the health care system through the International orientation program of Georgia State University, which focused on the procedures of seeing/consulting a doctor/nurse and getting required medicine. It also talks about the insurance policy and its benefit which I found bewildering. Mostly what I understood was that I have to pay 20% of my treatment expenses. I was fortunate enough to have few wonderful Bangladeshi people around me, and I turn to them when it comes to learn something new about U.S.A. What they said to me about insurance is more pragmatic than that I heard in the orientation for international students. Their suggestion was try to avoid seeking a treatment as much as possible since the insurance is confusing and full of loopholes that make it hard to approximate your treatment bill beforehand.

Munnah also underscored the importance of social network in getting accustomed with new health care system. I was going with him in his car to a tennis court where we play cricket, as cricket is not well known game here in USA there is no cricket field in Atlanta, as far as I know. This is how people meet new Bangladeshi people in Atlanta. Getting an opportunity to meet people is always beneficial for both the person the diaspora, Munnah told me while we were about to reach the field. I saw few new faces there and I assumed they are from Bangladesh. They were talking about the process of getting a driver's license, and later about the price of cars and where can they get good deal. This is what happens when a newcomer is surrounded by people who are experienced.

The transnational network is very crucial in the process of familiarizing with the new social settings and health care system. This process is, in fact, started before migration when people decide to move to the U.S.. The pre-migration preparation is a response to the knowledge about health care system that they gained from their social network-in Bangladesh and the U.S.. After migration, the network extends from diaspora to place of origin. Their Bangladeshi network helps them to find community members in the new place, and at the same time the diasporic people also helps them expand their network by introducing them to new people in the community. This extended transnational social network play a significant role in the whole treatment procedure.

### **5.3 The perception of disease/illness**

There is a difference between feeling unwell and feeling unwell enough to see a doctor. Understanding the degree of feeling unwell is very crucial in making decisions about whether to see a doctor or not. As seeing a doctor is not easy for people, especially those who do not have full coverage, people tend to be very strategic while making decisions. Identifying the health problem is the first crucial decision to make.

First of all the environment and health orientation of the U.S. is fundamentally different, and illness is culturally structured. In a new society the illness pattern and method of treating illness can be different. In Bangladeshi health orientation, fever, common cold, flu, dysentery, diarrhea and stomach-related illnesses are very common minor health issues. Tuberculosis, diabetes, and cardiovascular diseases are emerging threats. For minor issues, people do not bother much as they know what exactly they need to do. Sometimes they do not go to a doctor, as they learned from their previous experience what medicine to use. A medicine box, Jamil said, is a part of Bangladesh home which is an amalgamation of all necessary medicine required for

the whole family. This medicine box is created on the basis of the illness history of family members. However, in the U.S. they are exposed to some other, sometimes similar, health issues. Flu is a common problem they face, along with cold and fever, especially in the winter months. Tuberculosis is not an issue here, in fact as Jamil mentioned, none of his family member or other people he knows never had tuberculosis but he knows tuberculosis is a massive threat in Bangladesh. Part of the reason, he explained, is the attempt of GOs and NGOS to spread awareness through media. Billboard, newspaper, TV programs, posters and other tools are used there to spread information about common health treat of Bangladesh. But in the U.S., bipolar disorder, schizophrenia, and other health issues are advertised in TV, billboard, and newspapers, which is very uncommon in Bangladeshi media. But it does not imply people do not suffer those problem there, may be they don't talk about those issues. Thus, the illness patterns are different in the U.S. which define the medicine box as well.

However, the terminology related to disease and illness are different as well. According to Jamil:

There is lay nomenclature of illness in Bangladesh, even professional doctors use lay terms to explain disease/illness. There is difference between dysentery and diarrhea according to biomedicine, but all these together known as “stomach problem”. However, everything has a separate name here and there are few issues that you never think of a health issue before, like Bipolar Disorder. I got curious when I first heard this name and I tried to learn about it by myself through internet. There are tons of information available about it. However, one thing I realized this world is full of diseases. We knew a little about it when we were in Bangladesh because we are already inflicted with some serious threat and we don't have the luxury to talk about Bipolar Disorder. This is not life threatening like tuberculosis and cancer.

Jamil's words underscore two major points; the experience and understanding of illness is shaped by culture, and prevalence of disease in a society is contextual. Undoubtedly, the perception of illness is not universal rather than culturally specific. Illness may imply diverse

conditions cross culturally. The terminology, etymology, narratives of illness are not similar everywhere (Soho 2004). At the same times, the difference between the types of diseases prevalent in Bangladesh and the U.S. demonstrates the structural issues of both nations. Bangladesh is still struggling with structural violence which is, according to Farmer (2001), responsible for the unequal distribution and outcome of infectious disease like tuberculosis. But that does not mean the U.S. does not have major health issues. The range of health issues that health care providers deal with every day may not be less than what people have in Bangladesh. In fact, there are a number of health issues found in the U.S. that may not be a serious concern in Bangladesh. This is how the body politic works differently in different societies. Foucault (1975, 1979) mentioned the proliferation of diseases categories and associated medicines is an attempt to narrow the definition of “normal” and enlist majority of people into the sickness group. In this way, the individual body is disciplined and controlled through biopower.

#### **5.4 The anxiety of illness**

Do we feel the same level of apprehension if inflicted with disease while in home and while in unknown place? This was a common question I asked all my informants during my interview session. The reason I included this question in my questionnaire is I personally feel differently about sickness here. I observed my roommate suffering injury and a following cumbersome medical bill which he has not paid yet. As an international student I am not fully covered by insurance and co-payment is still high (20%). Besides, dental care and eye care are not included in the insurance coverage. Altogether, the financial burden due to a medical treatment can be unbearable.

Like me, others responded in the same way too, though most of them have better insurance coverage than mine. Health insurance is a tricky business as Jamil explained;

My whole family is covered by insurance. My insurance is covered by my employer. My wife and kids have insurance too, and I pay different amount of money for insurance premium for each of them. There is term in economics, “moral hazard”, means when you are ensured of something you become reluctant about that. Like if you have insurance coverage of your laptop you will be less careful handling it. But in case of health, though I have full coverage I don't feel secured. There are a lot of loopholes and complicacies in the insurance policy. I always want my kids not to be sick on weekends because their insurance coverage don't allow them seeing a doctor free on weekends. But in the weekdays I don't have to pay to see a doctor for them. There is a huge difference between your sickness and your kids' and wife's sickness. When you suffer something at least you can understand whether you need to see a doctor immediately. At least you can wait and observe. But when it comes to them you cannot wait because what seems like a simple cold may turn out to be pneumonia or anything else. If it requires antibiotic medicine you need a prescription from doctor. The whole process is time consuming, from seeing and doctor to getting medicine. There is no way you can wait. So, you are paying for insurance, sometimes doctor fee, and good portion of medicine bill. When you are seeing a doctor for yourself, the amount is very close to that as well. The economic burden is always a concern.

The anxiety of a medical bill is associated with a sickness, though not for all. Adnan, an engineer living here in Atlanta for more than five years, didn't feel the same way. He had, according to him, excellent insurance coverage through his company. He gets his medical checkup every year though he does not suffer any major health issues, except once he had an arm injury. The amount of money he earns and his insurance coverage explains a lot about his lack of anxiety regarding medical bill. However, what Adnan worries is the lack of support group.

A support group or therapy management group is always available when somebody is suffering illness/disease/injury in Bangladesh. This group encompasses family members, relatives, friends, neighbors, and so on. During suffering period and post suffering period a group is available to help take care of the person. But people who live here without family members, and when other people in the diaspora are too busy to help, sickness creates an anxiety due to lack of support group. When Adnan broke his arm, he constantly feel the lack of support group as he had to do other household works alone, which was really painful for him.

The anxiety of financial burden and lack of support group does not exist only when somebody is suffering, it can be a constant feeling in the U.S. life. This fear, both consciously and subconsciously, guides people's behavior as well. Consciousness of diet (I discussed it in the previous chapter), extra protection for cold weather, extra safety during driving, and other health safety measures are common behavioral issues are reported by informants during their interview. However, no one during the interview session characterized their life in Bangladesh as carefree, but the degree of consciousness of health is higher in their life in the U.S.

### **5.5 The diagnosis of health problem**

Typically seeking treatment starts with identifying the severity of the illness. The perception of severity is also variable. The difference between feeling unwell and feeling unwell enough to see a doctor is very crucial in decision making. Sometimes previous experience helps to decide what to do. Recognized symptoms sometimes help in measuring the severity of illness. The knowledge of previous health history or family health history are conducive to understanding person's vulnerability to a disease. This process is known as "lay epidemiology" (Davison et al. 1991). When there is a fear of economic burden and lack of support group, this method is useful, initially, to grasp the health condition. However, in the case of unfamiliar symptoms people may talk to other people in the network to discuss the health problem to find out the severity of the problem. This network may include people from diaspora, place of origin, or people from other community. In other, the transnational therapy network (Krouse2008) is involved here in diagnosing the issue.

Jamil usually calls his brother, who is a doctor living in New York, to discuss his condition, and based on his recommendation he decides whether to see a doctor or not. But there are people who do not have a doctor in their U.S. network. For Pavel, whose sister and brother-



in-law who are practicing physicians in Bangladesh, and decision making is largely influenced by them. For minor issues, doctors from outside Atlanta who do not get a chance to observe the symptoms make suggestions on the basis of the description provided by the patients. In most cases, they are well aware of patients' medical history as they are somehow related by family bonds or friendship which helps them to understand the situations. Sometimes, lay persons within the diaspora help determining the severity as well. In this case their experience is diagnostic tools. The person or the group of people involve in the diagnosis, what Phil Brown (1995) termed as lay diagnosis group, play a crucial role in the primary state of treatment seeking procedure.

However, when it comes to the sickness of children, their parents do not takes any risk relying on lay diagnosis group. Both Pavel and Jamil have kids and the health seeking procedure of their kids are different from their own. Pavel explained, he does not usually see doctors unless there is an unbearable problem because a regular appointment with doctor may cost 25 dollar and an emergency may cost close to 150 dollar. He is willing to wait couple of days to better understand his symptom. But he never wait if there is a health issue with his daughter.

Assessment of medical cost is also part of the decision making. The most significant concern regarding a treatment is the cost. Due to the complexity of the insurance policy, it becomes difficult to assess what a treatment cost would be. Sometimes it becomes very frustrating when the assessment is wrong and one has to pay more than the anticipated money. Munnah's mother, who lives in Florida with her another son, came to visit Atlanta in the last week of December 2015. She accidentally slipped in the pool which caused a leg injury. She had Medicare coverage as she is over 65 years. It turned out that she was not eligible for the facility

of Medicare in Atlanta which eventually raised the cost of the emergency treatment.

Understanding one's insurance policy is pivotal in decision making regarding treatment.

The initial diagnosis of illness and assessment of cost engage a collective work unless an emergency situation which requires instant step. In both processes, multiple people, from Bangladesh and the U.S., are engaged. Their initial job is to help the patient make a cost effective decision. This group can be a support group in the entire process of the treatment, from the decision making to post treatment supporting. However, some of them may only involve in lay diagnosis and assessment of cost. In some cases, some other people may involve in the rest of the stages of treatment. Pavel said, the very first time he saw doctor he went with his elder brother's friend whom he never met before. Unfortunately that person left Atlanta few months later and Pavel is not in communication with that person anymore. When it comes to transnational therapy network, Krouse (2008) characterized it as ephemeral, which is active in the treatment procedure but in other times the group may quiescent. The reason behind the dormancy of the group is that it contains people not only from family and relatives but also other people from community who may not be permanent member of Atlanta diasporic community. Diaspora is a dynamic community where the members are refreshed periodically due to interstate migration or international migration, which reflects the changing nature of diaspora.

## **5.6 Seeking treatment**

Upon the assessment and lay diagnosis, patients move forward to the next step of their treatment seeking. Though U.S. health care system is not as flexible as Bangladeshi health care system people somehow managed to create multiple therapeutic options for their treatment. I split this section of discussion into four parts and each of those describes treatment procedures of each therapeutic options.

### **5.6.1 Biomedical system**

Treatment within the biomedical system, the dominant of all healing methods in the U.S., is the most prevalent therapeutic options available in the U.S. A number of factors influences decision of seeking this options. In case of emergency- like severe injury, life threatening conditions, and something that lay diagnosis cannot figure out- biomedical system or formal treatment is the ultimate choice. And of course, when it comes to children, their parents do not take any risk. They immediately either call doctors or go to emergency. In the emergency situation, lay diagnosis group is inactive and the decision, which is not a collective one, making is very prompt. The therapy management group eventually emerges in the procedures, though they may not impact the initial decision making. Arranging this group is one of the toughest challenges in this method. The injured or afflicted person may in need of constant care after releasing from hospitals. Sometimes this group is arranged beforehand and sometimes after the hospitalization.

Pavel and his wife, Tanni, planned for months when they decided to have their baby. One of the main concern of they had was who would take care of the mother and new born child as both of them were PhD students that time. They decided to bring Tanni's mother from Bangladesh after 28 weeks of the pregnancy. As Pavel has to spent a great deal of time in the university, they thought a person was needed constantly beside the mother and the new born child. Besides, their friends in Atlanta paid regular visit whenever they got time to support them. Jamil also arranged his support group beforehand. In his case he took his wife to New York, in his brother's house, few months before they had their second baby. Jamil already had a three years old son, and according to him it was immensely difficult for him to manage everything. He talked to his brother who insisted him to bring them in New York. Jamil's sister in law was a

home maker who helped a lot throughout the procedure. Even, Jamil was unable to present at the time of birth of their child as he was in London for professional purposes and unexpectedly the boy was born early and doctors had no clue this might happen, but his wife's water broke suddenly.

However, Nabin, my ex roommate, did not have any family member in his therapy management group during his sufferings. He called 911 immediately after his accident, other people around him came to know later. He stayed in the hospital for two days before he released. Next twenty days was very challenging for him and his apartments as well. All other friends in the apartment had to take care of him. They helped him in every activities of regular life, from putting paste on his toothbrush to making bed.

### ***5.6.2 Seeking treatment from Bangladesh***

The therapy management group is perceived as group of people that are visible around the patient in the whole process of treatment. However, in transnational health seeking, when taking treatment across the border, the involved people may not be limited to them who are physically visible around them. Rather a range of people-from diaspora and place of origin- may involve in the process. This is what Krouse (2008) characterized as a transnational therapy network. When somebody is seeking treatment in the U.S. hospital, family members, relatives, and friends from home may also play a role; providing mental and financial support. But in case of seeking treatment from Bangladesh, network in both host and home country play a key role.

Typically the lay diagnosis group, which may be the part of the overall therapy management group, contributes to the assessment of severity of the illness/disease and medical costs that hospital may cause. People who play a role in the lay diagnosis includes people from both the U.S. and Bangladesh. However, the calculation of anticipated medical cost is usually

conducted by people of diaspora, especially those who have been living here for a while. But the decision making regarding selecting a therapeutic options is collective. Most of the time, this group includes a Bangladeshi doctor whose role is very crucial. Other than emergency situation and any health issue with children that I discussed earlier, people usually wait for few days to let the lay diagnosis group observe the pattern of the symptom. Their experience and knowledge (expert or lay) are important tools in measuring the severity of the illness. The next step is seeking treatment or doing nothing at all.

All of my informants stated that they have doctors in their social network who are the first point of contact in case of a sickness that they, by themselves, are unable to understand. For minor fever or cold that lasts for three to four days are not an issue to discuss with other people. But if that sustains for more than that they usually consult with Bangladeshi doctors, in Jamil's case his brother who practices in New York, to understand the situation. All these doctors are either family members, relatives, friends, or physicians who are familiar with their medical history. In fact, few of them know what types of Bangladeshi medicines are available in their patients' medicine box because they helped in making the list of medicine that traveled with my informants in the U.S.. Skype and phone call are main way of communication between them. Based on their symptoms doctors prescribe what to do next. If they are unable to understand due to long distance or if they observe a serious issue they immediately recommend patients to see a doctor in Atlanta. On the other hand, if the symptom is understandable they usually ask their patient to take Bangladeshi known medicine if that is available in their medical stock.

However, their diagnoses were not always accurate and sometimes may be counterproductive. Saikat, one of my informants studying at Georgia State University, has been living in Atlanta for three years. Initially he came as an immigrant later he changed his status as

an international student. During his time as an immigrant, he did not have insurance coverage. Just after one month of his arrival he started feeling feverish for three days with, what he described as, sharp chest pain. He talked to his parents, who were in Bangladesh that time. They arranged a skype conference with Bangladeshi doctor who recommended Azithromycin, an antibiotic used for sustained fever. Saikat had that in his medicine stock, and he took that medicine three times a day for 3 days but observed no amelioration of his health. He started to feel the anxiety, and subsequently discussed his situation with Pavel and Jamil who lived in the same apartment community. They took him to hospital and doctors learned that he was having pneumonia.

When it comes to dental issues and eye care, treatment seeking is predominantly taking place in Bangladesh, chiefly because of their insurance policy. Except Jamil and Adnan, none of their insurance cover dental and eye care. All of my informants reported that they had dental and eye checkup before they migrate and whenever they visit Bangladesh dental treatment/checkups and eye checkup are in their “things to do in Bangladesh” list. Biplob and his wife usually visit Bangladesh every December in the winter break. Biplob had serious dental problem and suffered a lot. Dental care in Bangladesh is cheap compare to the cost of dental care in the U.S. Though one may have dental insurance but the fear of copayment is always there. Thus, he decided to get treatment from Bangladesh. However, Jamil has dental insurance which cost his \$70 per month but he never sought any dental treatment, and he planned to avoid as long as possible. Adnan had taken dental treatment in Atlanta without knowing the implication of copayment. His insurance policy did not cover all types of treatment and he ended up with the liability of \$500. Adnan’s story demotivates Jamil to seek dental treatment. Jamil was waiting for his next trip to Bangladesh and he kept dental insurance in case of a dental emergency because he had sporadic

toothache but not unbearable enough to seek treatment immediately. But he felt it could be a serious problem.

### ***5.6.3 Seeking alternative medicine***

Medical pluralism and the use of alternative medicine are becoming increasingly prominent in the United States today. In a national survey conducted by the Journal of Women's Health, more than half of the respondents used complementary and alternative medicine as a supplement to conventional medicine (Wade et al. 2008). For Bangladeshi transnationals, using alternative medicine from Homeopathy, Ayurveda, Unani, and other healing methods is not unexpected as alternative medicine are widely used in both urban and rural Bangladesh. All of my respondents acknowledged that they used alternative medicine several times before they migrated. The cost of seeking alternative methods is very low in Bangladesh which makes it more popular among people. However, none of them described alternative medicine an effective option for serious health issues. They did not use or saw other people around them using alternative medicine for serious problem. I do not agree with that since my English teacher in primary school suffered cancer for years and used homeopathy medicine till his last day. In fact seeking multiple options at a time for the same illness is also not considered strange in Bangladesh.

However, the health care system in Atlanta is fundamentally different from Bangladesh. I have not seen a formal Ayurvedic chamber or homeopathy center in Atlanta. But I am informed that there are few practitioners of homeopathy and Ayurveda available in Atlanta, but all of them are from India and Pakistan where these methods are prevalent too. Only two of my informants reported that they still use alternative medicine but none of them saw an alternative medicine

practitioner here. They did not want to reveal the health problem they were suffering. However, they mentioned they carried homeopathy medicine from Bangladesh.

Apart from that, massaging chest with hot mustard oil and garlic paste in case of cold, a homemade drink of lemon, hot water, and honey in case of fever, use of turmeric paste for minor cut in the body and treating acne, and some more methods are so commonly used in Bangladeshi daily life that people don't think of them as alternative medicine, rather using of common sense. These methods are to some extent similar to Ayurvedic method but the use of these are more cultural behavior than seeking treatment. This health knowledge and use of these methods are passed down in families and cultural groups, not necessarily from an Ayurvedic practitioner. Very often, especially in the weekends, Jamil drink a cup of lemon squash with honey. He adopted this habit from his father who was very insistent during Jamil's childhood to drink this. Jamil added, it refreshes his body but he cannot drink it more often like he used to do before migrating.

### **5.7 Structure of treatment seeking**

The complicated nature of insurance is one of the fundamental features of the U.S. medical system that Bangladeshi medical system does not have. The public health care in Bangladesh is, by constitution, available for all though the number of the public hospitals are not adequate enough to meet the need, and facilities provided in every hospitals are not up to mark. Decision making regarding health care treatment is highly influenced by this factors. Undoubtedly, for transnational Bangladeshis the concept of health insurance is new. In Bangladesh, typically, a part of the salary is always preserved for emergency, including health catastrophes, for family members, and of course the amount varies from family to family. Economic consideration is an influential factors in health care decision making in both



Bangladeshi and the U.S. life for transnational. Bypassing an excessive expenditure for treatment is identical in both cases, though method of bypassing is different. Seeing alternative medicine in Bangladesh has also something to do with financial issues as all of my informants described those healing methods as affordable for all. The economic consideration, probably, intensified in Atlanta due to the cost of medical and living expenses.

Choosing therapeutic options from a pluralistic medical system is common in Bangladesh. The available medical system in Atlanta is not visibly as pluralistic as Bangladeshi medical system. Comparing to Bangladesh, there are fewer alternative medicine stores in Atlanta. However, transnational Bangladeshis somehow manage to create more options which is possible because of their transnational identity. Seeking treatment in Atlanta through biomedicine, alternative medicine and seeking treatment from Bangladesh in person or over phone call/skype provide more options for a patients. Of course selecting option/s in shaped by the severity of the illness.

The involvement of a group of people in the whole procedure, which I discussed here as therapy management group, is also a typical Bangladeshi decision making. In this case, the group encompasses a social network that extends from host country to place of origin. The decision making is collective which reflects the fundamental cultural behavior of Bangladeshi people. A health issue is discussed and negotiated within a group. This group contributes in the whole process of treatment- diagnosis, mental and financial support, takin care of the patient, and other issues necessitated by the illness. This practice is adopted from Bangladeshi life. Jamil mentioned that U.S. health care system fosters individualism which encourage taking responsibility of your own health, increasing health literacy (of course of biomedicine), making independent decisions, relying on hospitals and doctors. In contrast, the transnational

Bangladeshi community demonstrates dependency, or perhaps collectiveness and cooperation, in the treatment seeking and decision-making. Janzen (1987; 76) stressed, “[t]herefore, to understand the therapy management process, one must examine the cumulative, microhistorical character of social relations and personal exchanges.”

However, other types of crises may not entail consultation or involvement of a large group. Thus, this group is not a social support group who are involved in every issue. Krouse (2008) characterized the nature of this type of group as “ephemeral.” It activates during the sickness and remain dormant at other times. However, I argue that a part of the group is ephemeral who participates in the diagnosis or assessment procedure and remain uninvolved in the rest of the procedure. The Bangladeshi doctors may not be involved in the rest of the treatment procedures. A therapy management group includes not only people close to the patients rather people who may actually contribute in the procedures by providing information and support. But people are very selective in choosing people to discuss other issues of life. However, stigmatized disease may not engage a large group of people into the treatment management, rather only limited close people-such as parents or siblings-are involved only. Two of my informants were seeking alternative medicine, but they did not want talk about the health problem they were having. Thus, the values associated with disease or the perception of illness and disease is also a crucial factor in determining the role of the therapy management group.

## 6 5CONCLUSION

The continuous exchange of ideology, resources, methods, and technologies among nations is a hallmark of globalization. Especially in the arena of health care system, the exchanges are well evident, though one can characterize the exchange as mostly “one way”. The dominance of biomedicine all over the world substantiates this statement. It impacts other healing methods, by replacing or obliterating them. However, still other methods are visible, probably not as prevalent as biomedicine or the way they used to be previously. Other indigenous methods of healing are carried to the place of origin of biomedicine as well, though they are not dominant in those places. Therefore, the health care system all around the world is not monolithic rather an amalgamation of different approaches.

Transnational Bangladeshis- whom I define in this research as first generation Bangladeshis who maintain connections with both host society and place of origin, belong to the stage of liminality, and mobile between nations-come from a different social, political, and cultural environment. They are not fully acculturated into the larger U.S. society and neither they maintains a strict boundaries with other community. Throughout the thesis I tried to explore their perception of health and health seeking behavior which, I assumed beforehand, would be different from that of Bangladeshis.

The new structure of the U.S. society, especially in the health care system, impacts their perception of health and health seeking behavior largely. The health care system in the U.S. is fundamentally different considering the cost of treatment, insurance policy and complicity, access to medicine, and less prevalence of alternative medicine. All of my informants demonstrated higher consciousness of health after migrating to the U.S. They acknowledged that

their food preference and food habit pattern are changed after migration. The social network in the U.S. influences, significantly, their food preference. People are more aware of the nutritional value of their food and their consumption tends to make a nutritional balance. This new way of thinking about food or the degree of consciousness about food is adopted after migration.

Besides, the increase of health literacy and more access to health information make them more aware of their health. They learned more about their health after coming to the U.S. because the patients-doctor relationship is different here. Doctors in the U.S., according to my informants, more friendly and willing to explain health condition of patients rather than just prescribing medicine which most of the Bangladeshi doctors used to do in Bangladesh. In addition, the complicacy of the insurance system and the fear of financial encumbrance generate an anxiety among them which encourages them to be more concerned about their health. The low knowledge about insurance, which is understandable because insurance system is not prevalent in Bangladesh, and inability to calculate the treatment cost beforehand largely account for the higher consciousness due to anxiety. Moreover, the absence of constant support group, which they used to have in Bangladesh, is also a dominant factor here. Most of my informants come from extended family where a number of people are always available to help each other during any types of sufferings. The void of family members, relatives and friends, thus, pushes them to be more aware of their health.

In terms of health seeking behavior, there are both similarities and differences between Bangladeshis and transnational Bangladeshis. Their pre-migration preparation- including medical checkups, stocking Bangladeshi medicine, seeking short or long term treatment before migrating- implies their anticipation of different health care systems and fear of new unknown system. Despite the U.S. health care system is not as pluralistic as Bangladeshi health care

system, people somehow create multiple options for seeking treatment; seeking biomedicine, alternative medicine, seeking treatment from Bangladesh physically or over telephone/skype. However, the context of the illness and disease is very crucial in deciding which path to follow.

In every steps of the treatment seeking a group of people-discussed as therapy management group in this thesis-is involved, from the lay diagnosis of the illness to post treatment support. The health seeking decision making is collective rather than an individualized (which typically a character of U.S. culture). The group engages people from both host and place of origin which expands the network from The U.S. to Bangladesh; a transnational therapy management group.

The significance of this research is it would be a pioneering work investigating the health seeking behavior of transnational Bangladeshis living in the U.S. As I mentioned earlier, Bangladeshi transnational community, though currently consume only a small portion of the immigrants group, is expanding especially after 2002. This research contributes to understand this unexplored group's approach to deal issues. However, the significance of this research is not limited to a particular group. This research can provide an insight into other immigrant communities, especially whose pre-migration health seeking behavior is different from a typical U.S. citizen.

The aim of this research is not to close a book, rather introduce a new group into the discussion of medical anthropology. Instead of drawing a conclusion, I would like to introduce more research questions pertinent to this group. Georgia, New York, Washington, and California accommodate most of the Bangladeshi migrants. It would be interesting to investigate how transnational Bangladeshis in other places, with limited Bangladeshi social network due to lack of Bangladeshi people around them, negotiate health issues. Another intriguing issue would be to

look into health seeking behavior of the people who move back to Bangladesh after living a significant span in the U.S.

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