

# Health of Migrant Workers; A Matter Of Concern

Faisal Abdul Latif Alnasir

## Correspondence:

Faisal Abdul Latif Alnasir FPC, MICGP, FRCGP, FFPH, PhD  
 Professor of Family Medicine  
 Chairman; Dept. of Family and Community Medicine  
 College of Medicine and Medical Sciences  
 Arabian Gulf University  
 Former president; Scientific Council for Family &  
 Community Medicine of the Arab Board for Health Specialties  
**Email:** faisal.alnasir@gmail.com

## Abstract

Over the past few decades, mobility of people around the world has been incrementing, from about 82 million in 1970 to 200 million in 2005. It customarily transpires to both developed (which is the majority, 60%) and developing countries for a more preponderant life opportunity. The most astronomically immense migrants were found to settle, in Europe followed by Asia and North America. In 2000, the European countries received 56.1 million migrants, Asia 49.9 million, North America 40.8 million and Africa 16.3 million.

The Middle East, and in particular the Gulf countries (GCC) have had a tremendous influx of migrant workers (around 16 million, the majority, over 80%, were from Asia) due to its rapid development as reflected by marked increase in oil revenue. It is reported that over the past 10 years almost seven out of every ten members of the workforce in the GCC were foreigners.

Health issues impacting migrant workers are intricate and numerous, especially, when some host countries perceive these workers as exploitable, frugal and flexible labor. Despite that most of them work in 3D jobs; Dirty, Dangerous and Degrading.

They usually have poor living and safety conditions and the prominent consequential factor leading to their health disparities is the cultural differences affecting their health care seeking patterns, perception of health and compliance with treatment.

In this review article the health quandaries of the migrant worker in the GCC countries and factors playing in worsening those conditions, are elaborated. Withal we endeavor to find how to compact such health issues for the benefit of both the workers and the nation.

**Key words:** health, migrant workers

Review

Mobility of people around the world is perpetual and has never ceased since archaic time. People kinetically circumnavigate for many reasons, but economic factors and probing for a more preponderant life and future shape the most consequential issues for such acts. It has been estimated that three percent of the total world population peregrinates to other countries while the international mobility over the past four decades has doubled, incrementing from 82 million in 1970 to 200 million in 2005 [1].

For migrants who travel abroad for working purposes, the story is the same. Albeit, their number has been reported to be perpetually high, during the last century it has risen sharply due to rapid worldwide development. About 105 million people peregrinate abroad to work annually. Although, such migration occurs in both the developed and developing worlds, the majority (around 60%) settle in the developed countries. It was reported that the most immensely colossal single majority of migrants has settled in Europe, followed by Asia and North America. In 2000, Europe received 56.1 million migrants, Asia 49.9 million, North America 40.8 million, Africa 16.3 million, Middle East 16.00 million, Latin America 5.9 million and Australia 5.8 million migrants[1], (Figure 1). However, The United States is still considered to be the most attractive place for many migrants around the world.

Migration is not constrained to certain sectors or nationalities but it occurs from virtually all countries, in particular poor nations. According to the Philippines Overseas Employment Administration (POEA) more than ten million Filipinos have left seeking for jobs because of high unemployment levels in their country, of whom, the majority went to the Arab world (around 200,000 in Saudi Arabia alone)[2]. And the Filipino emigration towards the Middle East has grown by 29.5 per cent between 2007 and 2008[2].

In addition migration is not limited to a certain gender as women today are found to represent around half of the total international migrants worldwide. Eighty three percent of all domestic workers in the world are women. And the percentage of women’s employment in particular in Europe is increasing as betokened by the third European survey on working conditions[3].

Due to the economic boom during the last fifty years, the Middle East (ME) in general and the Gulf Cooperation Countries (GCC) in particular, have attracted many migrant workers from all around the world. Studies reported that in the 1980s, over 80% of these countries’ workers emanated from Asia (of whom 20% were Indians) and almost seven out of ten of its workforce are foreigners[4,5], to the extent that 90% of all workforce population in Qatar and the UAE alone, are expatriate[6] (Figure 2).

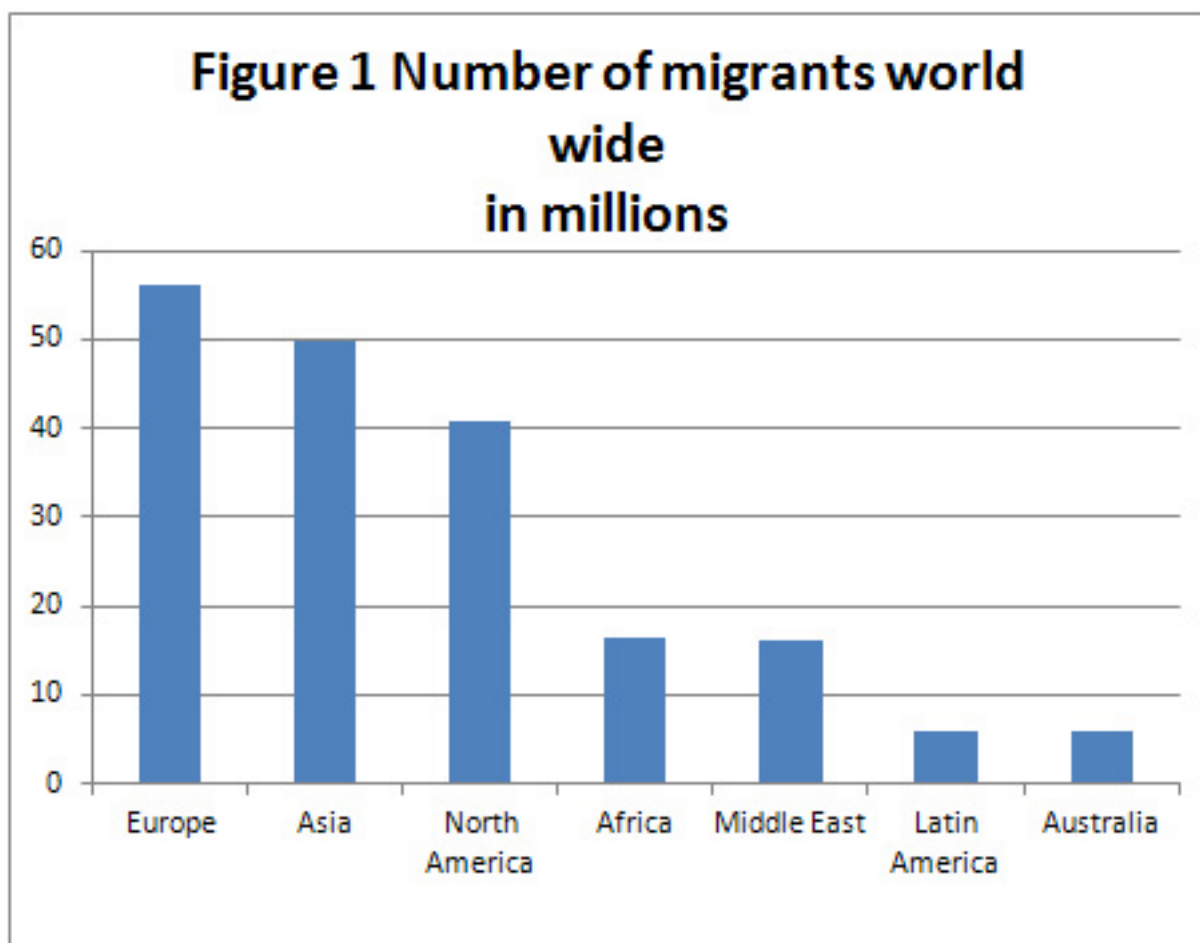
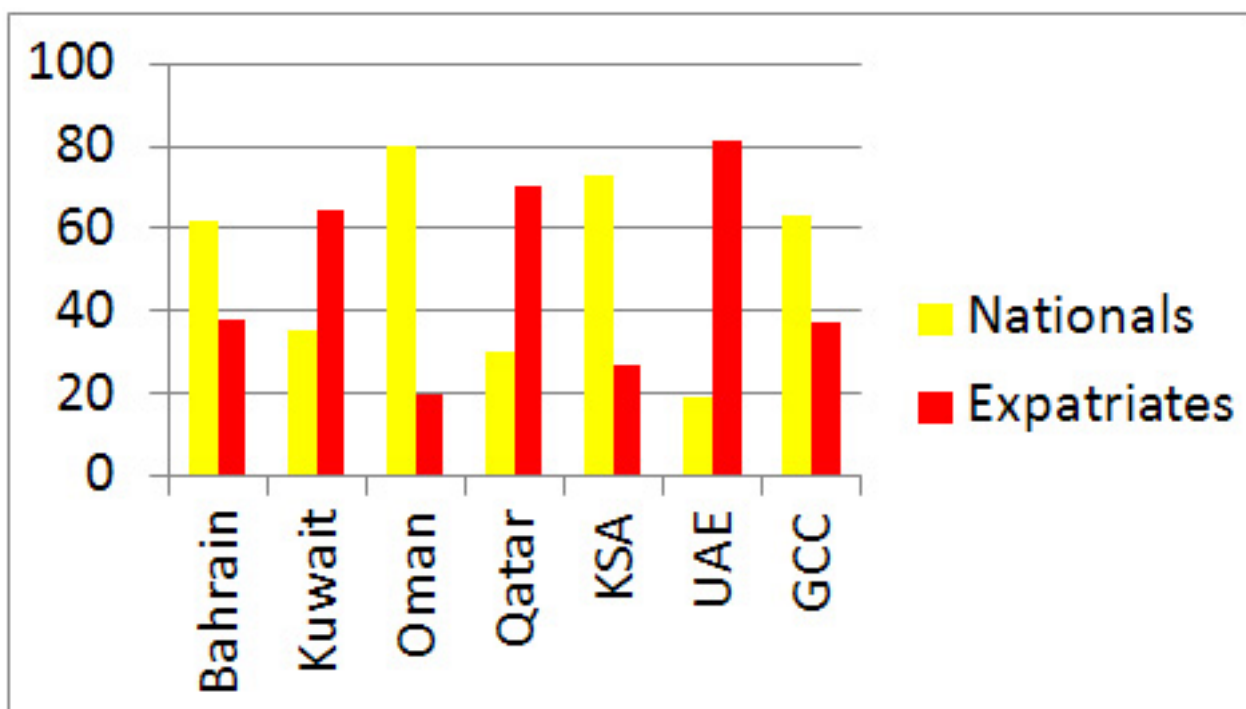


Figure 1



**Figure 2**

Andrzej Kapiszewski in his study in 2001 while illustrating the GCC migrant workers' nationalities denoted that in almost all of these countries, Indian formed the majority[7]

Despite the fact that the contribution of the immigrant workers to the host country's economy can't be estimated, it is unfortunate that in many instances they are perceived as exploitable, frugal and flexible labor, and therefore employed in 3-D jobs: Dirty, Dangerous and Degrading[8]. Kawon et al., (2011) reported that these migrants are often depicted as an encumbrance on society[9]. Hence they face earnest health quandaries due to discrimination, their licit position, low socioeconomic status or due to language barrier[10]. Moreover, many of them often face difficulties in adjusting to their new society including adopting safe and healthy lifestyles because the nature and quality of health care and the gregarious and health characteristics of re-settlement can withal determine the health status of migrants.

Health issues impacting migrant workers are intricate and numerous and factors that affect their health are vast and varied, of which the cultural difference in attaining health is one of the most consequential. When tailoring interventions to vulnerable populations, consideration ought to be given to the importance of diverse cultural beliefs. Since culture shapes an individual's perception of health, illness, and compliance with diagnosis and treatment regimens. Cultural differences in health care seeking patterns and differences in the perception of health care could markedly affect their health status[11]. In addition, the workers' educational level plays a vital role in their health status. A recent study concerning the health and lifestyle of Nepalese migrants in the United Kingdom has found that migrants with low level of education are more likely to lack good dental hygiene and regular exercise[12].

The precedent medical history of migrants, is also important since certain diseases are cognate to their nationalities. A study from the UAE reported that the obesity rate was high among certain nationalities while the presence of hepatitis C antibodies was virtually exclusive to, more or less, Egyptian workers[13].

Other barriers that put migrant workers in situations of vulnerability and risk of ill health are factors that are related to lack of knowledge of the health system and precarious work or exposure to higher risk working and occupational hazards and accidents. Occupational injuries and work accidents have a contribution on the health and the well-being of migrant workers. In highlighting that, the Nepalese government recently revealed that about 70 of their nationals died on building sites in one of the GCC countries since the beginning of 2012. Hundreds more are thought to have been injured in falls and accidents with machinery and vehicles[3]. Accommodation on the other hand forms a major health risk factor and workers health after migration could also deteriorate due to the living conditions. Conventionally workers live in an overcrowded insalubrious condition that lacks sanitation and is an environment for deterioration of physical and mental health. The mental health status and salubrity is also influenced by life-adjustment stressors, socioeconomic isolation and cultural alienation from mainstream society which result in somatization issues. Workers from poorer groups are usually at a higher risk of mental illness due to their living and working conditions.

Women migrant worker are no different, beside being at risk of acquiring many health hazards especially physical, they are prone to sexual and verbal abuse. The International Labor Organization (ILO) reported that Indonesian women migrant workers, a majority of whom work as domestic workers, are particularly vulnerable to gender predicated violence and to HIV that avails throughout the employment

period[5]. The POEA also indicated that some Filipino female workers face horrible working conditions as well[2].

In highlighting the health problem of the migrant workers, the BSR Migration Linkage's report in 2012[14] has stipulated four focal stations, that contribute to the health of any migrant worker: those which are related to pre-departure and transit such as the health risk and poor health in the country of origin and cultural beliefs that affect health; post-arrival factors such as language barrier, employment in 3-D jobs and lack of access to adequate health care services; while at work such as the inadequate living conditions, inadequate nutrition and greater susceptibility to mental health strains. And the last factor is related to when workers return to their county of origin such as lack of awareness of medium and long-term illnesses that can leave workers at heightened risk upon return.

To procure equitable, adequate, and efficacious access to health care services, migrants need initially to be inculcated and apprised about the health care system and how to approach it in the country of work. The more workers become integrated the more they would utilize health care services efficaciously[15].

It is the legal obligation of countries of destination, origin and transit to protect the human rights of migrants on their territory[3]. Countries that are dependent on migrant workers should review their health and safety procedures in order to prepare a healthy working environment for such workers. For such causes and in order to facilitate health accessibility for migrant workers the ILO in 1997 adopted guidelines "The Workers' Health Surveillance" that place workers' health surveillance within the discipline of occupational safety and health. The central purport is the primary obviation of occupational and work-cognate diseases and injuries. These provisions are considered to be the rudimentary requisites for the surveillance of workers' health, and are not intended to deter competent ascendant entities from adopting higher standards[10]. In that line the GCC countries started the implementation of proper screening programs for foreign workers in order to protect their health and to prevent the entry of possible infection that might be dangerous to their population. It includes epidemiological, psychological, neurological and sexual examinations and investigations besides other tests ensuring the public safety[16]. Despite that, most of workers in the GCC countries, are initially screened at employment, but without a strict longitudinal follow up.

To ensure the provision of a proper health service to migrant workers, Poureslami et al, recommended adopting multiple approaches, that include; mapping and identifying health risks for major migrant workers; building health profiles at the pre-departure phase; ensuring occupational health and safety procedures are communicated and enforced effectively to migrant workers; taking proactive steps to ensure the availability, accessibility, and acceptability of health services in the destination country; educating the migrants about how to approach such facilities; to overcome

the language barriers and finally avoiding overcrowding in accommodation compounds[17].

In conclusion, health issues impacting migrant workers are intricate and numerous. Therefore, their health provision should always be the responsibility of the government and not delegated to private sectors in order to ensure proper adoption and implementation of health policies for the health safety of these workers and the nation.

## Review

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