

The Precarious Health Situation of Migrant Workers in the Gulf

Assessment and Recommendations

The plight of migrant workers and their abuses are very well documented by officials and non-governmental organizations. Time and time again, stories of atrocities and human rights violations are told through published accounts from victims and qualitative evidence obtained by rights groups. However, perhaps less known, or less emphasised, is the overall health effects on the migrant workers due to unprotected exposure to dire working conditions.

The International Labor Organisation (ILO) estimates that about 17 million migrant workers are currently employed in Arab states, roughly the size of Chile or the size of the state of New York. Imagine an entire country's worth of people are abroad trying to find economic shelter and enough money to send back to their families; it is quite daunting. Moreover, the workers make up the majority of the population in Bahrain, Kuwait, the United Arab Emirates, and Qatar. Most of these workers come from southeast and south Asian countries like the Philippines, Nepal, India, Bangladesh, and Pakistan. These individuals occupy more than 90% of the construction and domestic work industry while sending back a projected USD 126.5 billion worth of remittances to their home countries in 2019.¹

The economic impact that migrant workers have on both the destination and origin countries is invaluable. The abuses they suffer are no secret. But how are the occupational burdens, the daily hazards, and the unfamiliar new lifestyles affecting the health of these workers? More importantly, why should GCC States care about their workers' health?

The very nature of being a migrant worker in GCC means that one is likely to be employed in sectors that are considered menial, labour-intensive, and/or dangerous; so-called "3D

¹<https://blogs.worldbank.org/peoplemove/data-release-remittances-low-and-middle-income-countries-track-reach-551-billion-2019>

industries” (Dirty, Dangerous, and Degrading). These employing industries include sectors such as construction, agriculture, stevedoring, maintenance, transportation, petroleum extraction and processing, and household work. Working in these positions marks the greatest risk of exposure to a myriad of occupational hazards. Indeed, the most feared complications of being employed outdoors and exposed to severe heat in the region are heat illnesses.

HEAT ILLNESSES

Common types of heat illnesses include heat stroke, heat exhaustion, cardiac conditions, and sunburn, all of which can lead to long-term comorbidities like chronic kidney disease. More frighteningly, thermoregulation is intricately linked to central nervous system function, so hyperthermia in severe cases can lead to convulsions, delirium, and even coma. This is especially prominent in the early days of employment when not enough time is given for the body to acclimatise, which generally takes two or three weeks and is often not long-lasting.² In an area where not much due diligence is given to health-conscious practice in employment, dehydration, overcrowding, and intense physical exertion can exacerbate the omnipresent risk of developing severe heat illnesses. In the US, it is estimated that being employed in agriculture carries a mortality rate from heat exposure up to 20 times more than the rates in other occupations.³ Despite limited regional statistics for the Gulf, I can only imagine that the figure is much worse in countries with daily high average temperatures. Each GCC country bans outdoor work during midday hours in summer, but workers often still work more than 12 hours a day in temperature that can reach 55°C (131°F). Dubai’s Rashid Hospital reported at least 2500 hospitalisations a month for heat-related injuries in 2004. Sometimes, treatment for these and other severe workplace injuries consisted of nothing more than “nurses handing out Panadol”.⁴

² Saudi Ministry of Health Publication Awareness on Heat Illnesses

<https://www.moh.gov.sa/en/Hajj/PublicationsAwareness/Publications/Documents/Heat-Illnesses.pdf>

³ Jackson LL, Rosenberg HR. 2010. Preventing heat-related illness among agricultural workers. *J. Agromed.* 15(3):200–15. <https://www.ncbi.nlm.nih.gov/pubmed/20665306?dopt=Abstract>

⁴ Sevil Sönmez et. al. Human Rights and Health Disparities for Migrant Workers in the UAE. *Health and Human Rights Journal.* 13(2). December 2011.

<https://www.hhrjournal.org/2013/08/human-rights-and-health-disparities-for-migrant-workers-in-the-uae/>

Table 1: Comparison of worksite injury liability and compensation across GCC Countries

Country	Liability	Contribution by employers to social security/medical cost (in case of employer liability)	Compensation	Law concerning compensation for worksite injuries
Saudi Arabia	Social insurance	2% of payroll	<p>In the case of temporary disability arising from work injury, the injured party shall be entitled to financial aid equal to his full wage for thirty days, then 75% of the wage for the entire duration of his treatment. If one year elapses or it is medically determined that the injured party's chances of recovery are improbable or that he is not physically fit to work, his injury shall be deemed total disability. The contract shall be terminated and the worker shall be compensated for the injury. The employer may not recover the payments made to the injured worker during that year.</p> <p>If an injury results in a permanent total disability or the death of the injured person, the injured person or his eligible beneficiaries shall be entitled to a compensation equal to his wages for three years, with a minimum of fifty four thousand riyals. If the injury results in a permanent partial disability, the injured person shall be entitled to a compensation equal to the percentage of the estimated disability in accordance with the approved disability percentage</p>	Article 137 and 138 of Saudi Labour Law (Royal Decree No. M/51)

			guide schedule multiplied by the amount of compensation for the permanent total disability.	
Bahrain	Social Insurance	3% of the employee's monthly earnings paid by the employer	The injured worker shall receive his wage during his treatment period. If the treatment duration exceeds six month, said worker shall receive half of his wage until his recovery or until his disability is evidenced.	Article 91 of Law No. 36 of 2012 Labour law
Qatar	Employer	Whole medical cost paid by employer	The Worker shall receive full Remuneration throughout the period of treatment or for a period of six months, whichever of the two is less. If the treatment continues for more than six months, he shall receive half of his Remuneration until proof of cure or permanent incapability is stated, whichever of the two is earlier.	Article 109 of Law No. 14 of 2004 issuing the labor law
UAE	Employer	Whole cost must be paid by employer	If the injury prevents the employee from carrying out his duties, the employer must pay him a financial subsidy equal to full pay throughout the period of treatment or for a period of six months, whichever is shorter. If treatment lasts from more than six months, said subsidy shall be reduced to the half for another period of six months or until the employee recovers from illness or his disability becomes certain or he dies whichever occurs first.	Article 145 and Article 144 U.A.E. Labour Law FEDERAL LAW NO. (8) OF 1980
Oman	Social insurance	1% of payroll	Set by Public authority for Social Insurance	Royal Decree No. 72/91

				Promulgating the Social Insurance Law
Kuwait	Employer	Whole medical cost paid by employer	A labourer who suffers a work injury or occupational disease shall be entitled to receive his wage for the entire treatment period fixed by the medical doctor. If the treatment period exceeds six months, he shall be entitled to half the wage until his recovery or proven disability or death. An Injured labourer or his beneficiaries shall be entitled to receive compensation for work injuries or occupational disease pursuant to the schedule to be issued by a resolution from the Minister, upon taking the opinion of the Minister of Health.	Article 93 and Article 94 of Law No. 6/2010 concerning Labour in the Private Sector.

CHEMICAL AND TOXIC AGENTS

On top of the heat illnesses, workers are additionally exposed to noxious and caustic (read melting) material that can severely damage internal organs. Agricultural pesticides, cement and processing tools, paint, cleaning agents, and irritant solvents are among the many causative agents commonly seen in hospital visits. These agents can lead to long-term damage to the skin, lungs, digestive tract, and reproductive organs. They can also be potentially cancerous. We are talking about even simple daily exposure to common household items like tobacco smoke and nail polish in salons.⁵ Also, working in the oil, plastic, rubber, nylon, fibre, and automotive industries means constant exposure to organic (i.e. hydrocarbon) compounds like benzene. Benzene poisoning can commonly lead to blood disorders like anemia and, worst-case scenario, cancers like leukemia, if proper

⁵ Sally C. Moyce and Marc Schenker. Migrant Workers and Their Occupational Health and Safety. *Annual Review of Public Health*. 2018 39:1, 351-365.

measures are not followed. The slow process of malignancy may manifest as non-specific, and benign-appearing symptoms like fatigue, headaches, and dizziness go unaddressed.⁶

Let's not also forget that metal poisoning sources can be found in poorly maintained plumbing and construction materials, such as lead and cadmium, that can lead to temporary or permanent neurological damage. Some metals like silica and asbestos can even cause permanent lung scarring that will negatively impact the workers' breathing capacity, which further worsens their quality of life. Asbestos, coal, and silica deposits are among the well-known causes of the so-called "coniosis" that lead to permanent lung scarring and impaired breathing for the remainder of the worker's life, not to mention an increased risk of lung cancer development. This has to be considered of particular importance in the context of the types of accommodation most lower-income workers are housed in.

Allergens, though not often deadly, are also a significant problem. At its least harmful, allergens irritate the protective barriers of the eyes, nose, and throat to cause obstructive symptoms. Yet, imagine a construction worker handling heavy and dangerous equipment, or a shepherd shearing wool off a sheep using sharp tools with an itchy eyeful of watery tears. Taking daily anti-allergens is expensive, which can sometimes mean forgoing medicine to feed yourself and your family back home. At its worst, allergens can lead to anaphylactic shock. If not addressed immediately, i.e. within minutes, the airpipe can be so obstructed that the person would suffer asphyxiation.

MUSCULOSKELETAL (MSK) ILLNESSES

Then there are the inevitable musculoskeletal implications of the intense demands of these jobs: 12-hour shifts of backbreaking toil that include carrying heavy materials and working with dangerous tools like the jackhammer or electric saws that spew a volley of projectile debris. For the average domestic worker, heavy lifting is only part of the job description, as they are subject to muscle strain from extremely harmful posturing and repetitive motioning, all while being kept to work sometimes at overtime without pay. I can name quite a few syndromes that are usually developed from this kind of toil – strains, plantar fasciitis, stress microfractures, contractures, patellofemoral syndrome, iliotibial band

⁶ Gonçalves, R.O., de Almeida Melo, N. & Rêgo, M.A.V. *Environ Monit Assess* (2016) 188: 334. <https://doi-org.proxygw.wrlc.org/10.1007/s10661-016-5340-1>

syndrome, Osgood-Schlatter disease, prepatellar bursitis (aka the “housemaid’s knee”), and perhaps most notoriously arthritis.

Migrant domestic workers (MDWs) are highly susceptible to developing MSK disorders. The work demands dexterity and exerts extreme pressures on critical joints of the body, even in cases of non-abusive situations. In an epidemiological study of MSK disorders among Filipino migrant workers in Malaysia, workers reported various MSK pains in order of prevalence: lower back and shoulders (60%), upper back (48%), and neck (45%). MDWs makeup 73% of those surveyed, and a majority of them endure some form of hip or thigh pain.⁷ Logically it makes sense: repetitive manual tasks and intermittent/continuous mechanical loading leads to traumatic damage to the ligaments and tendons, which then leads to sometimes inappropriate inflammatory responses when left unaddressed (and the development of chronic disorders like osteoarthritis).

Aside from MSK disorders, injuries from workplace accidents occur more commonly to migrant workers.⁸ Some areas like construction work are perilous in nature due to sophisticated machinery and precarious work environments – think standing on top of high scaffolds. In Qatar, a large epidemiological study found that workplace-related injuries constituted nearly 29% of trauma visits to the ER between 2010 and 2012.⁹ The majority (51%) were from falls, with patients largely migrant workers (66% South Asian, the rest are “others”, unclear what percentage Qatari nationals were in the makeup). They were mostly employed in areas like industrial work, transportation, installation/repair, and even housekeeping (notably, use of protective devices was not observed in 66% of the cases). Nearly half of those individuals had prolonged stays in the hospital. The study reported that the UAE and Oman had similar findings in patient demographics and methods of injury, with worse incidence and mortality rates (the data was collected amidst the Qatari World Cup construction boom, but the majority of deaths were unrelated to the World Cup projects). Complex machinery operation can lead to hand injuries from natural wear-down

⁷ Labao et. al. ‘Aches and Pains’ of Filipino Migrant Workers in Malaysia: A Profile of Work-Related Musculoskeletal Disorders. *Annals of Global Health*. 2018, 84(3), pp.474-480. DOI: <http://doi.org/10.29024/aogh.2331>

⁸ UN Human Rights Council, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover*, 15 May 2013, A/HRC/23/41, available at: https://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session23/A_HRC_23_41_ENG.pdf [accessed 13 January 2019]

⁹ Al-Thani, Hassan et. al. Workplace-Related Traumatic Injuries: Insights from a Rapidly Developing Middle Eastern Country. *Journal of Environmental and Public Health*. 2014, Article ID 430832: 8 pages. <http://doi.org/10.1155/2014/420832>.

and eye injuries from dislodged materials like wood chips. Finally, just to make matters worse, unaddressed mental health issues can dangerously increase the risk of work-related injuries, most likely due to impaired concentration while performing complex tasks that demand high technical and visuo-spatial focus.

MISCELLANEOUS ISSUES

Perhaps less apparent than physical injuries are the psychological scars inflicted on migrant workers in who live and work in isolated and abusive conditions. Mental illnesses like depression, traumatic disorders, and anxiety are notoriously associated with stressful jobs and sleep deprivation. Due to language barriers, inadequate access to healthcare, and social stigma with a mental health diagnosis, migrant workers often are unaware of the severity of these illnesses and availability of treatment, which can worsen their precarious well-being. Even if the migrant worker was able to successfully seek treatment for mental health disorders, the nature of migration can seriously impede ongoing treatment regimens. The UN Human Rights Council reported that “treatment interruptions, lack of follow-up and treatment failures are documented at higher rates among migrants than the stationary population.”⁸

Additionally, living in cramped conditions with flimsy sanitation, their health problems are aggravated by poor and unhygienic environments, food insecurity, and a dismantled access to health care. Organisms that thrive in these habitats are free to spread diseases like wildfire, including tuberculosis, mosquito-borne illnesses (think malaria), and dysentery (bloody diarrhea). The world has observed the horrid conditions of many detention centers constructed to house refugees and asylum-seekers. Sadly, these long-term detention facilities are often overcrowded and lack basic provisions like good hygiene, access to nutritious food and water. As such, long periods of detention can “facilitate the transmission of communicable diseases and can have a devastating effect on the mental health of migrant workers,” according to the UN HRC.

Even writing about sexually-transmitted illnesses is tricky because the data is highly controversial in the region (at one point during a conference in Washington, DC, I was shown a slideshow by the world-famous infectious disease expert Dr. Anthony Fauci, where Saudi Arabia miraculously had an HIV prevalence rate of zero). In a society dictated by doctrines of sectarian morality, it is hard to fathom any country in the region placing an

emphasis on sexually-transmitted infections (STI) awareness and management, let alone for migrant workers. Navigating the Saudi and UAE Ministries of Health websites, there appears to be no feasibly navigable way to obtain public information on STIs other than HIV/AIDS (more interestingly is the Saudi MOH's claim that ART therapy, a cornerstone of HIV treatment, is NOT recommended by WHO which is completely untrue).¹⁰ The Qatari MOH website at least appears on first search with a rather well-briefed info-sheet on prevention and treatment (including an anonymous hotline). Though through my research, I did find that many recruitment agencies screen for diseases like HIV and Hepatitis B/C, which when found positive in migrants automatically disqualify them from eligibility to migrate, without any referral for treatment services. Reporting about sexual abuse is out of the question in countries that penalise sexual crimes with severe corporal punishment, to both victims and perpetrators. If sexual abuse is another exploitation tool against the migrant workers, I cannot write with utmost certainty about the available resources for seeking mental and corporal redress. At least cardiovascular diseases and diabetes are the medical forefront for GCC countries, but alas, those illnesses are also worsened by occupational hazards, mental duress, and sexual violence.⁴

Table 2: Comparison of health insurance coverage for migrant workers across GCC states

GCC country	Mandatory health insurance?	Cost of health insurance	Access to Private/Public health care?
Bahrain	No (to be implemented soon) (National)	N/A	Public and Private with national health insurance. As of yet, only public
Saudi Arabia	Yes (Private)	Varies between authorized private health insurers	Public and private for the insured employee.
Kuwait	No (plans to implement soon) (National)	KD130	Dhaman medical centres and public hospitals.

¹⁰ Accessible at:
<https://www.moh.gov.sa/en/HealthAwareness/EducationalContent/Diseases/Infectious/Pages/AIDS1.aspx>

UAE	Only for the Emirates of Dubai and Abu Dhabi (Private)	Varies between authorized private health insurers	Public and private for the insured employee
Oman	No (to be implemented soon) (Private)	Varies between Insurance company licensed to carry out health insurance business in Oman	Expats don't have access to free or subsidized public health services Only emergency health care at public and private hospitals.
Qatar	No (enacted but not implemented) (National)	N/A	Public hospitals and clinics for non-Qataris with health cards.

DISCUSSION

In this op-ed, I have attempted to cover the most common occupational health illnesses that were documented among migrant workers, with a special focus on the Gulf region due to the exploitative nature of the sponsorship systems in place. For simplicity's sake, I avoided writing both about illnesses common to nationals and migrants like cardiovascular diseases (the mantra being that a heart attack does not discriminate) and direct abuses, physical and mental, since there is a general understanding of the health consequences (fractured bones, laceration scars, burn marks etc.). Despite mandatory healthcare coverage in some GCC states, migrant workers are often forced to cover their own health expenses while being exposed due to numerous risk factors, which perpetuates the stereotype of the "sick and lazy migrant" and further aggravates their poor access to healthcare services. They often have little capacity to voice their grievances due to language (or legal) barriers; so not only are they subject to longer hours of exposure to workplace hazards, but they also lack the means to ameliorate the consequences of these abusive environments, let alone addressing the abuses adequately and effectively.

The truly saddening aspect is that many of these workers start off their perilous travel to foreign lands as “healthy individuals,” yet “the complexity and diversity of circumstances throughout the various dimensions of the migration cycle may render them highly vulnerable to poor physical and mental health outcomes.”⁸ Furthermore, fear of detention and deportation, stigmatisation, language barriers, administrative barriers (incomplete paperwork, legal status, income level disqualification) heightens the difficulty in addressing their health pitfalls. It is this vicious cycle of servitude, unaddressed damage, and forced labour despite failing health that destroy their productivity. These apparent and hidden factors unfairly take away the workers’ rights to autonomy and healthy living as clearly denoted by the United Nations Universal Declaration of Human Rights and even the Arab Charter on Human Rights (of which many of the destination states are signatories).

Without regard to the human rights implications, the bottom line of this health disparity is mainly twofold: economic productivity and healthcare costs. When workers suffer from chronic diseases inflicted by poor working conditions, and without seeking proper management for those conditions, work productivity decreases overall. In fact, MSK disorders alone reportedly decreased productivity by 6-9%, about 1.5 working hours and \$25,000 per year of operational costs in medium-sized companies (and an estimated 1.8-6% loss in GDP).⁷ Mental illnesses are notably not considered an urgent issue in many cases. This behaviour can dangerously lead to low quality production and even outright ignorance of safety standards, with the Makkah crane collapse in 2015 being the *prima facie* case in point.

Secondly, it is widely observed through case studies around the world that when migrants and undocumented individuals do decide to address an ailment, they resort to utilising emergency services in community and government hospitals. The economic burden incurred by emergency treatment costs are above all felt beyond the individual and community level. Namely, the government is usually forced to pick up the tab as the last resort, shifting funding away from much needed areas like urban development and education. Had the migrants been cared for on a routine basis, resources could be properly allocated. Cutting down on emergency room visits and investing that savings into primary care can produce savings to be invested in other areas.

Even if the migrant workers were allowed provisions for basic check-ups, the UN HRC reported that laws may be dubiously enforced and the provision of care may be inappropriate (as in the case of Panadol for heat illnesses). In some cases, workers would be “forced to pay for health-care expenses, including emergency care, at rates that are sometimes disproportionately high compared to their income.”⁸ To top it off, health-care providers like myself may be forced to report irregular migrants to authorities under threat of prosecution, once again forcing workers to resort to unsafe treatment options or to forgo seeking care altogether.

RECOMMENDATIONS

- 1. Routine quarterly visits to caregivers are highly recommended, with costs absorbed by the company in the form of mandatory employee health insurances .**

Routine check-ups allow not only for efficient management of work-intrusive diseases like hypertension and joint pains, but also for the discovery and early intervention of insidious problems like anemia and respiratory syndromes.

From a medical economics standpoint, it is widely recommended that a healthier workforce leads to greater productivity, which leads to greater economic growth and greater savings in healthcare costs and employer operational expenses. GCC state policies acknowledge this at some level, as mandatory medical screenings to obtain a work visa are extremely stringent.

For example, Taiwanese law enforces mandatory “periodic health examinations” for foreign workers and treatment for infections like intestinal amoebiasis and tuberculosis, with proof of treatment submitted via certificates by employers (though some stipulations are unfortunately punitive and bars those with prolonged infections from re-entry into the country).¹¹

¹¹ Accessible at: <https://www.cdc.gov.tw/File/Get/s4hky6752X0aAGfW-J--lw>

2. Employers must be responsible - and held accountable - for workers' healthcare

It is irrational to depend on workers with limited literacy or language skills to understand the complexities and importance of maintaining good health without paying any heed to the cost of care. In fact, the UN HRC recommends that states "ensure that written employment contracts address issues such as the underlying determinants of health, including occupational health, access to health facilities, goods and services, and compensation for employment-related injury and death, as well as mechanisms for settling disputes."⁸

Contracts and low barriers to access are key, but enforcement is equally as critical. The responsibility ultimately befalls the companies and state governments to enforce the very same protective laws recently implemented in their countries. If merely paying a small fine is cheaper than fixing sewage pipe issues in labor camps, therein lies the problem. Governments need to impose harsher punishments to violators to deter abusive behavior and encourage proper conduct by simplifying the hiring process for good-practice companies (I could suggest imposing a heftier fine and possible seizure of property, but I am not an expert at public affairs).

3. Employers ought to take care of their workplace and residential environments as well.

The minute changes in air pollution and sanitation have been linked to the development of plenty of diseases, inflicting unnecessary opportunity costs in the form of lost productivity and avoidable ER visits. That much is obvious, but how about the insidiously damaging MSK disorders? Basahel et. al. conducted an intervention trial for improving ergonomics in posture and motioning among packaging workers in a Saudi food factory, and indeed the results have shown significant decreases in MSK problems post-intervention in 3 and 6 month intervals, in addition to lower physical and psychological stresses in surveys despite similar workloads.¹²

¹² Basahel, Abdulrahman M. et. al. Evaluation of the Impact of Engineering Ergonomic Interventions on Musculoskeletal Hazards and Psychosocial Factors Among Packaging Workers in a Food Factory. *International Journal of Ergonomics*. 2016, 6(1): p. 1-17.

It is therefore recommended that employers be wary of workplace stressors in manually intensive jobs and implement steps to mitigate these intermittent and unnoticeable damages. The Malaysian Department of Occupational Safety and Health Ministry of Human Resources provided a comprehensive ergonomic risk assessment toolkit that at first glance appears to be an excellent starting guideline for evaluating environmental hazards and addressing them.¹³

4. Following governmental breaktime guidelines, especially during sweltering summer days, is equally as important. Breaktime and fluid repletion allows the body to recuperate water losses and prepare additional energy by allowing time to process extra resources slowly and efficiently.

It comes down to basic metabolic utilisation of sugar reserves in the liver, which takes time. In high school, sports coaches impose mandated breaks and encourage plentiful water intake. If even recreational activities like that emphasise the importance of water regulation and breaktime to eventually produce better payoff, is it not safe to say the same for workers under the sun? Allowing several breaks would allow the worker's durability to yield more results and last longer (though perhaps, it is counterintuitive to a worker's right to work a reasonable set of hours per se). Whole rest days are also very important, since they allow time for workers to pursue health-related agendas like doctor visits, healthy cooking, and, most importantly, aerobic activity.

5. A migrant welfare fund, a sort of safety net for workers provided by their countries of origin, is a good but limiting idea.

The Philippines has an example of this by the name of Overseas Workers Welfare Administration, operated by the Department of Labor and Employment. Why is this idea lacking? The problem stems from the root causes of worker health dysfunction, which is the work environment itself and the myriad of causes I have written above.

¹³ Accessible at:
<http://www.dosh.gov.my/index.php/en/legislation/guidelines/ergonomic/2621-01-guidelines-on-ergonomics-risk-assessment-at-workplace-2017/file>

If the origin countries foot the bill for healthcare without paying heed to cause, then poor living and working conditions would persist with impunity. Moreover, they are already strapped in dealing with legal disputes and immigration costs. Placing a band-aid on an injury without any changes to the work environment will inevitably foster a climate of recycling workers through hospitals and back (with ER visits invariably costing the host governments even more). Once again, destination country governments and employers must have a stake in maintaining workers' health, and employer misconduct cannot be enabled simply because other countries are comfortable absorbing the costs.

My final recommendations are broad and draw from the UN HRC Special Rapporteur report, which contains an extensive list of recommendations that include abolishing discriminatory immigration policies like mandated pregnancy testing; preventing treatment interruption; dismantling administrative barriers to access; providing for mental health facilities; extending existing domestic occupational health and safety laws and social insurance schemes to include citizens and migrants; and avoiding detention and deportation based on health status.⁸ If implemented properly, these measures would certainly alleviate, if not eliminate, the precarious health situation of migrant workers in the Middle East.

A cursory look at the epidemiological data at the ILO on fatal occupational injuries show that the rates tend to be higher among migrant workers than nationals.¹⁴ Naturally, other than Qatar, there was no data on the GCC countries on the list, which seems to be a recurring theme in my research. More astounding is that as recent as 2015, in some richer countries with functionally better migrant support systems like Germany and Austria, migrant workers overall fare better in fatal occupational injuries than nationals! As a growing regional economic powerhouse, the Gulf has the capacity to apply sensible and rational solutions to tackle the epidemic of migrant disenfranchisement. If we cannot appeal to basic humanity and religious morality to convince the actors involved, then maybe the way to do so is to advise based on sound economic and healthcare policies. The conclusive message in this case is an homage to an old adage: a stronger, healthier workforce leads to a stronger, healthier economy.

¹⁴ Accessible at ILOSTAT at: <https://www.ilo.org/global/statistics-and-databases/lang--en/index.htm>