

VITAL SIGNS

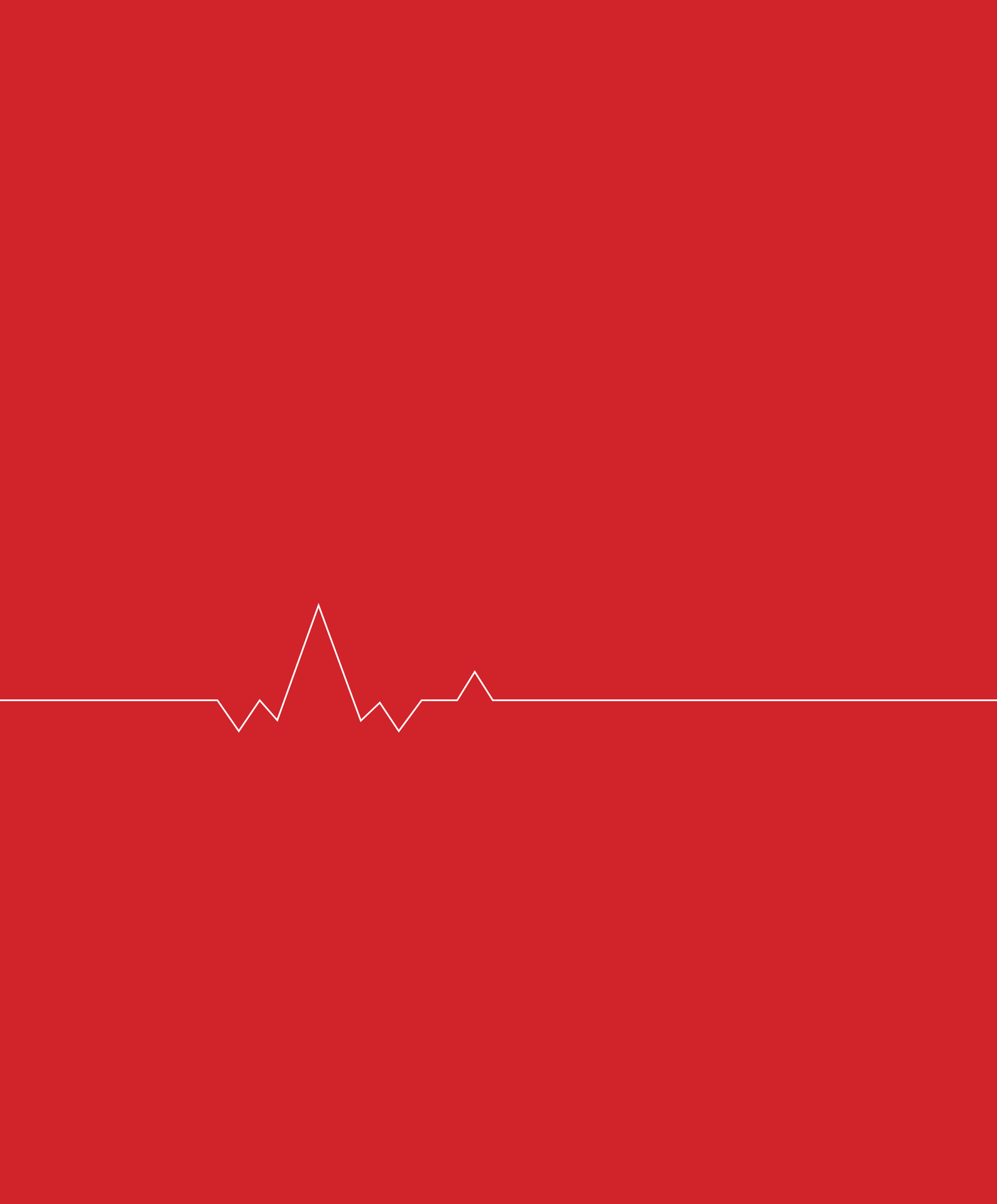
THE COST OF LIVING: MIGRANT WORKERS' ACCESS TO HEALTH IN THE GULF

REPORT 2 / NOVEMBER 2022



vitalsignsproject.org





The Vital Signs Partnership is a group of organisations working together to campaign for better protection for low-paid migrant workers in the six countries of the Gulf Cooperation Council (GCC). The partnership includes the Center for Migrant Advocacy in the Philippines, the Centre for Indian Migrant Studies, the Law and Policy Forum for Social Justice in Nepal, Justice Project Pakistan, and the Refugee and Migratory Movements Research Unit in Bangladesh. Supporting organisations include Migrant-Rights.org, which documents migrant workers abuses within the GCC, and Migrant Forum Asia in the Philippines. The project is overseen by FairSquare Projects, a non-profit human rights organisation based in London.

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EXECUTIVE SUMMARY

The first Vital Signs report outlined in detail how low-paid migrant workers in the six states of the Gulf Cooperation Council are subject to a wide range of cumulative risks to their physical and mental health. These risks originate from the workplace, their living conditions (encompassing their accommodation and their broader neighbourhoods), and the environment, and include: heat and humidity; pollution; abusive working conditions, which often include excessive working hours and heavy physical workloads; lax occupational health and safety (OHS) practices; exposure to long-term chronic psychosocial stress; and, in the case of female domestic workers, acute vulnerability to physical, psychological and sexual abuse.

The first report identified that despite the shortcomings of the available data on migrant worker deaths, it appears that as many as 10,000 people from South and Southeast Asia die in the Gulf every year (this figure will obviously be higher when migrant workers of other nationalities are included) and that more than one out of every two deaths is effectively unexplained, which is to say that deaths are certified without any reference to an underlying cause of death, instead using terms such as “natural causes” or “cardiac arrest”.¹

This second report examines the specific issue of migrant workers’ access to healthcare in the Gulf, focusing again on workers in low-paid sectors of the economy, drawing on a combination of quantitative and qualitative research. Its key findings are as follows:

- Easy access to healthcare is particularly critical for low-paid migrant workers in the Gulf due to the multiple adverse health conditions that can result from their work. The GCC states’ healthcare services are generally not tailored to the specific needs of this population, and there is obvious evidence of discrimination in access to healthcare for migrant workers, with lack of documentation and affordability the most significant obstacles.
- The inability of low-paid migrant workers to easily access non-emergency healthcare services has a detrimental effect on the general physical and mental health of this population, and it is likely that it is a significant factor both in the number of preventable deaths, and the high rate of unexplained deaths.
- The gradual shift in the region to mandatory private health insurance is more likely to further restrict access to care than to improve low-paid migrant workers’ access to healthcare.

1. The data that is available on the deaths of migrant workers in the Gulf is incomplete, in places contradictory, and it precludes effective analysis of the extent and gravity of the problem. See The Vital Signs Partnership, “[The Death of Migrants in the Gulf](#),” (March 2022).

Documentation and affordability as barriers to healthcare

Jose Raymond, also known as JR, a Filipino worker who worked in Saudi Arabia told the Vital Signs Partnership how he worked long hours every day without a break in a Riyadh coffee shop, despite pain in his stomach that caused him to collapse on several occasions.² “I still went to work even when I was sick— there was no one to take my place,” he recalls. “He [JR’s employer] said he would follow up on the health insurance, since there were ‘other things to pay for first.’” When JR returned to the Philippines, he had to have a large cancerous tumour removed from his lower intestine. Ludra, a 33-year old Nepali man who worked in the gardening sector in Qatar, and wasn’t provided eye protection despite having to work in close proximity to industrial wood cutting machinery, wasn’t able to go to hospital to address severe eye irritation because his employer had also failed to provide him with the Qatari identification card that he needed to access subsidized healthcare.³ After he went blind in one eye, he faked passing out in order that his employers would call an ambulance. “The company won’t take it seriously unless someone is dying,” he said. Ahmad, a Pakistani who worked in the construction sector in the United Arab Emirates told the Vital Signs Partnership, that “most of the labourers had some sort of physical issues” and that “everyone got mentally disturbed” over time, but that none of them had the health insurance that they needed to access healthcare.⁴

These accounts, of low-paid migrant workers unable to access the Gulf states’ vast array of public hospitals and private clinics because of a lack of the required documentation, are mirrored in the findings of an in-person survey of 1,101 low-paid migrant workers in Kuwait conducted for this report between May and July 2022.

The survey provides a clear picture of the barriers to healthcare that low-paid migrant workers face. Cost was a significant barrier, with 30 percent of respondents saying that they could rarely or never afford healthcare, and only 18 percent of respondents saying they could always afford healthcare. On its face this finding seems at odds with Kuwait’s policy of subsidizing healthcare for its migrant worker population with the aim of making it affordable. The key barrier to care was a lack of proper documentation, with more than half of respondents - 51 percent - saying they had been discouraged or prevented from accessing healthcare due to not having physical proof of their identity.

Lack of documentation can take many forms in relation to healthcare. Many workers are simply undocumented and don’t have residence and work permits, either because their permits have expired, or because they arrived in the Gulf on tourist or visitors’ visas. Many have arrived through formal channels for employment, but their employers haven’t provided them with, or renewed their national ID cards, or the health insurance that all foreign workers in Saudi Arabia and the United Arab Emirates require. Any of these factors can mean that migrant workers cannot access subsidized non-emergency healthcare, and their salaries mean that non-subsidized care is often unaffordable to them. The migrant workers we spoke to reported a wide range of barriers that discouraged or prevented them from accessing healthcare, with many reporting that racial discrimination was a factor. “We feel we are not important when we go to the hospital,” said one Filipino respondent in our Kuwait survey, where 25 percent of those who said that they endured racial discrimination said that it had manifested in them being denied treatment altogether.⁵

It should be noted that emergency healthcare is provided free of charge irrespective of any lack of documentation in all of the Gulf states, and many of the migrant workers we spoke to had positive experiences when admitted for serious illnesses to emergency rooms. The most obvious problems are when migrant workers’ illnesses or injuries do not meet the threshold for free emergency care. “I think the worst situation to be in is when you are in the mid-range of injured in an accident,” a food delivery driver in Dubai’s emerging low-paid gig economy told the Vital Signs Partnership.⁶ “If it’s minor, you can just get a painkiller or see a doctor in a nearby clinic and you are back on the road. Insurance or not, it is affordable. If you are near death, then you will go to emergency. But if you are in the mid-range, you have to figure out insurance-covered clinics and deal with all that. And you lose out on work. And you are in pain.” He praised the standard of care in emergency rooms in Dubai, but said that any non-emergency care was not affordable to him and his colleagues, many of whom had been involved in road accidents.

Although emergency care in the Gulf’s hospitals is generally of a high standard, migrant workers told us that it can be difficult to be admitted. “They [emergency rooms] will only take you in if you are in critical conditions. Otherwise, they don’t have the capacity and will send me here and there. It is not enough that my leg is painful, they will only care if my leg was cut off,” said Nawaz, a 53-year old Pakistani driver.⁷ A

2. Telephone interview with JR Banaag, 2 July 2022.

3. In-person interview with Ludra Bahadur Sunar, 15 June 2022.

4. In-person interview with Ahmad, June 2022.

5. In-person survey in Kuwait, May-July 2021.

6. In-person interview with Liaqat, 29 May 2022.

7. In-person interview with Nawaz, 12 June 2022.

doctor in one of Jeddah's public hospitals told the Vital Signs Partnership that there can be serious risks for undocumented workers accessing emergency care, noting that medical staff in emergency rooms are required to report any cases where they treat undocumented patients for life-threatening illnesses, in order that the Saudi authorities can either fine or deport the individual after the treatment.⁸

As in many other realms of worker protection and abuse, the role of the Gulf's sponsorship system is a central factor in workers' inability to access healthcare, since it is sponsors that have the responsibility to ensure that migrant workers have the documentation that they need to access affordable care. The impact of the kafala system is particularly profound in the case of domestic workers, who occupy a distinct legal status in the Gulf.

Women domestic workers' access to healthcare

Domestic workers face specific and distinct barriers to accessing healthcare services.

A 35-year old Bangladeshi woman who worked as a domestic worker in Saudi Arabia recounted to the Vital Signs Partnership a pattern of abuse in Kuwait that had a serious and lasting impact on her physical and mental health.⁹ She was seriously overworked, physically beaten, and told that she had to buy herself medicine and menstrual products, despite not being allowed to leave the house. She had to rely on medicine that she had brought with her from Bangladesh, but this quickly ran out. Within four months, Nasima said, she became severely ill but her employer refused to let her visit a doctor until she became completely bedridden. Upon her return to Bangladesh, she was diagnosed with jaundice and liver damage, and continues to suffer from gastro-intestinal issues. A domestic worker from the Philippines, who left work in Kuwait while she was still breastfeeding her nine-month old son, described a similar pattern of overwork that culminated in her having a serious mental breakdown.¹⁰ Only then did her employers take her to hospital, but she was discharged after three days and went back to work, where employers gave her Panadol.

Vani Saraswathi, an expert on domestic workers' rights in the Gulf explained how the dependence on the sponsor is heightened in the context of domestic work. "The ability to leave the employer's house and get their own health card... to independently decide to see a doctor when they are ill just does not exist for domestic workers across the region."¹¹ Saraswathi also noted how the long working hours and low wages of domestic workers led them to disproportionately access emergency medical care. "When a domestic worker can visit medical facilities, if at all, is dependent on the schedule of the employer and the schedule set by the employer. Workers may, for instance, have suffered from stomach pains all day but they only tend to be free very late into the night. And you see this reflected in who the patients tend to be in the ER [Emergency Room]." Saraswathi's testimony is corroborated by a 2016 study conducted by Saudi healthcare professionals, which states that the "overuse of emergency rooms (ER) is a public health problem", with Ministry of Public Health hospitals in Jeddah singled out as notably problematic and low-income patients a particular risk factor for ER overuse.¹²

Private health insurance as a further barrier to care

"Good insurance isn't cheap and cheap insurance isn't good," an insurance broker in the United Arab Emirates told the Vital Signs Partnership, in reference to the problems that mandatory health insurance causes for low and middle income migrant workers.¹³ Research for this report suggests that the Gulf states' shift to mandatory private health insurance for all, including low-paid migrant workers, is likely to pose a further barrier to access to healthcare.

Non-citizens, including the low-paid migrant workers who constitute the most populous and most vulnerable sections of Gulf societies, are not eligible for free non-emergency care and require either private health insurance or government-issued health cards in order to access affordable care in government hospitals or private clinics. (Undocumented migrant workers in the Gulf generally have no access to formal channels of healthcare.) The use of private health insurance for non-citizens in Saudi Arabia and the United Arab Emirates is well established, and the other Gulf states have either recently followed suit, in the case of Qatar, or are in the process of doing so.

8. Interview with anonymous healthcare professional in Jeddah, June 2022.

9. In-person interview with Nasima, 26 May 2022; telephone interview with Nasima, 29 June 2022.

10. Telephone interview with Natalie, 23 June 2022.

11. Telephone interview with Vani Saraswathi, Migrant-Rights.org, 13 September 2022.

12. Sundus Dawoud et al, "[Utilization of the Emergency Department and Predicting Factors Associated With Its Use at the Saudi Ministry of Health General Hospitals](#)," *Global Journal of Health Science*, (January 2016): 90-106.

13. Telephone interview, 28 June 2022.

The shift to privatisation both in the provision of care and in its funding appears to be at least partially motivated by the desire to open up new revenue streams and thereby help to mitigate the dependency of the Gulf economies on oil revenues.¹⁴ A 2022 study on the impact of private health insurance in Dubai found that although it encouraged people to access more healthcare, this general effect was not reproduced in the case of low-paid migrant workers in particular, who did not increase their per capita use of health services. Vital Signs Partnership research among migrant workers in Saudi Arabia and the United Arab Emirates demonstrated a variety of problems, much of it related to private health insurance.

Workers' success in navigating the health system depends to a large extent on the willingness of their employers to support them through the process, said migrant workers interviewed in Saudi Arabia. Hassan, a 44-year old Indian construction worker in Jeddah, said that his employers arranged all the necessary hospital appointments for him after he received a serious burn injury at work in 2022.¹⁵ His colleague said, had his employer not intervened on his behalf with an insurance claim for surgery (ultimately approved) then he would not have challenged the insurance provider and would have either not had the operation or would have had to pay the full cost himself. He said that he would not have known how to challenge any rejection of his claim and that he wouldn't want to "get in trouble" by doing so.¹⁶ The most serious problem in accessing healthcare in Saudi Arabia arises when employers simply refuse to either provide migrant workers with health insurance, or when workers become undocumented and no longer have a valid Iqama (residence) card. As noted above, all low-paid migrant workers can theoretically access emergency healthcare, assuming their condition is sufficiently serious and they are able to negotiate their admission, albeit with language barriers and discriminatory attitudes presenting potentially significant obstacles.

In the United Arab Emirates, each individual emirate sets its own regulations on private health insurance.¹⁷ We spoke to food delivery riders working in Dubai's gig economy who described how employers exploit the different regulations to avoid providing health insurance to their workers, and how health insurance providers can limit, delay or prevent migrant workers from accessing health care.

Three of the four riders said that although they were working in Dubai, they were employed by third-party agents registered in Sharjah and Ajman, where there is no legal requirement that employers provide health insurance to their employees.^{18, 19} A 27-year old Indian called Amir, said that he has an employer-provided insurance policy but complained that it is only accepted by a limited number of clinics.²⁰ "I have insurance that my agents paid for but it covers nothing," he said. All the riders said that there have been times when their insurance provider had rejected a claim even though they were previously informed that their insurance policy would cover it.²¹ We also spoke to higher-income migrant workers in Dubai, who despite not being as vulnerable to the same health risks as low-paid migrant workers, also said that the UAE's mandatory private health insurance had resulted in them encountering difficulties in accessing healthcare.²²

Jeannie, a 25-year old Filipino who works for a large outsourcing company in Abu Dhabi, told the Vital Signs partnership that there are only three hospitals - both over an hour's drive from where she lives - that she can go to for insurance-covered treatments.²³ "Luckily I don't need to see a doctor much but it is still worrying," she says. "Some people are paying [out of their own pockets] to upgrade their plans. I might also do that next year because this [situation] is useless." Brian, a 33-year old Filipino who works as a graphic designer in Dubai said that his employers told him that he would have to cover additional insurance coverage costs associated with pre-existing medical conditions.²⁴ "With my pre-existing condition, my premium shot up to AED 85,000 (US \$23,140). I was asked to cover this on my own, I don't even make that much money in a year."

There is clear evidence to suggest that private health insurance has the effect of discriminating against low-paid migrant workers in Saudi Arabia and the United Arab Emirates. This alone should give cause for concern in light of the imminent shift to mandatory private health insurance across the Gulf, and it should be set in the context of evidence of discrimination in practice in healthcare, and allegations of discriminatory intent in the privatization of health services. Nearly half of respondents in our Kuwait survey - 47 percent - said that they had felt discriminated against while seeking healthcare. Of the respondents who answered a question about the type of discrimination they had been subjected to,

14. Laura El-Katiri, "Vulnerability, Resilience, And Reform: The GCC And The Oil Price Crisis 2014–2016," (December, 2016); "Kuwait Vision 2035 "New Kuwait", Ministry of Foreign Affairs, (2021); Redwanur Rahman, "The Privatization of Health Care System in Saudi Arabia." *Health services insights* vol. 13 (23 Jun. 2020); "Privatization Program," *Saudi Vision 2030*, (2022).

15. In-person interview with Hassan, 12 June 2022.

16. In-person interviews with Ashraf, 12 June 2022.

17. "Health Insurance," *The United Arab Emirates Government Portal*, (15 May 2022).

18. In-person and telephone interviews, May-June 2022.

19. See Migrant-Rights.org, "Comparison Of Health Care Coverage For Migrant Workers In The GCC", (February 2020). The only emirates where it is compulsory for employers to provide private health insurance to their employees are Dubai and Abu Dhabi.

20. In-person interview with Amir, 29 May 2022.

21. In-person and telephone interviews, May-June 2022.

22. In-person and telephone interviews, June 2022.

23. In-person interview with Jeannie, 25 June 2022.

24. In-person interview with Brian, 25 June 2022.

25 percent said that racial discrimination had manifested in healthcare staff's refusal to provide them treatment. A group of Kuwaiti doctors issued public criticism of Kuwait's plans to privatize healthcare in 2011, calling it a "plan to create a separate health system for expatriates," and stating that it would "introduce a physical barrier to the already existing behavioural and financial obstacles suffered by the nation's most destitute populations."^{25, 26} Although they made this prediction more than ten years ago in relation to the provision of healthcare, it has contemporary relevance in the field of the privatization of healthcare funding.

Informal channels of healthcare and use of non-prescription medicine

The various barriers that migrant workers face in accessing formal healthcare mean that they often seek care through informal channels. Numerous low-paid migrant workers in Jeddah in Saudi Arabia told us that they would often seek the paid or unpaid assistance of doctors. Salma, an undocumented 39-year old Yemeni woman, said that her family has relied upon Yemeni nurses and doctors in Jeddah for all their healthcare needs over the past two decades.²⁷ However, she said that they were now having great difficulty accessing these informal healthcare channels because Saudi government efforts to displace the Yemeni diaspora in the country had resulted in every Yemeni healthcare worker the family knew leaving the country. "Everything is possible through *wasta* [connections] here and when your *wasta* is gone, then what?" she said. A Pakistani doctor who has been practicing in a Jeddah public hospital for almost two decades, said that it used to be possible to treat migrant workers in public hospitals without formally registering them and that he knew of several cases where essential surgery had been arranged for migrant workers.²⁸ He said this had now become more difficult: "Everything is computerized now so it is not possible to see patients that easily unless they come through the system," he said. However, even so, he said that he knew of several cases where doctors in public hospitals have arranged for essential surgery for migrant workers without formally registering them into the admissions system. He said that when cases are extremely serious and he cannot help, he advises migrant workers to go back to their country for treatment.

Workers who aren't able to access doctors either formally or informally often resort to the use of non-prescription medicines, which they either bring with them from their home countries, or source from pharmacies or colleagues. 65 percent of respondents in our Kuwait survey said that they took non-prescription medicine to treat a "serious illness" when they could not access better healthcare. Of those who had taken non-prescription medicines, 65 percent of those who responded said they had taken the painkiller Panadol. The use of non-prescription medicines was a recurrent theme among the low-paid migrant workers we spoke to. A 36-year old Pakistani factory worker in Dubai recounted a typical story: "The person who arranged my visa and tickets advised me to take Panadol, and Brufen [Ibuprofen] to Dubai because they are often needed and difficult to obtain in Dubai. We always requested someone arriving from Pakistan to bring medicines along with him. Everyone had their own medicines in the labour camp. Once I had a strain in my neck along with a high fever, so I had to request a Pakistani tailor in Dubai to get me medicine since the supervisor was not willing to listen to my problems. My employers never arranged a doctor or hospital visits for us. In the factory, however, there was a supervisor who had a first aid kit and gave me Indian medicine for healing."²⁹

Professor Vivekanand Jha, the Executive Director at The George Institute for Global Health, India, and Chair of Global Kidney Health at Imperial College London described the health risks associated with overuse of non-prescription medicine. "The general principle is that the indiscriminate use of painkillers is very problematic and can lead to all sorts of health complications such as kidney disease and electrolyte imbalances."³⁰

Access to health as a contributory factor to preventable and unexplained deaths

It is not possible to state with any degree of certainty how many deaths of low-paid migrant workers could have been prevented with timely and regular access to healthcare, but healthcare professionals who spoke to the Vital Signs Partnership offered expert insight on the potential links not just between deaths and access to health, but also on the

25. Migrant-Rights.org, "What's the real deal behind Kuwait's segregated healthcare?" (30 September, 2016).

26. Note that the group and their website- <http://www.q8health.org/health-reform/>- is no longer active. This statement had been obtained by Migrant-Rights.org when the "experimentation" project was still a proposal. Also see "KHI and Health Care Reform Advisory Group Tackle Health Reform in Kuwait", *PrWeb*, (November 27, 2010).

27. In-person interview with Salma, 20 June 2022.

28. Interview with anonymous healthcare professional in Jeddah, June 2022.

29. In-person interview, June 2022.

30. Telephone Interview with Professor Vivekanand Jha, The George Institute for Global Health, India/ Imperial College London, 24 September 2022.

high rate of unexplained deaths and workers' inability to easily access healthcare.

Professor Jha outlined to the Vital Signs Partnership why access to health for any population is essential.³¹ "Without easy access to healthcare, preventable diseases go untreated and can develop into more serious conditions, and chronic diseases will be detected later. In both cases these place a further burden on health services." A senior Nepalese doctor from the Manmohan Cardiac Center, who spoke to the Vital Signs Partnership under condition of anonymity said that, "timely access to health services prevents a large number of deaths."³² Dr Rashidee Mahboob, the former president of the Bangladeshi Medical Association expressed concern at the high rate of deaths of low-paid migrant workers attributed to natural causes in the context of risks to which they are exposed in the Gulf and told the Vital Signs Partnership that "extra precautions" were required for South Asian workers in the Gulf.³³ Professor Jha offered a similar view.³⁴ "We know that this population is doing dangerous work, and the data is very

clear that this can lead to multiple adverse health conditions, whether those are cardiovascular or respiratory or other types of disease. They need regular check-ups to prevent these adverse health consequences, and more regular check-ups than those doing sedentary work."

Dr. Birat Krishna Timalisina, a cardiologist at the Shahid Gangalal National Heart Centre and Metro Hospital in Kathmandu has been conducting heart screening services for migrant workers heading to Qatar.³⁵ He told the Vital Signs Partnership that failure to provide easy access to health "would be a contributory factor in the number of preventable deaths, particularly in an environment where workers are exposed to extreme heat, or other environmental conditions and high levels of stress", and added that the failure "could be a factor in the high number of unexplained deaths". Professor Jha said that in his view, the inability of workers to access healthcare was in all likelihood "a critical factor" behind the high rate of unexplained deaths.³⁶

31. Telephone Interview with Professor Vivekanand Jha, The George Institute for Global Health, India / Imperial College London, 24 September 2022.

32. In-person interview, Manmohan Cardiac Center, Teaching Hospital, 16 September 2022

33. Telephone interview with Dr. Birat Krishna Timalisina, Shahid Gangalal National Heart Centre and Metro Hospital, Kathmandu, 14 September 2022.

34. Telephone Interview with Professor Vivekanand Jha, The George Institute for Global Health, India / Imperial College London, 24 September 2022.

35. Telephone Interview with Dr Rashidee Mahboob, former president of the Bangladeshi Medical Association, 14 September 2022.

36. Telephone Interview with Professor Vivekanand Jha, The George Institute for Global Health, India / Imperial College London, 24 September 2022.



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1. ABOUT THIS REPORT

Vital Signs Partnership

The Vital Signs Partnership is a group of organisations and individuals working together to campaign for better protection for low-paid migrant workers in the six countries of the Gulf Cooperation Council (GCC). The partnership includes the Center for Migrant Advocacy in the Philippines, the Law and Policy Forum for Social Justice in Nepal, Justice Project Pakistan, and the Refugee and Migratory Movements Research Unit in Bangladesh, and researchers and advocates in India. Supporting organisations include Migrant-Rights.org, which documents migrant worker abuses within the GCC, and Migrant Forum Asia in the Philippines. The project is overseen by FairSquare Projects, a non-profit human rights organisation based in London.

The Vital Signs Partnership commissioned the Kuwait Aid Network to conduct an in-person survey of 1,101 low-paid migrant workers in Kuwait between May and July 2021, with 334 respondents from the Philippines, 398 respondents from the South Asian countries of Bangladesh, India, Nepal, Pakistan, and Sri Lanka, 109 Egyptians, and 81 Cameroonians. 575 men (52 percent) and 524 women (48 percent) took part in the survey.

In Bangladesh, the Refugee and Migratory Movements Research Unit (RMMRU) interviewed five men and one woman who had worked in the Gulf states. In the Philippines the Centre for Migrant Advocacy (CMA) interviewed five former migrant workers, three men and two women, numerous Filipino health professionals employed in the GCC and migrant worker support organisations in Qatar and Kuwait. In Nepal, the Law and Policy Forum for Social Justice (LAPSOJ) interviewed one former migrant worker and a team of migrant worker support professionals in Kathmandu. Separately, a consultant for the Vital Signs Partnership spoke to 24 migrants, working or living in the United Arab Emirates, seven in person and eleven by telephone. Eleven of the migrants interviewed worked in low-paid sectors, including four delivery drivers working in the gig economy, twelve worked in professional roles, including four medical professionals and two insurance brokers. We also spoke to the dependant of one migrant worker. In Saudi Arabia, a Vital Signs consultant spoke to 15 low-paid migrant

Methodology

Data collection

The research for this report was carried out by a wide range of organisations and individuals in four origin countries and three Gulf states between May and September 2022.

workers from a range of employment sectors in Jeddah, as well as three healthcare professionals.

We also conducted interviews with numerous experts in the field of migrant workers' rights and numerous medical experts. The medical experts consulted included Professor Vivekanand Jha, the Executive Director at The George Institute for Global Health, India, and Chair of Global Kidney Health at Imperial College London; Dr Rashidee Mahboob, the former president of the Bangladeshi Medical Association; Dr. Birat Krishna Timalina, a cardiologist at the Shahid Gangalal National Heart Centre and Metro Hospital in Kathmandu; Dr. Ernesto Gregorio Jr., from the University of the Philippines Manila College of Public Health; and Dr. Dennis Batangan, a second public health specialist from the Philippines. Other experts consulted included Dr Hiranthi Jayaweera, an expert on domestic workers' access to health and a former Senior Researcher at the School of Anthropology and Centre on Migration, Policy, and Society, University of Oxford; representatives of Sandigan Kuwait Domestic Workers' Association; and representatives of an informal organization supporting migrant domestic workers in Qatar. On condition of anonymity we also spoke to several medical professionals and professionals working in the United Arab Emirates and Saudi Arabia, and people working in professional positions in the UAE's private health insurance sector.

In addition to these primary sources, we have included a wide range of secondary source material, including NGO reports, newspaper articles, and peer-reviewed academic articles from various disciplines.

The report draws to a large extent on field research conducted in Saudi Arabia, the United Arab Emirates, and Kuwait. The specific findings from one country cannot simply be extrapolated to another, however there is striking consistency in the barriers to access to healthcare in these three countries, which include the Gulf state's most populous countries, Saudi Arabia and the UAE. In view of the fact that there is general uniformity in the risks to which low-paid migrant workers are exposed in all six of the Gulf states, and significant similarities in the manner in which they are increasingly relying on the private sector to both provide and fund non-emergency healthcare, we have made general recommendations in this report that we believe are appropriate to all of the Gulf states.

A rights-based approach

This report takes a rights-based approach to the issue and examines the extent to which laws, policies and practices prevent low-paid migrant workers from accessing healthcare services in the Gulf states.³⁷

Under international human rights law, individuals have the "the right to the highest attainable standard of health" and this implies a clear set of legal obligations on states to ensure appropriate conditions for the enjoyment of health for all people without discrimination.³⁸ As the World Health Organization has noted, with reference to guidance provided by the UN Committee on Economic, Social and Cultural Rights: "A human rights-based approach to health provides a set of clear principles for setting and evaluating health policy and service delivery, targeting discriminatory practices and unjust power relations that are at the heart of inequitable health outcomes. In pursuing a rights-based approach, health policy, strategies and programmes should be designed explicitly to improve the enjoyment of all people to the right to health, with a focus on the furthest behind first."³⁹

Critically, governments are obliged to take immediate steps within their means towards the fulfilment of the right to health, and the principle of anti-discrimination, which underpins much of human rights law aimed at social advancement, means that discrimination in access to health care is prohibited on the basis of race, colour, sex, language, or other status that has the intention or effect of impairing the equal enjoyment or exercise of the right to health.⁴⁰

Report outline

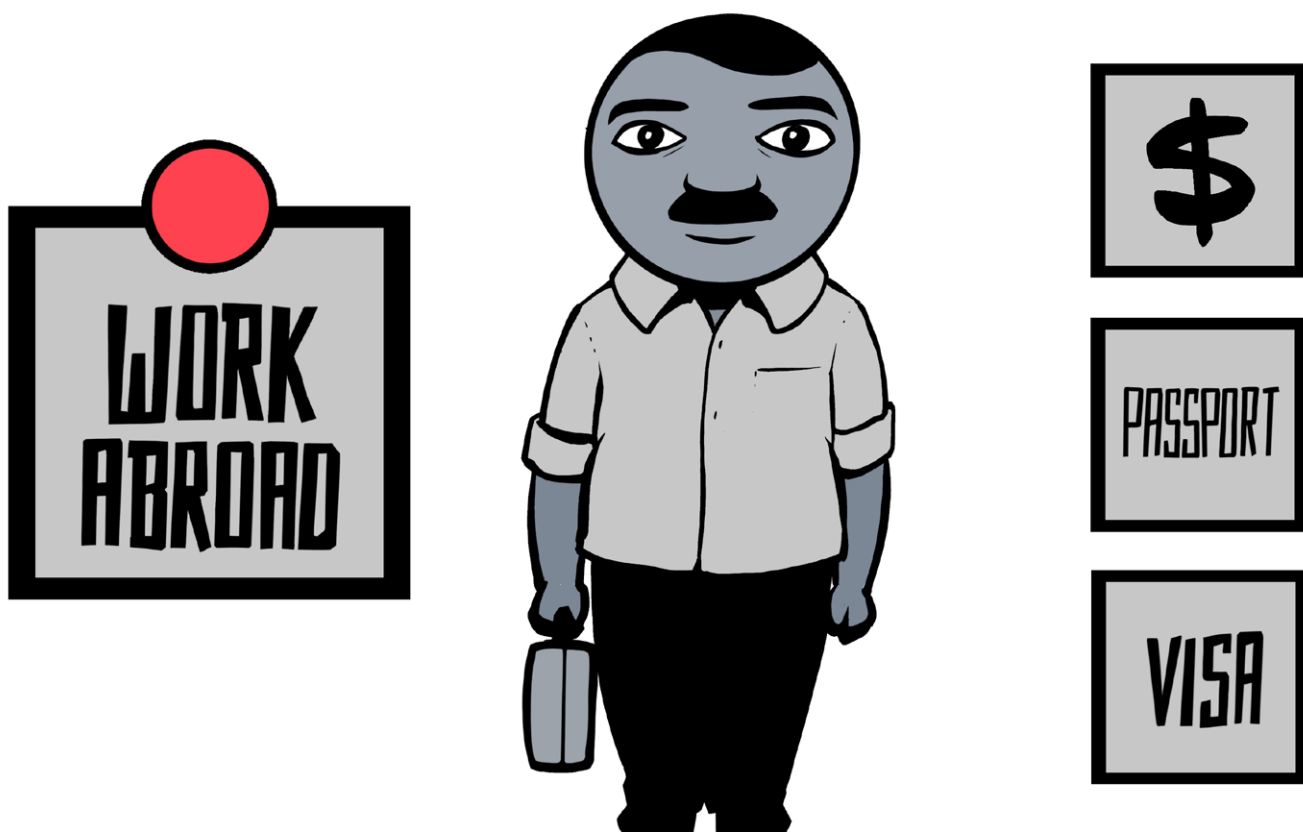
The report contains seven sections, addressing either specific cross-cutting issues or specific countries, interspersed with four case studies. The first section describes the results of a survey of low-paid migrant workers in Kuwait. The second section is an examination of the healthcare systems in the Gulf and an analysis of the shift towards universal systems of mandatory private health insurance for migrant workers. The third section examines the specific problems that women domestic workers encounter when trying to access healthcare. The fourth and fifth sections examine the two Gulf states which not only have the largest populations of migrant workers, but which are the two countries that have long-established systems of mandatory private health insurance for migrant workers: Saudi Arabia and the United Arab Emirates. The section examines migrant workers' access to health in Qatar, where the 2022 FIFA World Cup has placed the country's record on workers' rights under particular scrutiny. The seventh and final section draws on the expertise of medical experts with a view to determining the links between migrant workers' difficulty accessing healthcare and the number of preventable and unexplained deaths in the Gulf states.

37. In the field of development, the achievement of universal health coverage is part of Sustainable Development Goal 3, and is assessed according to a wide range of health-related indicators. See World Health Organization, "Targets of Sustainable Development Goal 3," (2022)

38. United Nations Committee on Economic, Social and Cultural Rights, "CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)", (11 August 2000).

39. World Health Organisation, "Human Rights and Health", (29 December 2017)

40. United Nations Committee on Economic, Social and Cultural Rights, "CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)", (11 August 2000).



Artwork by Appupen

2. A SURVEY OF MIGRANT WORKERS' ACCESS TO HEALTH IN KUWAIT

The small oil-rich emirate of Kuwait, which borders the northern coast of the Gulf has a total population of 4.2 million, with 2.8 million non-Kuwaitis making up approximately 67 percent of the total population, of which approximately 65 percent is male.⁴¹

As part of this project, the Kuwait Aid Network was commissioned to conduct an in-person survey of 1,101 low-paid migrant workers in Kuwait between May and July 2021, seeking responses on a range of issues related to their ability to access healthcare. To the best of our knowledge, this is the largest survey of its kind in the Gulf region. The responses provide evidence that low-paid migrant workers in Kuwait have tremendous difficulty accessing healthcare, and illuminate the reasons for, and consequences of this difficulty.

The largest group of participants was from the Philippines:

334 respondents or 30 percent. There were 398 respondents from the South Asian countries of Bangladesh, India, Nepal, Pakistan, and Sri Lanka. 109 Egyptian and 81 Cameroonian nationals answered the survey. 177 people from another 26 countries also took part.

575 men (52 percent) and 524 women (48 percent) took part in the survey. However, while the overall survey population was well-balanced from a gender perspective, there were imbalances among national groups. 246 of 334 of Filipino respondents, 71 of 82 Cameroonian respondents and 94 of 96 Sri Lankan respondents were women. 79 of 79 Bangladeshi respondents, 106 of 109 Egyptian respondents and 109 of 135 Indian respondents were men.

62 percent of respondents were under the age of 40, while 35 percent were between 40 and 59.

41. Central Statistics Bureau, "Population Estimates in Kuwait by Age, Nationality and Sex at 1-1-2022," (2022).

Nationality	Total	Sex			Age					
		Male	Female	Not given	18 - 30	30 - 40	40 - 50	50 - 60	60 +	Not given
Bangladeshi	79	79	0	0	22	35	19	3	0	0
Cameroonian	82	11	71	0	33	48	1	0	0	0
Egyptian	109	106	3	0	20	62	24	3	0	0
Filipino	334	88	246	0	28	150	107	42	7	0
Indian	135	109	26	0	20	42	45	24	4	0
Nepali	32	27	5	0	11	20	1	0	0	0
Not given	1	0	1	0	0	1	0	0	0	0
Other	177	101	75	1	42	61	44	22	7	1
Pakistani	56	53	3	0	10	18	10	11	7	0
Sri Lankan	96	1	94	1	18	43	21	9	5	0
Total	1,101	575	524	2	204	480	272	114	30	1

Respondents were asked to give their occupation. We subsequently grouped the 197 responses into 15 broad categories. The two largest categories were domestic work and construction. 322 respondents, 312 of whom were women, were employed as domestic workers. 34 men and 1 woman worked as drivers, some of whom may also be employed by private households. 265 men and 4 women were employed as labourers or in other construction roles.

The respondents in these two largest sectors (domestic work and construction) were from a range of nationalities. In other sectors, certain nationalities dominated the respondents. For example, 70 out of 77 cleaners who took part were from Bangladesh, while 41 of the 50 respondents who said they were nurses or in other medical roles were from the Philippines.

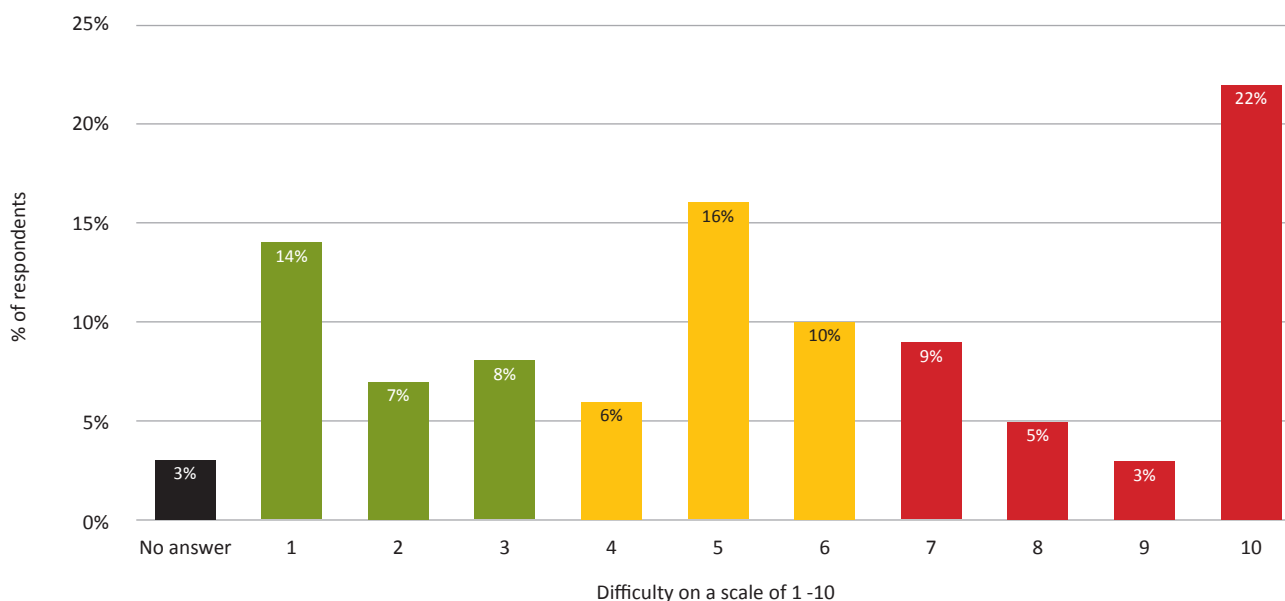
Occupation	Total	Sex			Nationality									
		Male	Female	Not given	Bangladeshi	Cameroonian	Egyptian	Filipino	Indian	Nepali	Other	Pakistani	Sri Lankan	Unknown
Beauty sector	16	0	16	0	-	-	-	7	3	-	6	-	-	-
Cashier	38	28	10	0	-	-	3	10	20	1	3	-	1	-
Cleaner	77	74	3	0	70	-	-	1	1	3	2	-	-	-
Domestic worker	322	10	312	0	1	69	1	125	14	-	30	-	82	-
Driver	35	34	1	0	-	3	4	7	12	1	7	-	1	-
Food and retail sector	47	27	20	0	-	2	4	25	4	2	7	2	1	-
Housewife	30	0	30	0	-	-	-	2	2	-	24	2	-	-
In-office catering	19	18	1	0	-	-	-	-	2	16	-	-	1	-
Manual labour / construction	269	265	4	0	4	3	76	18	56	4	62	46	-	-
None	9	4	5	0	-	-	2	-	-	-	7	-	-	-
Nursing / medical	50	14	36	0	-	-	4	41	1	-	4	-	-	-
Offic worker	105	56	49	0	3	4	6	65	12	4	8	2	1	-
Other	48	29	19	0	-	1	4	20	6	1	12	2	1	1
Security guard	5	5	0	0	1	-	4	-	-	-	-	-	-	-
Unknown	31	11	18	2	-	-	1	13	2	-	5	2	8	-
Total	1,101	575	524	2	79	82	109	334	135	32	177	56	96	1

How difficult is it to access healthcare?

Respondents were asked to say how easy or difficult they found it to access healthcare by giving a score of between 1 and 10, with 1 representing 'very easy' and 10 representing

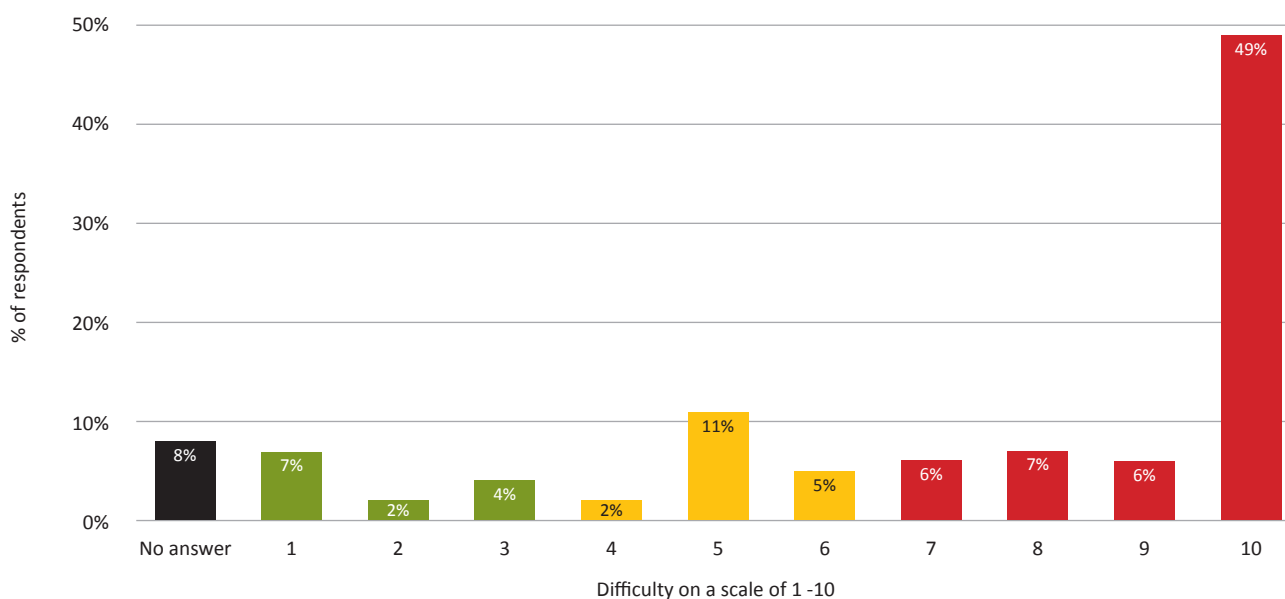
'very difficult'. The most widely chosen score was 10, the highest mark available, indicating that accessing healthcare was very difficult. 21 percent of respondents selected this option. The mean score of the respondents who gave a score was 5.65.

On a scale of 1 -10, 1 being very easy, 10 being very difficult, how difficult or easy was it to obtain the healthcare services you have needed in the time that you've been in Kuwait?



The survey indicates that accessing healthcare became significantly more difficult during the Covid-19 pandemic, with 45 percent of respondents giving the maximum score for difficulty and the mean score rising to 7.64.

On a scale of 1 -10, 1 being very easy, 10 being very difficult, how difficult or easy was it during the COVID-19 pandemic for you to access the healthcare services you needed?

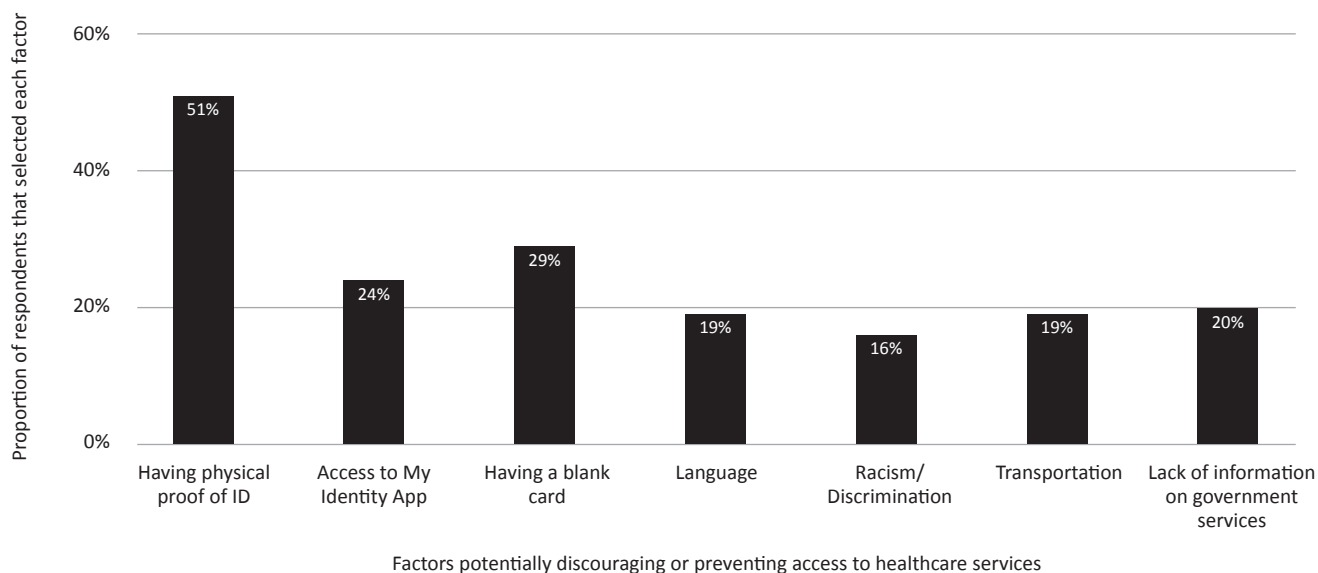


Non-financial barriers to healthcare

Participants were asked what non-financial obstacles to accessing healthcare they faced. They were able to select more than one option. 51 percent of respondents said that the lack of a Kuwaiti ID prevented or discouraged them from accessing healthcare. Migrant workers without an ID can only access healthcare in private clinics, where the costs of care are not subsidized. 24 percent of respondents said that not having access to their ID on their smartphones was an issue. Of the other factors researchers asked respondents about:

- 29 percent said that the fact they didn't possess a bank card prevented or discouraged them from accessing healthcare;
- 19 percent said language barriers was a factor;
- 16 percent said racism and/or discrimination was a factor;
- 19 percent said transportation was a factor; and
- 20 percent said a lack of information on government services was a factor.

Which of the following has discouraged or prevented you from access to healthcare services?



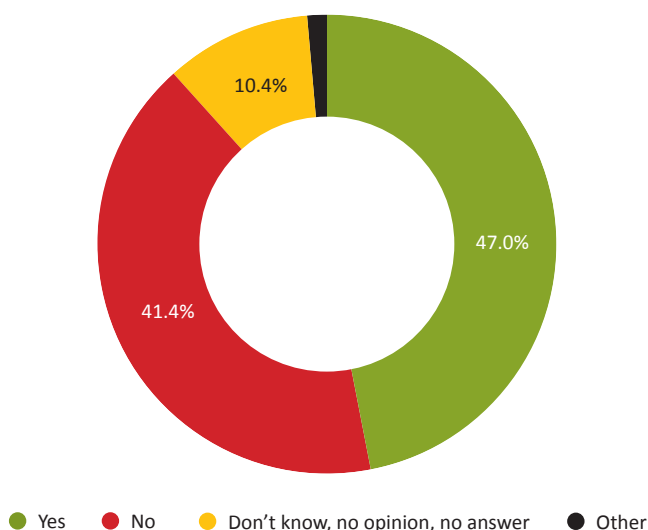
These responses indicate that the most prevalent non-financial barrier to access, of those we asked about, is a lack of basic documentation, and that this is compounded by

other barriers that Kuwaiti nationals or migrant workers with higher socio-economic status are extremely unlikely to face.

Discrimination

47 percent of respondents said that they had felt discriminated against while seeking healthcare, against 41 per cent who said they had not.

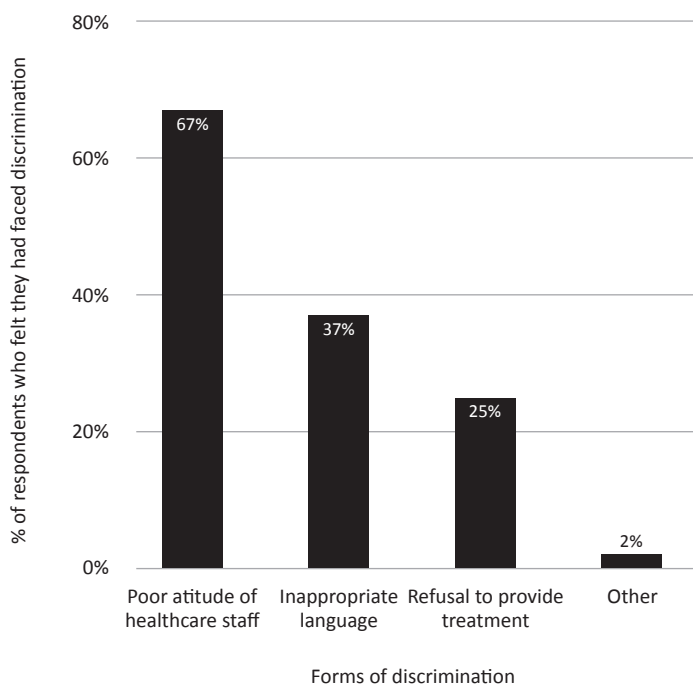
Have you ever felt discriminated against while seeking healthcare? **Where respondents gave an answer that was not yes or no*



Those who said yes were asked what form this discrimination took. Of those who answered this follow-up question:

- 67 percent said that they had experienced healthcare workers displaying negative attitudes towards migrant workers
- 37 percent said they had been subjected to inappropriate language from healthcare professionals, and
- 25 percent said that they had been denied treatment altogether.

If so, what type of discrimination? **Not all answers included*

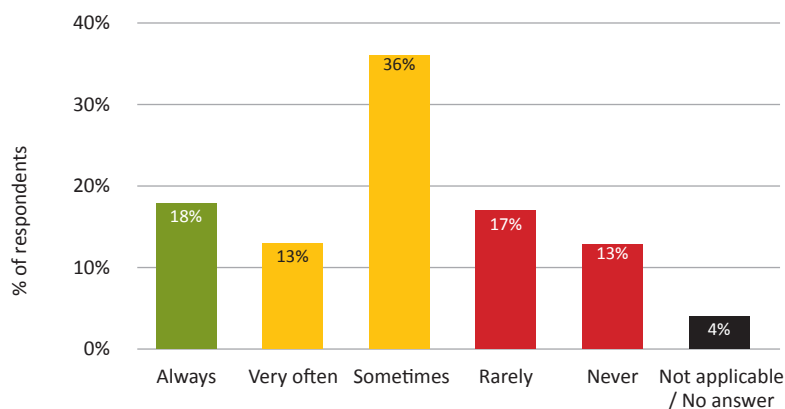


One respondent told researchers that “we feel we are not important when we go to the hospital.”⁴² Several respondents said that migrant workers were generally treated as lower priority than Kuwaiti nationals.

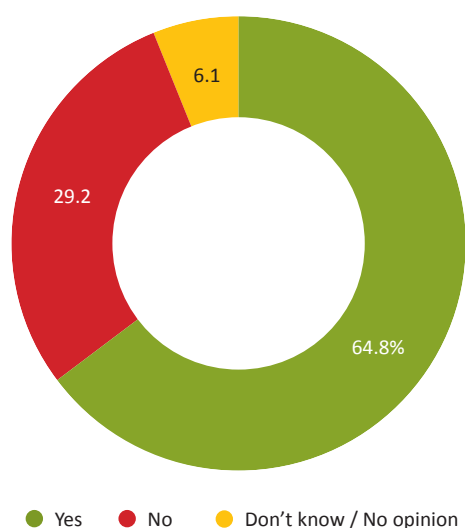
Financial barriers to healthcare

30 percent of respondents- nearly one in three- said that they could “rarely” or “never” afford healthcare. 36 percent said that they could “sometimes” afford healthcare, while only 18 percent of respondents indicated that they were “always” able to afford healthcare.

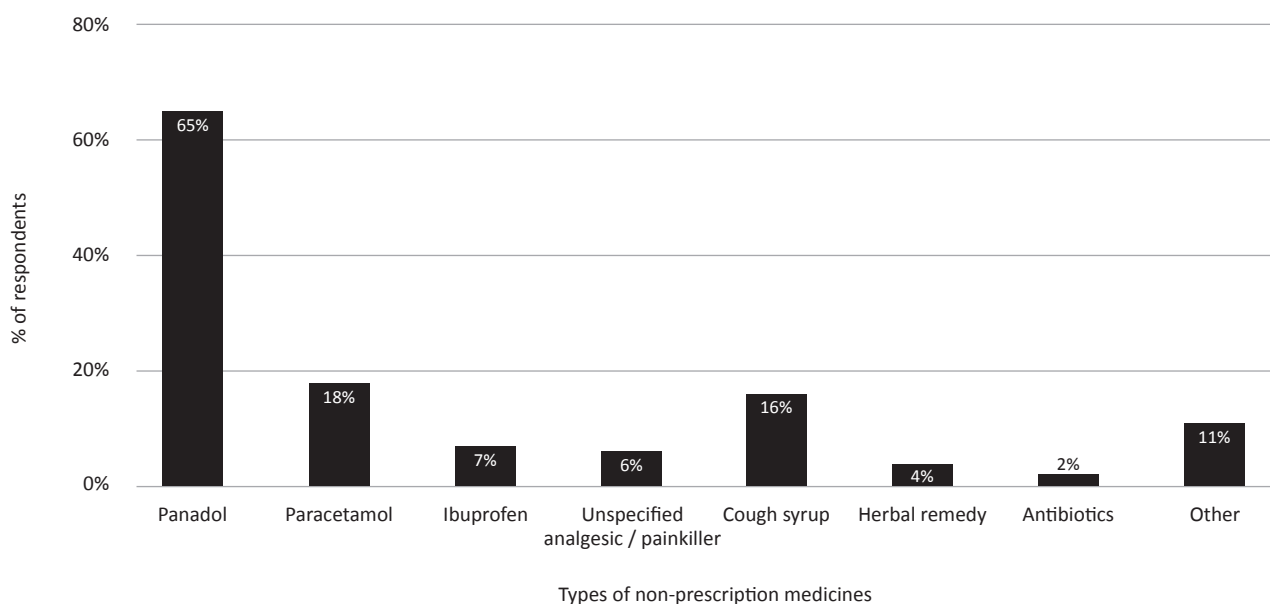
42. In-person survey in Kuwait, May-July 2021.

Are the healthcare services available affordable to you?**Consequences**

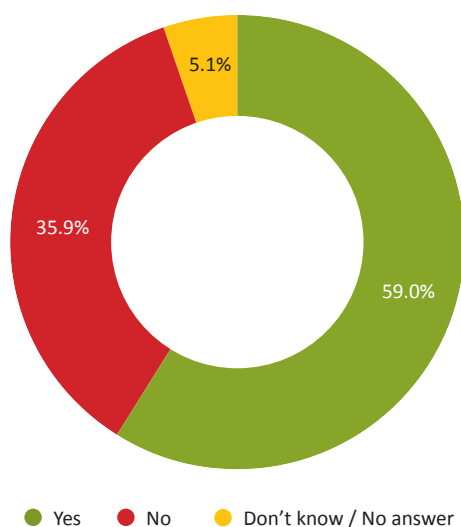
65 percent of respondents said that they took non-prescription medicine to treat a “serious illness” when they could not access better healthcare.

Have you ever taken non-prescription medicines (e.g. panadol, cough syrup or ibuprofen) to treat a serious illness because you could not access better healthcare services?

Those who said yes were asked what types of non-prescription medicines they had taken. 65 percent of those who responded named Panadol.

If yes, can you tell us what non-prescription medicines you took?

In the past 3 years, have you reduced your spending on essential needs, such as food or clothing, to be able to cover healthcare costs?



The results of the survey support long-standing concerns about the inability of low-paid migrant workers in Kuwait to access healthcare. Among the most significant findings is that 21 percent of respondents indicated that accessing healthcare was very difficult and respondents returned a mean score of 5.65 when asked to rank the ease of accessing healthcare from 1 (very easy) to 10 (very difficult). This median score increased significantly to 7.64 during the Covid-19 pandemic, at a time when public health was dependent on easier access to healthcare. Notably, respondents did not rank inability to physically access healthcare as one of the more significant barriers to healthcare, nor did they indicate that the quality of service they received (when they were able to) was poor. On the contrary, 67 percent of respondents said that the care they received in Kuwaiti hospitals was of good quality. These findings alone suggest serious failings in the system, and that the failings relate to migrant workers' inability to access the available healthcare, not a lack of provision of care, or poor quality of care.

The survey provides a clear picture of the barriers that low-paid migrant workers face. Cost was a significant barrier, with 30 percent of respondents saying that they could rarely or never afford healthcare, and only 18 percent of respondents saying they could always afford healthcare. On its face this finding seems at odds with Kuwait's policy of subsidizing healthcare for its migrant worker population with the aim of making it affordable, but in order to access these subsidies migrant workers need to have access to a Kuwaiti identity card or a 'My Identity' smartphone application. More than half of respondents- 51 percent- said they had been

discouraged or prevented from accessing healthcare due to not having physical proof of their identity. 29 percent of respondents cited the lack of a bank card, which can also be linked to a lack of formal documentation, as a factor that discouraged or prevented them from accessing healthcare. The survey clearly indicates that the interlinked issues of affordability and documentation are the most significant barriers to healthcare, but they are not the only ones. Between 16-20 percent said that language barriers, racist discrimination, transportation and a lack of information on government services were barriers. With regard to discrimination, nearly half of respondents- 47 percent- said that they had felt discriminated against while seeking healthcare. Of the respondents who answered a question about the type of discrimination they had been subjected to, 25 percent said that racial discrimination had manifested in healthcare staff's refusal to provide them treatment.

The survey also shows the extent of low-paid migrant workers' use of non-prescription medication with 65 percent of respondents saying that they had resorted to over-the-counter medicines to treat a serious illness because they could not access better healthcare services. Respondents cited Panadol as the most popular non-prescription medication.

The survey findings paint a deeply troubling picture of migrant workers' inability to access healthcare, and indicate that health policy, strategies and programmes in Kuwait have not been designed with its most vulnerable populations in mind, resulting in a system that clearly discriminates against its low-paid migrant worker population.

The survey findings cannot be extrapolated to the other five GCC countries, but given the similarities in the healthcare systems (addressed in detail in the following section) and the similar risks to which migrant workers are exposed in all six of the Gulf states, as a result of their living and working conditions, they provide empirical evidence of structural problems that should be of concern to governments across the region, as well as governments in countries where many of these low-paid workers originate. One critical point to note, and which is addressed in the following section, is that

Kuwait is in the process of moving to a system of mandatory private health insurance. The stated goal of these private health insurance schemes is to enhance the quality of care available, but as the following sections of this report will demonstrate, with reference to studies of the two Gulf countries where mandatory health insurance is already operational, the evidence suggests that mandatory health insurance is more likely to present a further barrier to low-paid migrant workers's access to healthcare.



Artwork by George Mathen

Artwork by Appupen

3. HEALTHCARE AND PRIVATE INSURANCE SYSTEMS IN THE GULF

There is a stark difference between the manner in which the Gulf states fund care for their citizens and the manner in which they fund care for non-citizens.⁴³

Emergency care is free to all irrespective of nationality, migration status or health insurance coverage. Where non-emergency care is concerned, whether primary care (general practitioners), secondary care (specialists), or tertiary care (hospitalisation for serious illnesses), the Gulf states either fund it directly by making healthcare free in government hospitals, or indirectly through funding the insurance premiums that allow their citizens to access care.⁴⁴

Non-citizens, including the low-paid migrant workers who constitute the most populous and most vulnerable sections

of Gulf societies, require either private health insurance or government-issued health cards in order to access affordable non-emergency care in public or private hospitals and clinics. (Undocumented migrant workers in the Gulf generally have no access to formal channels of healthcare.)

In Bahrain, it costs 72 Bahraini dinars (US \$191) per year for a health card.⁴⁵ In Kuwait, migrant workers require a civil identification card which costs 5 Kuwaiti dinars (US \$16), and an annual fee of 50 Kuwaiti dinars to access government hospitals and clinics (US \$161).⁴⁶ Both Bahrain and Kuwait are planning to introduce mandatory health insurance schemes for migrant workers.⁴⁷ In Qatar, migrant workers have typically required a Hamad Health Card, at a cost of 100 Qatari riyals (US \$27) generally - 50 Qatari riyals (US \$14) for domestic

43. For detailed background see Ibtihal Fadhil, et al, "[Review of National Healthcare Systems in the Gulf Cooperation Council Countries for Noncommunicable Diseases Management](#)," *Oman medical journal* vol. 37,3 e370. (10 May, 2022); Shreena Malaviya, et al, "[Socioeconomic disparities in healthcare utilization under universal health coverage: evidence from Dubai household health survey](#)," *International journal for equity in health* vol. 21,1 90. (25 June, 2022); A Alkhamis, A Hassan, P Cosgrove, "[Financing healthcare in Gulf Cooperation Council countries: a focus on Saudi Arabia](#)," *Int J Health Plann Manage*. (29 Jan, 2014); and Migrant-Rights.org, "[Comparison Of Health Care Coverage For Migrant Workers In The GCC](#)," (February 2020).

44. Ibid.

45. "[Fees](#)," *Labour Market Regulatory Authority, Kingdom of Bahrain*, (2022).

46. "[First Time Registration of Expatriates](#)," *Kuwait Government Online, State of Kuwait*, (2021); Kuwait Aid Network, "[Migrant Rights](#)," (2022). ; Oxford Business Group, "[Compulsory health care coverage for expatriates in Kuwait to boost insurance premiums](#)," (2017); Migrant-Rights.org, "[Comparison Of Health Care Coverage For Migrant Workers In The GCC](#)," (February 2020).

47. See Bahrain's [Law No. 23 of 2018 Promulgating the Health Insurance Law](#), Official Gazette 3369, 7 July 2018, and Kuwait's [Law No. 125 of 2019 Regulating Insurance](#), 1 September 2019; "[Bahrain to implement expat health insurance soon](#)," *Zawya*, (23 June 2022); "[Dhahan Hospital CEO: Public-private hlt partnerships 'integral' to Kuwait Vision 2035](#)," *Kuwait News Agency (KUNA)*, (23 February, 2022); "[Kuwait: Mandatory health insurance for expats in private sector](#)," *Gulf Insider*, (7 August, 2022).

workers- but this will change as the government continues to implement the mandatory private health insurance legislation it introduced in May 2022.⁴⁸ Oman has historically had the most costly system for migrant workers, who have had to pay for all non-emergency care, but it is moving towards introducing mandatory health insurance for all private sector employees in 2023.⁴⁹ Saudi Arabia, and Dubai and Abu Dhabi in the United Arab Emirates have had mandatory health insurance schemes in place for some time.⁵⁰

It is generally the legal responsibility of migrant workers' employers or sponsors to provide their employees with the identification that they need to access healthcare, or to pay the insurance premiums they require, in countries where mandatory private health insurance is already in place. The care available to migrant workers therefore depends to a large extent on whether their employers adhere to these legal obligations, and whether the government ensures their compliance. If employers don't provide health cards or health insurance to their workers, it is the workers who will pay all healthcare costs themselves, which makes anything other than basic care unaffordable to low income workers in high income economies.⁵¹

With the imminent shift to mandatory health insurance schemes in all six Gulf states, migrant workers' access to healthcare will depend not only on employers providing them with insurance but also on the scope of the coverage they provide. A Konrad-Adenauer-Stiftung survey of 119 migrant workers from the Philippines, Egypt and Pakistan in Jeddah and Dubai in April and June 2020 found that 23.1 percent reported not having medical insurance due either to their irregular status or more recently due to the impact of the Covid-19 pandemic.⁵² If employers provide very basic insurance, this could significantly restrict both the scope of the care available to them, and limit the number of clinics they are able to access.

See the annex to this report for a more detailed comparison of the Gulf states' healthcare systems.

Mandatory health insurance schemes and privatization

The implementation of national mandatory health insurance schemes has coincided with an increase in the privatization of healthcare services in the Gulf states. Healthcare was one of sixteen government sectors identified for privatization under Saudi Arabia's Vision 2030 national strategy document, for example, with the aim being to "enhance the quality and efficiency of public services, and support contributions to economic development."⁵³ (All of the Gulf states have produced similar 'vision' documents and the shift to full or partial private funding of healthcare is a consistent policy they outline.)⁵⁴ In 2020, Saudi Arabia met its objective of increasing private sector contribution in healthcare spending to 35 percent. In the Gulf region generally, the share of private hospitals increased from 39 percent in 2015 to 41 percent in 2019. Private healthcare expenditure has risen from 28 percent of total expenditure on health in 2015 to about 37 percent of total expenditure on health in 2020.⁵⁵

The shift to privatisation both in the provision of care and in its funding appears to be at least partially motivated by the desire to mitigate the dependency of the Gulf economies on oil revenues and develop a sustainable industry by transferring the cost of healthcare from the government to employers, in the face of increased demand for healthcare due to an increase in population, improved life expectancy, and higher incidences of non-communicable diseases.⁵⁶ A study of the development of privatisation of healthcare services in Saudi Arabia noted that increases in privatisation have coincided with falls in the price of oil.⁵⁷ A similar pattern was evident in the UAE in 2016 when low oil prices prompted the UAE government to introduce a range of economic reforms in preparation for the post-oil economy, one of which was the reform of private health insurance.⁵⁸

48. "Health Card," *Primary Health Care Corporation*, (2020); Migrant-Rights.org, "Qatar: Compulsory Health Insurance System Introduced," (28 June 2022); "MOPH's Preparations to Implement New Healthcare Services Law," *Ministry of Public Health*, (18 May, 2022). See Law No. 22 of 2021 Regulating Health Care Services (November 2021).

49. See Decision No. 78 of 2019 Issuing the Health Insurance Rules, Official Gazette 1312, 6 October 2019.) Qasim Al Maashani, "Rollout of Mandatory Health Insurance in 2023," *Oman Observer*, (19 September 2022).

50. *Cooperative Health Insurance Law No. 71*, Royal Decree No. M/10, 12 August 1999; "Health Insurance," *The United Arab Emirates' Government Portal*, (15 May 2022).

51. In Saudi Arabia, insurance is directly linked to an individual's Iqama card, which also serves as a residence and work permit.

52. Fahad L. Al-Ghalib Alsharif and Froilan T. Malit, Jr., "Migration and The COVID-19 Pandemic in the Gulf", *Konrad-Adenauer-Stiftung*, (October 2020).

53. "Privatization Program," *Saudi Vision 2030*, (2022).

54. See, for example "From Regional Pioneer to Global Contender," *The Economic Vision 2030 for Bahrain*, (2008), and "Moving Forward with Confidence," *2040 Oman Vision*, (2020).

55. Ardent Advisory and Accounting, "GCC Healthcare And Pharmaceutical Sector," (June 2021), pgs. 5, 12-13

56. Laura El-Katiri, "Vulnerability, Resilience, And Reform: The GCC And The Oil Price Crisis 2014–2016," (December, 2016); "Kuwait Vision 2035 "New Kuwait", Ministry of Foreign Affairs, (2021); Redwanur Rahman, "The Privatization of Health Care System in Saudi Arabia." *Health services insights* vol. 13 (23 Jun. 2020); "Privatization Program," *Saudi Vision 2030*, (2022). T Khoja, S Rawaf, W Qidwai, D Rawa, K Nanji, A Hamad, "Health Care in Gulf Cooperation Council Countries: A Review of Challenges and Opportunities." *Cureus*, (21 August, 2017).

57. Redwanur Rahman, "The Privatization of Health Care System in Saudi Arabia." *Health services insights* vol. 13 (23 Jun. 2020).

58. Laura El-Katiri, "Vulnerability, Resilience, And Reform: The GCC And The Oil Price Crisis 2014–2016" (December, 2016).

It is notable that in 2017 the Gulf states' healthcare expenditure as a percentage of GDP (3.8 percent) was much lower than the global average of 10 percent.⁵⁹ This suggests that at least one of the driving forces behind privatization was the desire to diversify the economy, and open up new non-hydrocarbon revenue streams for its private sectors.

As Migrant-Rights.org noted in a 2016 report, there was a concerted effort by the Kuwaiti government in the mid-2010s to generate support for, and thereby preemptively justify, segregationist policies in healthcare provision:

*"During [2013-2016], the health ministry, with the help of media, popularized a discourse to support their claims [that segregation will afford Kuwaitis the best care]; in the past year, many networks and newspapers created polls to depict the project as democratic and supported by most citizens. This included blaming expats, who make up two-thirds of the population, for long waits in hospitals and clinics... despite the fact that Kuwait's parliament and politicians have publicly and regularly criticized the government for failing to reform or meaningfully expand health services since the 1970's."*⁶⁰

An independent group of Kuwaiti doctors, the Health Care Reform Advisory Group (HCRAAG), issued strongly-worded opposition to plans for privatization as far back as 2011, citing its likely impact on non-citizens, whom they said were already subject to discriminatory practices.

*"Kuwait's plan to create a separate health system for expatriates will introduce a physical barrier to the already existing behavioral and financial obstacles suffered by the nation's most destitute populations. Evidently, this concept does not stem from existing health policy evidence. Rather it has been formulated by policy-makers seeking a rapid, "band-aid" solution to the nationals' concerns over overcrowding in healthcare facilities. Segregation of health services is already seen in Kuwait. Separations are enforced in primary care clinics and in certain intensive care units. ...Contrary to the way this has been marketed by its proponents, this scheme is in obvious violation of basic human rights, is not financially viable, and will not result in high quality services."*⁶¹

Evidence of segregation in healthcare is not limited to Kuwait. Bahrain's current healthcare scheme for "workers of establishment" also allows an employer of more than 50 people to avoid providing insurance coverage for workers if a licensed medical unit is set up at the establishment, although it is not clear how many such medical units exist.⁶² A 2011 survey found that 75 percent of Qatari respondents believed that migrants put a strain on the country's health services.⁶³ In 2013, The Hamad Medical Corporation (HMC) built the Hazm Mebaireek General Hospital (HMGH) in the Industrial Area of Doha exclusively for adult males (low-income) living in that area. One industry expert told researchers in 2016 that Qatar's "stratification [of healthcare facilities] has led to a number of problems for citizens and migrants alike such as poor quality service and inefficiency across the system."⁶⁴ This is anecdotal and there is no evidence that the healthcare that Qatar has provided specifically for its migrant worker population offers a lower standard of care than the public hospitals in Doha that also cater to Qataris and wealthier migrant workers. The clinic provides healthcare in an area that is heavily populated by low-paid migrant workers and the construction of easily accessible healthcare services in this area is an appropriate public health response, but it should also be set in the context of the physical segregation of low-paid workers in labour camps. In July 2020, the UN Special Rapporteur on Racism issued a report on Qatar and raised "serious concerns about racial discrimination in the provision of the right to adequate housing."⁶⁵

Impact of private health insurance on low-paid migrant workers

Saudi Arabia, and Dubai and Abu-Dhabi in the United Arab Emirates have each had mandatory private health insurance schemes in place for more than a decade.⁶⁶ Research from the UAE suggests the introduction of this system has not benefited low-paid migrant workers there.

A 2022 study compared the effect of ISAHD, Dubai's mandatory health insurance scheme which was introduced in 2014, on the utilisation of healthcare (meaning how often people access healthcare services) and out-of-pocket

59. T Khoja, S Rawaf, W Qidwai, D Rawaf, K Nanji, A Hamad, "Health Care in Gulf Cooperation Council Countries: A Review of Challenges and Opportunities." *Cureus*, (21 August, 2017).

60. Migrant-Rights.org, "What's the real deal behind Kuwait's segregated healthcare?" (30 September, 2016)

61. Note that the group and their website - <http://www.q8health.org/health-reform/> - is no longer active. This statement had been obtained by Migrant-Rights.org when the "experimentation" project was still a proposal. Also see "KHI and Health Care Reform Advisory Group Tackle Health Reform in Kuwait", *PrWeb*, (November 27, 2010).

62. See *Order No. (29) of 2014* With Regard to Specifying and Regulating Basic Health Care for Workers of Corporations

63. Elizabeth H. Shlala, and Hiranthi Jayaweera, "The Right to Health: Sri Lankan Migrant Domestic Workers in the GCC" *Muslim World Journal of Human Rights* 13, vol no. 1 (2016): 75-100, pg. 91.

64. Elizabeth H. Shlala and Hiranthi Jayaweera, "The Right to Health: Sri Lankan Migrant Domestic Workers in the GCC" *Muslim World Journal of Human Rights* 13, vol no. 1 (2016): 75-100, pg. 91.

65. United Nations, General Assembly, Human Rights Council, "Visit to Qatar: Report of the Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance", A/HRC/44/57/Add.1, (15 June-3 July 2020).

66. *Cooperative Health Insurance Law No. 71*, Royal Decree No. M/10, 12 August 1999; "Health Insurance", *The United Arab Emirates' Government Portal*, (15 May 2022).

(OOP) expenditures on different social-economic groups.⁶⁷ It found that “the presence of insurance lowered the effective out of pocket prices for medical goods and simultaneously increased utilization as well as total out of pocket spending.”⁶⁸ Thus the overall effect of the introduction of private health insurance was positive: people spent less of their own money and accessed healthcare more often.

However, the impact on non-citizens in collective households and labour camps- i.e. low-paid migrant workers- did not follow this general trend. Low-paid migrant workers did not increase their per capita use of health services. The report found evidence that low-paid migrant workers were generally enrolled in private insurance schemes, leading the researchers to conclude that the fact that migrant workers were not accessing healthcare more frequently was a result of “remaining non-financial barriers”, possibly including “obstacles in scheduling, transport, and logistics, cultural and language barriers, health literacy, and coverage awareness.”⁶⁹

A 2012 study found that 95 percent of Abu Dhabi's population was enrolled in one of three insurance plans: the ‘Thiqa’ plan for nationals, and the ‘Enhanced’ and ‘Basic’ plans for expats – the latter largely reserved for low-income expats. The report found that UAE nationals constituted 40.7 percent of the total sum claimed from insurance providers and made an average of 14 claims per member per year, whereas funds paid out to ‘basic’ insurance-holders (typically low-paid migrant workers, who constitute the majority of the population) represented only 26.5 percent of the total sum claimed. People with ‘basic’ policies only made an average of 3 claims per member per year.⁷⁰ The study's authors concluded that people on the basic plan, which had a higher level of co-payments (the percentage of the total cost not covered by the insurance provider and instead paid by the individual) under-utilised their insurance plans.⁷¹

The following section examines the particular barriers that female domestic workers face in accessing healthcare, and examines two specific cases, where women in Kuwait and Saudi Arabia suffered serious physical and mental harm.

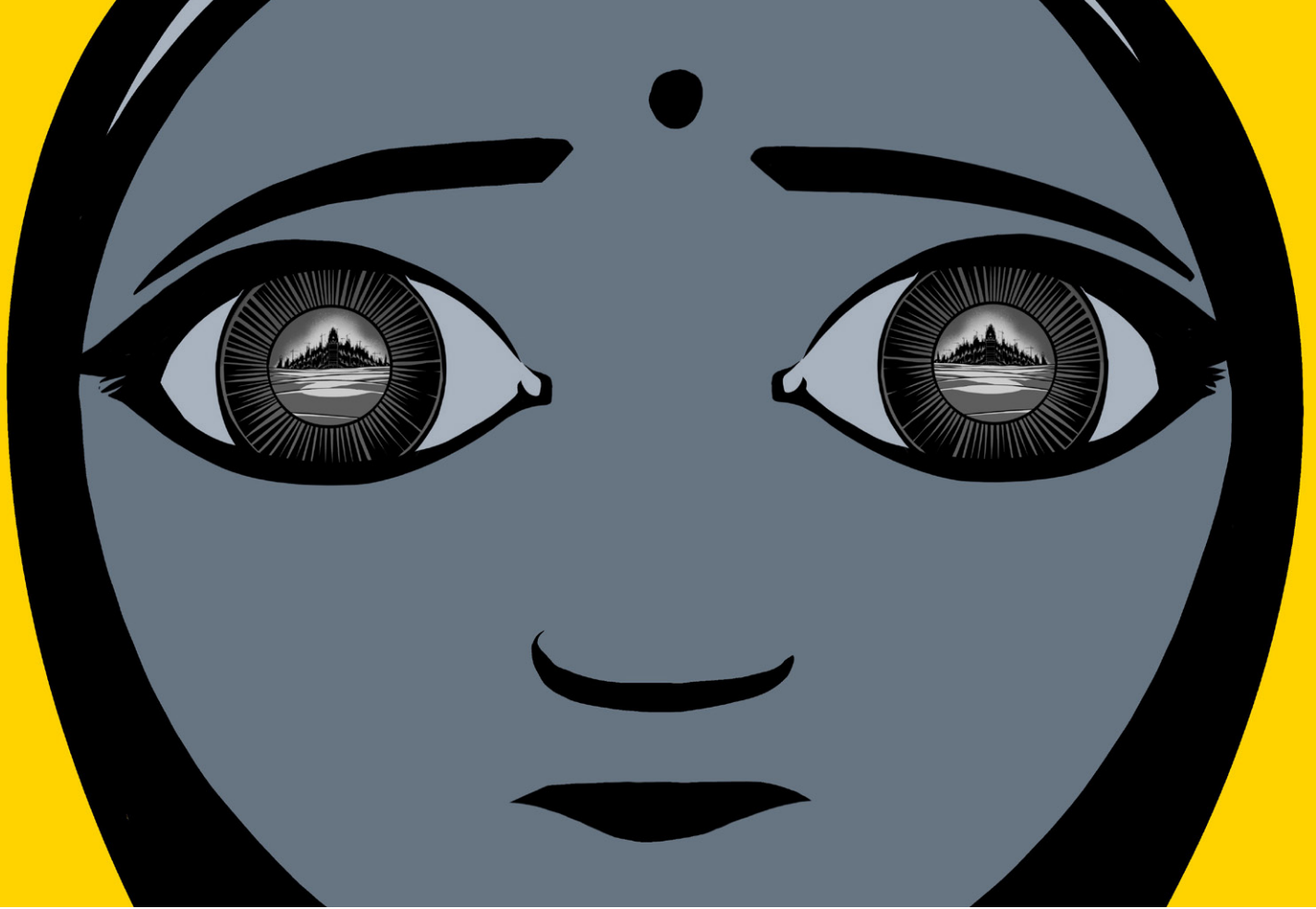
67. Shreena Malaviya, David Bishai, Meenu Mahak Soni, and El Daw Suliman “[Socioeconomic disparities in healthcare utilization under universal health coverage: evidence from Dubai household health survey.](#)” *International journal for equity in health* vol. 21,1 90. (25 June, 2022).

68. Shreena Malaviya, David Bishai, Meenu Mahak Soni, and El Daw Suliman et al. “[Socioeconomic disparities in healthcare utilization under universal health coverage: evidence from Dubai household health survey.](#)” *International journal for equity in health* vol. 21,1 90. (25 June, 2022).

69. Shreena Malaviya, David Bishai, Meenu Mahak Soni, and El Daw Suliman et al. “[Socioeconomic disparities in healthcare utilization under universal health coverage: evidence from Dubai household health survey.](#)” *International journal for equity in health* vol. 21,1 90. (25 June, 2022).

70. Erik J.Koornneef, Paul B.M.Robben, Mohammed B.Al Seiri, and Zaid Al Siksek “[Health system reform in the Emirate of Abu Dhabi, United Arab Emirates.](#)” *Health Policy*. (December 2012): 115-121

71. The authors also note that the higher utilisation of healthcare by ‘Thiqa’-holders may be partly attributable to the health-based differences between the low-income expat, and the national population of Abu-Dhabi. The citizen population is older, and showcases a higher propensity for lifestyle diseases like diabetes. Meanwhile, the –especially lower-income – expat population is younger, and likely to have undergone pre-departure medical tests to enter the country, hence constituting a healthier cohort.



Artwork by Appupen

4. FEMALE DOMESTIC WORKERS' ACCESS TO HEALTH ACROSS THE GULF

As noted in the first Vital Signs report, female domestic migrant workers in the Gulf, most of whom live and work in their employers' homes where they are often cut off from support networks, are particularly vulnerable to physical, psychological and sexual abuse.⁷² Representatives of a Qatar-based organization of Filipino migrant workers, Bayanihan ng Manggagawa sa Konstruksyon ng Qatar, offered a straightforward assessment of the problem: "domestic workers are more vulnerable than [workers in] other sectors because of their gender and [the fact that] their employers are not monitored."⁷³

The most serious abuses can result in serious injury or death, such as when a Sri Lankan woman had 24 nails and needles inserted into her body by her employers in Saudi Arabia, or when a 29-year old Filipina was found dead inside her employer's freezer in Kuwait, with apparent signs of torture.⁷⁴

Rothna Begum, who has conducted extensive research on the abuse of domestic workers in the Gulf states, described to the Vital Signs Partnership how social factors and racial stereotyping combine to toxic and violent effect on this overwhelmingly female subset of the migrant worker population.⁷⁵ Begum referred to instances where domestic workers told her about boiling water being thrown at them, being burned with irons, or having bottles or pots and pans thrown at them. She told us that while not all domestic workers are subjected to such extremes of violence, over many years researching the topic, domestic workers had repeatedly recounted similar patterns of abuse to her. A Human Rights Watch report that Begum authored on abuses against female domestic workers in Oman and the United Arab Emirates found that 21 out of 87 domestic workers interviewed experienced "psychological or health problems upon their return because of their exploitative working conditions in the Gulf."⁷⁶

72. The Vital Signs Partnership, "The Death of Migrants in the Gulf," (March 2022).

73. Telephone interview with Eliseo Bermido and Meliza Ortiguerra, 2 July 2022.

74. BBC News, "Nails removed from 'tortured' Sri Lankan maid", (27 August 2010); BBC News, "Joanna Demafelis: Employers of Filipina maid found dead in freezer arrested", (24 February 2018).

75. Telephone interview with Rothna Begum, Human Rights Watch, 6 December 2021.

76. Human Rights Watch, "'Working Like a Robot': Abuse of Tanzanian Domestic Workers in Oman and the United Arab Emirates", (14 November 2017).

Given the abuses to which female domestic workers are often subjected, it is imperative that they can easily access physical and mental healthcare, but to compound the problems they encounter, they also face particular barriers in accessing healthcare. A 2014 report on migrant domestic work by the Migration Policy Centre, GLMM identified the lack of social and legal recognition of domestic work, which it notes is a global and historical gendered problem, as “a serious obstacle” to ensuring the rights of domestic workers in the Gulf, leading to the denial of the same entitlements as workers in other sectors.⁷⁷ Experts have noted that while domestic labour is “nominally recognised as a contractual relationship of employment”, it is routinely construed in many countries across the world as a “private, personal and intimate relation” that is used to deny domestic workers the right to live independently outside the homes of their employers. Instead, they are “incorporated as dependents within the family they work for, a designation used by employers to obfuscate their contractual obligations and by governments to abdicate responsibility for these workers.”⁷⁸

This is also used to deny domestic workers labour law protection. Where separate laws specifically designed for domestic workers exist, for example in Qatar, their protection falls below international standards.⁷⁹ A 2015 report by the Centre for Women’s Research (CENWOR) reported that even when health-related provisions are specified in the employment contracts of Gulf-based domestic workers, the lack of “systematic and effective monitoring of employer compliance with contract terms” means that domestic workers often “endure employer violations” of these provisions.⁸⁰ Thus, where protective legal mechanisms exist, they are undone by the absence of complementary implementation mechanisms.

Academics who have conducted anthropological research on migrant domestic workers’ right to health in the Gulf states have noted that that, as with other categories of low-paid migrant workers, “the role of the employer-sponsor under the Kafala remains the critical element for deciding whether the [domestic] worker can, or cannot, access the health care

system.”⁸¹ Shlala and Jayaweera’s research adds to a large body of research from NGOs and shows that employers-sponsors’ “in-practice” control of domestic workers’ access to healthcare “produces subjective and inconsistent results.”⁸² Andrew Gardner, former professor of anthropology at Qatar University makes a similar point, noting that “the experience of any particular labour migrant is highly dependent on his or her employer and/or sponsor.”⁸³ As Shlala and Jayaweera explain, this dependence on the sponsor is heightened in the context of domestic work “although most Gulf countries require proof of health insurance [or health fees] in order to issue the residence permit to a migrant worker”, in the case of domestic workers, most “do not have access to their own health insurance card”. Instead, “employers/sponsors fraudulently use their own health care cards to get medicine and health services for their domestic workers who should have their own... it is also the employer-sponsor who determines whether the domestic worker can take time off, leave the home, or access medicines and/or treatments for ailments.”⁸⁴

A 2020 Amnesty International report on domestic workers in Qatar also pointed to the lack of adequate and sensitive legal redress, alongside the aforementioned lack of legal protection and enforcement, as inhibiting workers’ access to their rights, health-based and otherwise, by granting employers impunity.⁸⁵ The report revealed that despite the introduction of Domestic Workers Law in 2017 and the establishment of the Committees for the Settlement of Labour Disputes in 2018, none of the women Amnesty spoke to had seen their abuser held to account.⁸⁶ The women also spoke of their fear of retaliatory measures, such as “absconding” charges that carry criminal penalties, if they complained or wanted to leave. Further, since their visa and residence permit, not to mention their income and shelter, is dependent on the employer, domestic workers face severe deterrents to lodging, and then waiting on the processing of, complaints.⁸⁷

77. Bina Fernandez, “Essential yet invisible : migrant domestic workers in the GCC”, *Migration Policy Centre, Technical Report, GLMM, Explanatory note* (April 2014).

78. Mark Johnson, and Christoph Wilcke. “Caged in and Breaking Loose: Intimate Labor, the State, and Migrant Domestic Workers in Saudi Arabia and Other Arab Countries,” *Migrant Encounters: Intimate Labor, the State, and Mobility Across Asia* (2015): 136. Johnson and Wilcke suggest that Middle Eastern governments “deploy a gendered concept of privacy to justify systems of migrant domestic worker employment that bind employees to their employers, confer unregulated power on the latter, and divest receiving states of responsibility for migrants.” And this construction of privacy is intimately related to political legitimacy. “In the case of Saudi Arabia, in particular, the legitimacy of the ruling elite”, they contend, “depends in part on its being seen to moderate outside influences and guard against the corrupting influence of foreign culture by publically affirming the privacy of the home and the protection of the modesty of women within it.” [pg 136].

79. Human Rights Watch, “Domestic Workers’ Rights in Qatar”, (26 June 2018).

80. Hiranthi Jayaweera and Elizabeth Shlala, and the Centre of Women’s Research, “Access to Healthcare, Insurance Provision and Health Status of Sri Lankan Migrant Domestic Workers” (October 2015): Executive Summary

81. Elizabeth H. Shlala and Hiranthi Jayaweera. “The Right to Health: Sri Lankan Migrant Domestic Workers in the GCC” *Muslim World Journal of Human Rights* 13, vol no. 1 (2016): 92.

82. Elizabeth H. Shlala and Hiranthi Jayaweera “The Right to Health: Sri Lankan Migrant Domestic Workers in the GCC” *Muslim World Journal of Human Rights* 13, vol no. 1 (2016): 78.

83. Gardner, Andrew M., “Ethnography, anthropology and migration to the Arabian peninsula : themes from an ethnographic research trajectory,” *Migration Policy Centre, GLMM, Technical Report, Explanatory note* (October, 2014):5

84. Shlala, Elizabeth H. and Jayaweera, Hiranthi. “The Right to Health: Sri Lankan Migrant Domestic Workers in the GCC” *Muslim World Journal of Human Rights* 13, vol no. 1 (2016): 75-100, pg. 78, 87

85. Amnesty International, “‘Why Do You Want To Rest?’ Ongoing Abuse Of Domestic Workers In Qatar” (2020).

86. Vani Saraswathi from Migrant-Rights.org said in a telephone interview with the Vital Signs Partnership on 13 September 2022 that ‘labour disputes’ are anyway unlikely to cover health access related violations, since although the employer is legally obliged to pay the health fees for domestic workers, the employer is not legally required to, for instance, take their illness seriously and drive them to a clinic.

87. Amnesty International, “‘Why Do You Want To Rest?’ Ongoing Abuse Of Domestic Workers In Qatar” (2020)

Vani Saraswathi, Director of Projects at Migrant-Rights.org, which has extensively documented abuses against domestic workers in the Gulf states and campaigned for better protection, told the Vital Signs Partnership about the specific challenges of domestic workers. “The ability to leave the employer’s house and get their own health card...to independently decide to see a doctor when they are ill just does not exist for domestic workers across the region.”⁸⁸ Saraswathi also noted how the long working hours and low wages of domestic workers led them to disproportionately access emergency medical care. “When a domestic worker can visit medical facilities, if at all, is dependent on the schedule of the employer and the schedule set by the employer. Workers may, for instance, have suffered from stomach pains all day but they only tend to be free very late into the night. And you see this reflected in who the patients tend to be in the ER [Emergency Room].”

Hiranthi Jayaweera, from the University of Oxford’s Centre on Migration, Policy and Society, addressed the critical issue of access to mental health services in an interview with the Vital Signs Partnership.

“In my research I found that there was no access to mental health care. That was really significant. This was something most domestic workers we spoke to struggled with, because most were isolated, couldn’t leave their houses, worried about their families, worried about their health, worried about dying. Many said they prayed and meditated. But employers just tended not to take the mental health of migrant women seriously, so these women weren’t supported.”⁸⁹

Citing the specific case of Qatar, Saraswathi also drew attention to the introduction of mandatory health insurance and the increasing use of cashless transactions as further barriers to access to health.

“At the moment, healthcare is generally free or nominally priced with a health card, though this may change with the introduction of mandatory health insurance laws. But even then, there are problems. For instance, most clinics operate on cashless transactions. So, if you don’t have a debit card when you go to the clinic, you become dependent on other patients to buy medicines, pay for appointments from their card. And most domestic workers will not have a bank account... they are

not part of the Wage Protection System like other workers in Qatar so they will tend not to have a debit card.”

A representative of the organization Sandigan echoed the concerns of other experts in an interview with the Vital Signs Partnership. *“Whenever workers get ill they just endure it because they don’t have knowledge about where and how to seek help. As per law, all migrant workers must have health insurance, however, lack of knowledge about the law and the language barrier makes it difficult for the workers to remind their employers about this. It is common that OFWs would rely on taking Panadol whenever they feel unwell.”⁹⁰*

A further problem faced by many domestic workers and other female migrant workers in the Gulf is their inability to access sexual and reproductive healthcare services and the consequences for those who seek ante-natal healthcare services after falling pregnant outside of marriage. Pardis Mahdavi interviewed 213 female intimate laborers (the term she used for domestic workers) in the UAE and Kuwait between 2004 and 2014 and found that there is a “selective giving and withholding of sexual and reproductive health services”, which “constitute[s] an obvious violation of human rights for intimate laborers in the Gulf.”⁹¹ Mahdavi’s related 2021 paper on ‘migrant mothers and carceral politics’ explained how zina laws – which criminalise sex outside of marriage – and contractual terms that require celibacy, apart from denying women their intimate lives, also have a crucial role in regulating access to sexual and reproductive health. Mahdavi described the case of a domestic worker, Josie, who had been regularly raped by her employer. Josie escaped to a hospital to seek medical care, without her personal identity documents or any money. Hospital staff cleaned and dressed her wounds, but they also administered a pregnancy test which came back as positive. Despite Josie reporting the sexual violence she had experienced, hospital staff called the police, who arrested Josie and transferred her to Al-Awir prison, where she spent at least ten months, and gave birth to her son refusing any medical assistance because of her distrust in the system.⁹² Josie’s case highlights how for migrant women, the medical system can act as a node in a patriarchal surveillance network that deters migrant women from accessing sexual and reproductive care.⁹³

88. Telephone interview with Vani Saraswathi, Migrant-Rights.org, 13 September 2022.

89. Telephone interview with Hiranthi Jayaweera, 15 September 2022.

90. Telephone interview with spokesperson for Sandigan Kuwait Domestic Workers’ Association, 22 June 2022.

91. Mahdavi, Pardis, “Colliding rights and wrongs” *Routledge Handbook on Human Rights and the Middle East and North Africa* Routledge (7 November, 2016): 223.

92. Mahdavi, Pardis. “Contractually Sterilized: Migrant Mothers and Carceral Politics in the Gulf Coast Cooperation (GCC) Countries.” *Journal of Contemporary Ethnography* 50.3 (2021): 298

93. To illustrate this point, antenatal care in the UAE requires that you first present a marriage certificate, and a UAE ID. If you are unmarried and pregnant, you will need to either get married or expatriate. Unmarried expectant mothers will need to return to their home countries for the delivery.

The cases of Nasima and Natalie

Nasima

Nasima Akhtar is a 35-year old Bangladeshi widow, supporting an 18-year old daughter and a 13-year old son.⁹⁴ She decided to leave her children and seek work in Saudi Arabia after the death of her husband in 2021, taking on a debt of 200,000 Bangladeshi taka (US \$1915) to pay the fees of the local recruitment agent. She successfully cleared the mandatory pre-departure health screenings for her arrival in Saudi Arabia in 2021, but on arrival was immediately subjected to the types of abuses that many domestic workers endure, with serious consequences for her health.

Nasima recounted to the Vital Signs Partnership a pattern of abuse that had a serious and lasting impact on her physical and mental health. She said that she was passed around to work in the homes of her employer's relatives, who were neighbours. She was not afforded any rest time, and was made to take care of the employer's sick mother including throughout the night. Her employers did not give her adequate food or water, and they told her it was up to her to buy herself medicine and menstrual products, even though she was not allowed to leave the house. Nasima said that if she fell asleep when she was supposed to be working, or refused to work, or pleaded to quit, her employers beat her. She said that she was threatened with sexual violence by her employer's brother, and would lock herself in the toilet if she was alone in the house with him. On occasions she said her employers threatened to kill her. She was generally not permitted to see any healthcare professionals and had to rely on medicines that she had brought with her from Bangladesh if ever she was ill, but these quickly ran out. Within four months, Nasima said, she began to experience extreme abdominal pains, fever, and had difficulty keeping food down but her employer refused to let her visit a doctor until she became completely bedridden, at which point her employer drove her to a public hospital, where she stayed for three days. She told the Vital Signs Partnership that despite language barriers, she was able to communicate with one nurse in the hospital, but in general she said that hospital staff were not helpful and didn't respond to her requests for information.

Unlike other low-paid migrant workers, who require private health insurance, domestic workers are eligible for non-emergency care in public hospitals in Saudi Arabia, but Nasima said that she had to pay for food and saline injections. She said that the hospital did not run any tests, or offer further treatment. Nasima said that she considered approaching the police, but did not want to risk punishment from her employer.

She was able to contact her family from the hospital in Saudi Arabia, and with the help of a Bangladeshi community leader, who warned her employer that they would take action against him if he did not permit Nasima to leave the country, she was able to return to Bangladesh. Upon her return, she was diagnosed with jaundice and liver damage, and continues to suffer from gastro-intestinal issues. She said she is struggling to afford the medical tests that she still needs to resolve her medical problems.

Nasima told the Vital Signs Partnership that despite working in Saudi Arabia for four months, she was only paid for 2 months' work. Her family is now sustained through the money that her children earn, although she said that her daughter has fallen sick due to "physical and mental stress" and that her son (aged 13) has lost his job as a dishwasher in a local restaurant.

Natalie

Natalie left her home in Tigaon in the Philippines for work in Al Rumaithiya, Kuwait, in March 2022 when her youngest child was only 9 months old.⁹⁵ She was still breastfeeding when she left and said she had had a breakdown in the months after the birth, but nonetheless passed pre-departure medical tests. She told the Vital Signs Partnership that

94. In-person interview with Nasima Akhtar, 26 May 2022; telephone interview with Nasima Akhtar, 29 June 2022.

95. Telephone interview with Natalie, 23 June 2022.

she wanted to help her husband, whose salary from factory work barely covered the family's needs, and to provide some financial support to her parents in the aftermath of her father suffering a stroke.

On arrival in Kuwait, her employers gave her her own air-conditioned room with a comfortable bed. Her initial experience with her employers was positive, but she said that soon her female employer began to make increasing demands of her, and the workload, which included taking care of her employers' young children, as well as cleaning the house, was considerable. Natalie was also forced to work for her female employer's mother. They went there every day and stayed until the evening. When they arrived home, Natalie said, she still had to do household chores. Her workload was particularly gruelling in Ramadan, when she would have to stay up all night and would only get to bed at dawn. She worked every day even though her contract stipulated that she should have one day off per week. She wanted to bring up the matter of her right to a day off per week to her employers, she said, but was too afraid of angering them. She quickly developed wounds on her hands from using strong chemical cleaning products without gloves, for which her employer gave her petroleum jelly. She frequently experienced headaches, but her employers did not take her to see a doctor, and simply gave her Panadol. Not long after her arrival in Kuwait, her employers moved house and Natalie was tasked with moving items that had not fitted into the rental truck that her employers had hired. This included heavy luggage and household appliances.

One day, she fainted. "I was assisted by my co-workers. I really could not remember anything, they told me that I fainted head first. I was brought to the hospital by ambulance, but they were not allowed to come with me. I did not know what was happening to me and at that time I could not feel anything. They just told me that an ambulance came to check what was happening to me and they were already pumping air through my mouth." After checking that her blood sugar and blood pressure levels were normal the hospital discharged her, although Natalie said that a Filipino doctor told her that in his opinion she was suffering from depression. She said at the time she was also arguing with her husband over the phone and was stressed about the situation of her parents. The only medicine that her employer gave her in the aftermath of her discharge from hospital were painkillers. Eventually her employers took her back to the recruitment agency that had arranged her employment in Kuwait. There, she described suffering a panic attack - extreme pain in her chest which made it difficult for her to breathe. The recruitment agency gave her water to calm her down, she said.

"They told them that I was just being dramatic, that what is happening to me is nothing. The owner of the agency told me and my employer that," she said. During her stay there she experienced another attack, during which she felt extreme pain in her chest which made it difficult for her to breathe. Natalie received help from those who were also staying there. She was not sent to a hospital; giving her attention only when she became distressed, when they would give her water to try and calm her down. Eventually, her sister was able to secure the assistance of the Philippines Overseas Worker Welfare Association and her employer provided her with an air ticket home, but she only received 10 days' worth of pay. She told the Vital Signs Partnership that she continues to experience headaches and feels lightheaded, but said that she does not have the money for medical checks.



Artwork by Appupen

5. MIGRANT WORKERS' ACCESS TO HEALTH IN JEDDAH, SAUDI ARABIA

According to Saudi Arabian government statistics, the country's population was 34.1 million in 2021, with 36.4 percent of this population non-Saudi nationals.⁹⁶ Jeddah, a port city on the Red Sea coast, is the country's second most populous city with approximately 4.5 million inhabitants (more than the populations of Bahrain, Kuwait or Qatar), including a large population of low-paid migrant workers from India, Pakistan and Bangladesh. It is difficult to obtain precise data on the total number of low-paid migrant workers in Saudi Arabia or in its major cities because of the large number of undocumented workers in the country. Historically, this is due to a combination of factors: visitors overstaying Hajj visas, the difficulty of policing the porous border with Yemen, and distrust among businesses of fickle government immigration policies, which resulted in them keeping pools of under-utilised workers whom they then allowed to work independently.⁹⁷

According to 2020 data from the Saudi Ministry of Public Health, Jeddah has more physicians per 100 beds than all but two of Saudi Arabia's 20 health regions.⁹⁸ A 2020 research paper by Saudi geographers found that a large part of the population of the city of Jeddah is located at a relatively high distance from a public clinic, with the paper noting how small private clinics vastly outnumbered government-run public hospitals and private hospitals.⁹⁹

The Vital Signs Partnership spoke to 15 low-paid migrant workers from a range of employment sectors in Jeddah, as well as three healthcare professionals. They described how various factors obstructed migrants' ability to access healthcare.

96. "Population Estimates in the Midyear of 2021", *General Authority for Statistics*, (2021).

97. FairSquare Projects, "[Policy Brief #1: Migrant Workers in Saudi Arabia](#)", (October 2020).

98. In 2020 (the most recent data available) Jeddah's public hospitals had 105 physicians for every 100 beds, with only Makka (120) and Qunfadah (124) having proportionally more physicians per public hospital beds. "[Statistical Yearbook 2020 Chapter](#)", *Ministry of Health*, (26 April 2022).

99. Belarem, M., Hamza, M.H. and Ajmi, M. "[The Spatial Distribution of Public Dispensaries in the City of Jeddah](#)" *Kingdom of Saudi Arabia. Open Access Library Journal*, 7: e6194. (2020). In 2016, there were 13 Ministry of Health hospitals, 40 private hospitals, and more than 300 private clinics.

Public hospitals and emergency care

Medical professionals in Saudi Arabia told us that migrant workers, irrespective of their nationality or immigration status, are entitled to emergency medical care in public hospitals.¹⁰⁰ A healthcare professional in Jeddah explained that all patients in emergency rooms go through a triage system, ranking the seriousness of their condition from 1 to 4, and those who fall into categories 1 and 2 are considered to be critical and need urgent care.¹⁰¹

“They [emergency rooms] will only take you in if you are in critical conditions. Otherwise, they don’t have the capacity and will send me here and there. It is not enough that my leg is painful, they will only care if my leg was cut off,” said Nawaz, a 53-year old Pakistani driver.¹⁰² Arif, a 37-year old Bangladeshi home security guard, also said he had experienced difficulties accessing care in public hospitals, but said he still used them.¹⁰³ As domestic workers, employed directly by a Saudi family to work in their homes, Nawaz and Arif are eligible for healthcare in the country’s public hospitals.¹⁰⁴ Arif said that he has chronic back pain and has been seeing doctors fairly regularly, despite what he says is the racism he faces at public hospitals.

Although migrant workers can access emergency care, a doctor in one of Jeddah’s public hospitals said that there can be serious risks for undocumented workers who did so. He told the Vital Signs Partnership about the recent case of an undocumented Bangladeshi patient in his hospital who required surgery but who was in triage category 4 and therefore was not an urgent case.¹⁰⁵ After nearly three weeks, he had the surgery he needed, but only because the doctor used his *wasta* (influence) to insist that his department perform the surgery and also discharge the patient in such a way as to prevent the police from getting involved. He said that medical staff in emergency rooms are required to report any cases where they treat undocumented patients in order that the Saudi authorities can either fine or deport the individual after the treatment.

A 2016 paper by Saudi healthcare professionals said that the “overuse of emergency rooms (ER) is a public health problem”, with Ministry of Public Health hospitals in Jeddah singled out as notably problematic and low-income patients a particular risk factor for ER overuse.¹⁰⁶ The paper did not go so far as to say that this overuse of emergency care was the result of low-paid migrant workers going to the ER because they cannot access non-emergency care, but that is clearly a problem in Saudi Arabia, not least on account of the number of undocumented migrant workers in the country.

Private health insurance for non-emergency care

The overwhelming majority of the country’s migrant workers are not eligible for free non-emergency care, and all businesses that employ foreign workers must provide them and all of their dependents in the country with private healthcare insurance.¹⁰⁷

These mandatory insurance plans are typically chosen by employers and operate on a co-payment system, whereby the insurer pays 80 percent of the cost of healthcare, and the insured patient pays 20 percent. The employer pays the insurance premiums. Insurance is accepted in all private hospitals and clinics in the Kingdom.¹⁰⁸

Until 2019, health insurance providers issued health insurance cards that migrant workers would have to produce at hospitals or clinics, but since January 2020, insurance is directly linked to each individual’s unique *Iqama* number and workers’ health insurance status can be checked online through the Council of Cooperative Health Insurance website simply by entering an individual’s *Iqama* details.¹⁰⁹

Eight of the fifteen workers we spoke to had private health insurance. The other seven did not. The system’s effectiveness is to a large extent dependent on employers paying their employees’ insurance premiums but the workers we spoke to also said that their employers had to actively assist them

100. In-person interview with ENT surgeon, Mecca Province, 13 June 2022; Telephone interview with GP, Mecca Province, 14 June 2022; Telephone interview with medical intern, Mecca Province, 19 June 2022.

101. Interview with anonymous healthcare professional in Jeddah, June 2022.

102. In-person interview with Nawaaz, 12 June 2022.

103. In-person interview with Arif, 12 June 2022.

104. The only other category of foreign workers who are also entitled to this care are non-Saudis employed in the public sector.

105. Interview with migrant workers in Jeddah, June 2022.

106. Sundus Dawoud et al. “Utilization of the Emergency Department and Predicting Factors Associated With Its Use at the Saudi Ministry of Health General Hospitals”, *Global Journal of Health Science*, (2016).

107. Yazed Al Ruthia et al. “How can Saudi Arabia reform its public hospital payment models? A narrative review,” *Saudi Pharmaceutical Journal*, (December 2020).

108. Ibid.

109. See the Council of Cooperative Health Insurance website here.

to access healthcare. Five of the low-income migrant workers we spoke to said that they needed their employers' assistance with booking hospital appointments, as they were not confident with how to do this, and explaining the workings of the insurance system to them.¹¹⁰ Three of these five workers said that their employers had been reluctant to help them, although only in relation to what they described as non-critical medical problems, and they all said that they eventually received the care they requested.

Workers' success in navigating the health system depends to a large extent on the willingness of their employers to support them through the process. Hassan, a 44-year old Indian construction worker, said that his employers arranged all the necessary hospital appointments for him after he received a serious burn injury at work in 2022.¹¹¹ Hassan had three outpatient visits to the hospital that he stated were conducted without any problems. He had to co-pay 20 percent for each consultation and treatment but this amounted to no more than SAR 15 (4 USD) per session. The cost of consultation that Hassan had to pay from his pocket was SAR 8 (2 USD). Hassan said that he had also regularly attended hospital to manage a long-standing high blood pressure issue and that he has never faced any difficulty in doing so. He attributed this to having good employers and said that, in addition to arranging appointments, they have intervened with his insurance providers to ensure that they provide the necessary coverage to Hassan. Hassan's 40-year old Indian colleague, Ashraf, confirmed this, saying that when his insurer refused to approve minor surgery of a total cost of SAR 1500 (USD 400), their employers also intervened on his behalf and the coverage was eventually approved.¹¹² Ashraf said that if his employers had not helped, he would not have challenged the insurance provider and would have either not gotten the surgery or would have had to pay the full amount himself. He said that he would not have known how to challenge any rejection of his claim and that he wouldn't want to "get in trouble" by doing so.¹¹³

The husband of a 52-year old Pakistani woman who returned to Pakistan for eye surgery after their insurer in Saudi Arabia rejected her claim, said that someone who speaks Arabic and "doesn't look Pakistani" would have helped them take a stronger stance against their insurers.¹¹⁴ They had no one to help and attempted to make a claim on their own using partial Arabic. He said that they decided to return to Pakistan for the surgery because there was "no point in arguing" with the insurance providers.

Some workers complained about their management being reluctant to help them get a doctor's appointment.¹¹⁵ They said that in general employers preferred not to allow workers to take days off work unless they are extremely unwell.

The most serious problem in accessing healthcare arises when employers simply refuse to either provide migrant workers with health insurance, or when workers become undocumented and no longer have a valid Iqama (residence) card. As noted above, all low-paid migrant workers can theoretically access emergency healthcare, assuming their condition is sufficiently serious and they are able to negotiate their admission, albeit with language barriers and discriminatory attitudes presenting potentially significant obstacles. However, without an Iqama card, migrant workers struggle to access medical care in non-emergency circumstances. Those who do not have a valid Iqama cannot legally access any government-provided services in the country, including healthcare, and face arrest and deportation.

Informal channels of healthcare

According to the migrant workers and the healthcare professionals we spoke to, it is common for migrant workers to rely on their compatriots who are working as medical professionals. An undocumented Indian woman said that there are small clinics that will see patients who aren't documented for small fees.¹¹⁶ She is diabetic and goes to the clinic quite regularly for check-ups and to obtain insulin.

Hassan and Ashraf also said that having insurance is helpful but "knowing a doctor personally is better".¹¹⁷ Hassan works part-time as a gardener at an Egyptian doctor's household and says that the doctor regularly provides him and his colleagues with basic medication and does not charge them.

Salma, an undocumented 39-year old Yemeni woman, said that her family has relied upon Yemeni nurses and doctors in Jeddah for all their healthcare needs over the past two decades.¹¹⁸ However she said that they were now having great difficulty accessing these informal healthcare channels because Saudization policies and Saudi government efforts to displace the Yemeni diaspora in the country, had resulted in every Yemeni healthcare worker the family knew leaving the

110. In-person and telephone interviews, June-July 2022.

111. In-person interview with Hassan, 12 June 2022.

112. In-person interview with Ashraf, 12 June 2022.

113. Ibid.

114. Telephone interview, 26 July 2022.

115. In-person and telephone interviews, June-July 2022.

116. In-person interview with A.L., 20 June 2022.

117. In-person interviews with Hassan and Ashraf, 12 June 2022.

118. In-person interview with Salma, 20 June 2022.

country. “Everything is possible through *wasta* [influence] here and when your *wasta* is gone, then what?” she says.

A Pakistani doctor who has been practising in a Jeddah public hospital for almost two decades, said that it used to be possible to treat migrant workers in public hospitals without formally registering them and that he knew of several cases where essential surgery had been arranged for migrant workers.¹¹⁹ He said this had now become more difficult: “Everything is computerized now so it is not possible to see patients that easily unless they come through the system”. However, even so, he said that he knew of several cases where doctors in public hospitals have arranged for essential surgery for migrant workers without formally registering them into the admissions system. He told the Vital Signs Partnership that he now helps as and when he can, but in a limited capacity- such as by supplying medication or informal consultations. He also said that he still regularly treats South Asian workers from his community outside the scope of his work for free: “My knowledge is mine so I can always help how I can outside work hours.” He said that when cases are extremely serious and he cannot help, he advises migrant workers to go back to their country for treatment. When asked about the risks involved, he replied, “I know these people. It is like helping friends or

family. I don’t see it as a big issue.”

In summary, migrant workers’ access to healthcare in Jeddah, and to healthcare in Saudi Arabia more broadly, depends on a range of factors. Documented migrant workers with a valid Iqama card and employers who not only pay their insurance premiums but assist them in arranging appointments and dealing with insurers can access a wide range of well-resourced public and private hospitals. However, there are numerous ways in which low-income migrant workers’ access to healthcare can be obstructed. In the first and most obvious instance, undocumented workers have no access to non-emergency care and will necessarily have to access informal channels, relying either on sympathetic medical professionals or paying to access unsubsidized care in private clinics willing to risk assisting undocumented workers. Emergency rooms in public hospitals will accept migrant workers whose conditions are critical, but even in those instances, the admissions system will require that they notify the authorities, placing their patients at risk of deportation after their treatment. Saudi Arabia’s reliance on private insurers to deliver healthcare appears to discriminate against low-income migrant workers who often do not understand the system or lack the confidence to challenge it when their claims are denied.

Case study - the pain kept coming back. I just endured it

Jose Raymond, also known as JR, is a 36-year old Filipino who looked for work overseas after the birth of his first child.¹²⁰ He secured a 2-year contract to work in a coffee shop in Riyadh, Saudi Arabia, and underwent a comprehensive pre-departure medical examination.

He arrived in Saudi Arabia as a 32-year old in June 2018, and started work without any formal training or any discussion of issues such as health and safety or medical insurance. JR told the Vital Signs Partnership that he and his colleagues worked in excess of the hours stipulated in their contracts without overtime pay and that for the first five months he worked seven days per week with barely a day off. JR said that he was too scared of his employer, who worked as a captain in the Saudi police force, to complain about his long hours.

JR told the Vital Signs Partnership that the departure of a colleague meant he had to run the coffee shop almost single-handed for three months and that his employer stopped looking for extra staff, upon realising that JR was capable of handling the excess workload. JR said that he tried at all times to maintain a good working relationship with his employer despite the working conditions.

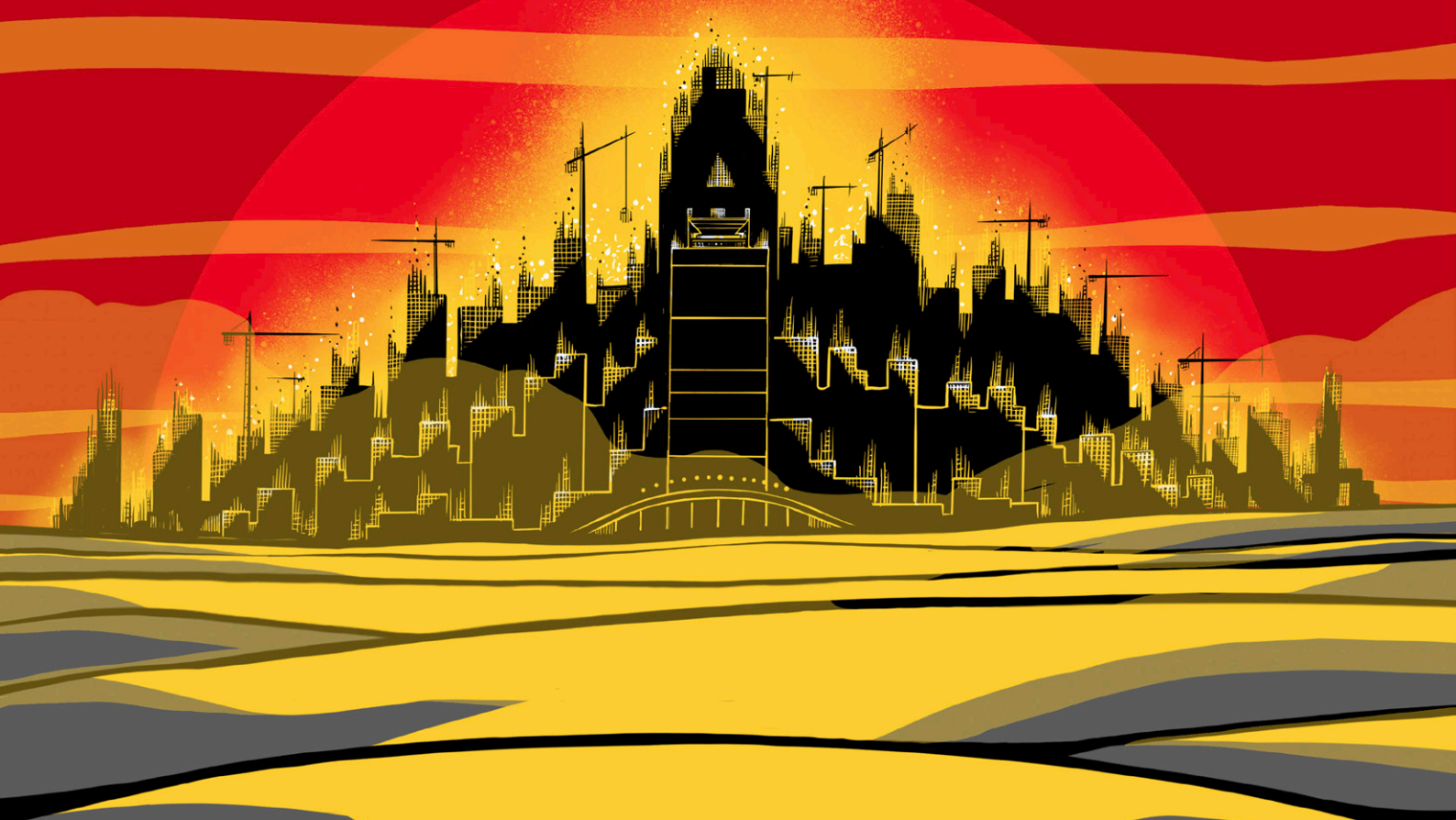
JR started to suffer from stomach pain but due to his employer’s failure to provide him with health insurance and the demands of the job, he was not able to see a doctor and kept going to work. “I still went to work even when I was sick – there was no one to take my place,” he recalls. “He [JR’s employer] said he would follow up on the health insurance, since there were ‘other things to pay for first’.” By this time, JR was enduring significant periods of recurring pain to the point where he nearly collapsed on several occasions, but he was only able to take non-prescription painkillers. “The pain kept coming back. I just endured it.”

119. Interview with anonymous healthcare professional in Jeddah, June 2022.

120. Telephone interview with JR Banaag, 2 July 2022

JR told the Vital Signs Partnership that on one occasion he was taken to hospital by his employer after he collapsed during a bout of pain. He said that a nurse administered painkilling injections and he was prescribed a painkiller, although he doesn't remember the name or the brand.

The Covid-19 pandemic and the mass repatriation of thousands of Filipinos from Saudi Arabia may, ironically, have saved JR's life since it was only in the Philippines that he was able to access the healthcare that led to a colonoscopy and the diagnosis of a large cancerous tumour in his lower intestine. Doctors in the Philippines successfully removed the tumour in September 2020, although the operation was expensive. JR remains in the Philippines but said that he would not rule out the possibility of going abroad again for work.



Artwork by Appupen

6. LOW-PAID AND WHITE-COLLAR MIGRANT WORKERS IN THE UAE

The United Arab Emirates is a federation of seven semi-autonomous emirates, of which Abu Dhabi and Dubai attract the vast majority of nearly 8 million migrant workers, who make up nearly 90 percent of the total population.¹²¹

The Vital Signs Partnership spoke to 24 migrants, working or living in the United Arab Emirates, seven in person and eleven by telephone. Eleven of the migrants we spoke to worked in low-paid sectors, including four delivery drivers working in the gig economy, twelve worked in professional roles, including four medical professionals and two insurance brokers. We also spoke to the dependant of one migrant worker.

The country has 40 public hospitals as well as many private medical facilities. Emergencies and critical care are free for everyone in all hospitals and clinics across the Emirates. For UAE nationals, healthcare is subsidized by the government, although regulations vary from emirate to emirate.¹²² Non-Emiratis working in the country require private health insurance to access clinics, but only two of the country's

emirates - Abu Dhabi and Dubai - oblige employers to provide insurance for their non-Emirati employees.¹²³

A doctor working in the trauma department of one of the country's biggest hospitals outlined how the system works at his hospital.¹²⁴ "Generally any medical center will have to first decide if a patient can be included or excluded in trauma or emergency," he said. "Every institute will have its own criteria but if someone is included in the [emergency] category, they will be provided urgent care, regardless of anything else. Insurance and all come second."

Outside the emergency care category, cost plays a much more significant role. An Indian doctor who recently started a practice in the UAE offered a general assessment of the system for non-emergency care.¹²⁵ "I think the doctors here are really good in terms of skills and they also have very good resources. But it is all very expensive and you need a very good insurance plan with a very high cap to truly utilize what is available," she said.

121. "International migrant stock (percent of population) - United Arab Emirates," *The World Bank*, (2015).

122. "Health Insurance", *The United Arab Emirates' Government Portal*, (15 May 2022)

123. "Health Insurance", *The United Arab Emirates' Government Portal*, (15 May 2022)

124. Interview with doctor 1, Dubai, June 2022.

125. Interview with doctor 2, Dubai, June 2022.

Low-paid construction workers

A 36-year old Pakistani man, K.W., who had worked in the United Arab Emirates from November 2017 until 2021, when he returned to Pakistan, described how living and working conditions contributed to poor health outcomes for migrant workers, and their difficulties in accessing healthcare. K.W. described crowded living quarters with eight to fifteen men sharing a room, and three toilets and two baths for sixty men, twelve hours of work, six days a week and for salaries of 1150 dirhams (US \$313) rather than the 2400 dirhams (US \$653) promised.¹²⁶

“My work involved cutting dates and I used to work under camera by sitting on a chair for 11 hours which caused swelling. When I told my supervisor about my feet getting swollen and that I could not walk to work, he would tell me to talk to my *rubab* [recruitment agent].” Ahmad (not his real name) said that “most of the labourers had some sort of physical issues” and that “everyone got mentally disturbed” over time. He said that another young worker, whom he referred to as a boy, “used to cry in such a way that the sound of his crying could be heard even in the last room”, and recounted how an outbreak of violence in the labour camp on New Year’s Day in 2018 left one Indian worker needing 18 stitches.

Ahmad worked in the emirate of Ajman, where there is no requirement that employers provide health insurance, which he said was unaffordable for him. “Insurance is quite expensive, it might be more than a month’s salary, [so] even if you start to gather money for insurance, you would have to wait years to collect enough.” He said that in his camp, it was the recruitment agent who was able to arrange healthcare for the workers. “Insurance documentation is done in the *rubab*’s name and service is only provided if the *rubab* is willing to provide it to you.”

Ahmad said that he had never accessed any formal healthcare services in the UAE and that he and his colleagues typically relied on non-prescription medication that they sourced themselves.

“The person who arranged my visa and tickets advised me to take Panadol, and Brufen [Ibuprofen] to Dubai because they are often needed and difficult to obtain in Dubai. We always requested someone arriving from Pakistan to bring medicines along with him. Everyone had their own medicines in the labor camp. Once I had a strain in my neck along with a high fever, so I had to request a Pakistani tailor in Dubai to get me medicine

since the supervisor was not willing to listen to my problems. My employers never arranged a doctor or hospital visits for us. In the factory, however, there was a supervisor who had a first aid kit and gave me Indian medicine for healing.”

Another Pakistani worker, who spoke under condition of anonymity, told the Vital Signs Partnership that he became physically weak and very ill on more than one occasion, and lost a substantial amount of weight. He had arrived in the UAE on a visit visa, which would not allow him to work, meaning he was effectively undocumented. He told the Vital Signs Partnership that he wasn’t even able to afford the medicine from pharmacies and that he had to rely on medicine that other migrant workers gave him.¹²⁷

Several Pakistani workers currently employed in the United Arab Emirates and speaking anonymously said that due to not having health insurance and the high cost of seeing doctors without insurance, their primary means of healthcare was the use of non-prescription medicine. “I had some medical complications so I brought medicines from Pakistan, however, I have consumed all of them and now have to rely on the chemist for prescriptions rather than doctors.” Another said that he had also brought medicine with him from Pakistan to deal with an allergy but that it had run out. “I have to rely on the chemist’s opinion for medicines rather than a doctor since I cannot afford one.” He said he had had to resort to taking Panadol “because of poverty” and told the Vital Signs Partnership “that is what most [migrant workers] do.”

Gig economy workers

The Vital Signs Partnership spoke to four delivery food riders working in Dubai.¹²⁸ They described how employers exploit varying regulations to avoid providing health insurance to their workers and how health insurance providers can limit, delay or prevent migrant workers from accessing health care.

Food delivery riders in the Gulf states are engaged in high-risk work, and it can be particularly hard for them to access the healthcare services they need due to the particularities of their employment relationships, whereby they are employed by third parties, rather than the companies under whose names they operate.

In 2021, the Associated Press reported how the Covid-19 pandemic had led to a surge in demand for food delivery services.

126. In-person interview with Ahmad, June 2022.

127. In person interview with anonymous worker, June 2022.

128. In-person interviews, 29 May 2022; Telephone interview, 2 June 2022

*"The boom has transformed Dubai's streets and stores and drawn thousands of desperate riders, predominantly Pakistanis, into the high-risk, lightly regulated and sometimes-fatal work. With most paid between \$2 to \$3 per delivery rather than a fixed salary, riders race in the scorching heat to keep pace with a relentless rush of orders."*¹²⁹

Migrant-Rights.org have since detailed how the Gulf's emerging gig-economy places migrant workers at risk, examining the cases of Uber and Careem taxi drivers in Qatar, and Deliveroo and Talabat drivers in the United Arab Emirates.¹³⁰ In May 2022, Reuters reported two work strikes involving Deliveroo and Talabat drivers in Dubai.¹³¹ Two Deliveroo riders separately told Reuters the company had sought to cut earnings per delivery by 15 percent to 8.75 dirhams (\$2.38) and extend their shifts from 9 hours to 12 hours. Both riders, who said they were employed via agencies, said they had to pay for fuel, housing and employment visas out of their own wages.¹³²

The Vital Signs Partnership spoke to four food delivery riders, three working for Talabat and one for Deliveroo, about their employment conditions and their ability to access healthcare.¹³³ Two of the four riders said that although they were working in Dubai, they were employed by third-party agents registered in Sharjah and Ajman, where there is no legal requirement that employers provide health insurance to their employees.¹³⁴

"My visa is from Ajman so my agents don't need to give me insurance," Liaqat, a 23-year old Pakistani rider working for Talabat in Dubai told the Vital Signs Partnership.¹³⁵ "I got my own insurance, paid 900 Dirhams (US \$245) for it- I need it in case of an accident."

In 2020, many of the riders who spoke to the Associated Press said that they knew of several riders who had died in road accidents in the course of their work. Of the four riders who spoke to the Vital Signs Partnership, three had been in a minor road accident in the previous few months, and said that accidents are extremely common amongst riders. "I think the worst situation to be in is when you are in the mid-range of injured in an accident," said Liaqat.¹³⁶ "If it's minor, you can just get a painkiller or see a doctor in a nearby clinic and you are back on the road. Insurance or not, it is affordable. If you are near death, then you will go to emergency. But if you are in the mid-range, you have to figure out insurance-covered clinics and deal with all that. And you lose out on

work. And you are in pain." Liaqat said that he has only had to see a doctor twice, once for a fracture and once for a stomach problem, but he said that he did not use his insurance for either visit, because his plan requires a pre-authorization for outpatient treatments and he said that it was difficult for him to navigate the process, which he said was relatively complex and time-consuming whether done over a call or online. "I was in a lot of pain and the clinic nearby is not too expensive. It is expensive for me because my salary is so low but compared to how much things cost in Dubai, it was okay," he says. "I think it was AED 100 (US \$27) for the stomach problem and AED 300 (US \$81) for the fracture. I just paid for it myself." Liaqat said that he had helped a colleague who had been in a more serious accident and praised the standard of care in such situations. "The emergency, I think that is what it is called, was very efficient," he said. "There was no shortage of doctors or nurses and everyone was helpful." His colleague recovered, he said, but was unable to afford the physiotherapy he needed as part of his recovery and moved back to Pakistan to avail of more affordable options. Liaqat said that he has been fortunate to not have any pre-existing conditions and, therefore, has been able to find an affordable insurance plan. He said he worries about how useful his insurance would be if something more serious happened, or if he needed treatment that isn't available at the polyclinics (small private clinics) that he typically uses.

Another rider, a 27-year old Indian called Amir, said that he has an employer-provided insurance policy but complained that it is only accepted by a limited number of clinics.¹³⁷ "I have insurance that my agents paid for but it covers nothing," he said. "Last year I got really sick in the summer, I had kidney pain so bad that I couldn't move. The clinic nearby that is covered by my insurance does not have any kidney specialists, so they referred me to see a specialist, but finding one that is covered by my insurance was so hard." He added that once he was able to find and visit a medical facility that had the specialist he needed and that was also covered by his policy, getting claims approved from the insurance company also took some time. "It was okay but it did take a few weeks," he says.

However, all of the riders, in a discussion, said that there have been times when their insurance provider had rejected a claim even though they were previously informed that their insurance policy would cover it. "A sir [person with authority] I know told me that when insurance does this, I should push them back and ask for reasons why a claim is rejected and

129. Isabel Debre, "As Dubai's food delivery booms, dangers and casualties mount", *Associated Press*, (13 September 2021).

130. Migrant-Rights.org, "Rideshare platforms in Qatar: Big business, poor ethics", (5 April 2022); Migrant-Rights.org, "Rare labour protests by Deliveroo and Talabat riders in Dubai shed light on gig exploitation", (12 May 2022).

131. Alexander Cornwell, "Deliveroo backs off plan to cut pay of UAE delivery riders after strike", *Reuters*, (2 May 2022).

132. Alexander Cornwell, "Deliveroo backs off plan to cut pay of UAE delivery riders after strike", *Reuters*, (2 May 2022).

133. In-person interviews, 29 May 2022; Telephone interview, 2 June 2022.

134. See Migrant-Rights.org, "Comparison Of Health Care Coverage For Migrant Workers In The GCC", (February 2020). The only emirates where it is compulsory for employers to provide private health insurance to their employees are Dubai and Abu Dhabi.

135. In-person interview with Liaqat, 29 May 2022.

136. Ibid.

137. In-person interview with Amir, 29 May 2022.

often they will often then approve the claim,” said Amir, noting that the person he was referring to was someone more fluent in English than him, who worked on the finance team of the delivery company he worked for.¹³⁸ “He said the people on the phone working for insurance companies are just told to say no first. I asked him to talk on my behalf once when this happened and it did work.”

For non-critical treatments many of the migrants we spoke to said they preferred to use small, independent clinics known as ‘polyclinics’ due to their reliability and affordability. “We are part of the community,” said a nurse working for a polyclinic in Hor Al Anz, one of Dubai’s most densely populated neighbourhoods where mostly lower-wage migrants live.¹³⁹ “Whether you have insurance or not, whether you know how your insurance works or not, you can walk into one of these clinics and at least be able to speak to someone who looks like you and get some guidance, even if not the treatment you need.”

Healthcare for higher-income migrant workers

Many migrant workers in the UAE are employed in administrative, clerical and other forms of office-based work that mean they are not exposed to the occupational risks attendant with work in lower-paid sectors of the economy. There are still many factors that influence just how accessible affordable healthcare is for them and their dependents.¹⁴⁰

Jeannie, a 25-year old Filipino, works for a large outsourcing company in Abu Dhabi. She told the Vital Signs partnership that there are only three hospitals- both over an hour’s drive from where she lives- that she can go to for insurance-covered treatments.¹⁴¹ “Luckily I don’t need to see a doctor much but it is still worrying,” she says. “Some people are paying [out of their own pockets] to upgrade their plans. I might also do that next year because this [situation] is useless. I think I will have to pay 2000 dirhams (US \$540) from my salary.”

Brian, a 33-year old Filipino works as a graphic designer in Dubai and said that his employers told him that he would have to cover additional insurance coverage costs associated with

pre-existing medical conditions.¹⁴² “My company has group insurance for all employees that costs AED 2000 (US \$540), I think. But with my pre-existing condition, my premium shot up to AED 85,000 (US \$23,140). I was asked to cover this on my own; I don’t even make that much money in a year.” He said that his condition doesn’t cause him any complications so his company arranged another insurance provider, to whom he did not disclose his condition. Treatments related to his pre-existing condition will not be covered. “I will just go back home if I need to get treatment,” he says. “There is no way I could afford any of this [medical treatment].”

In Dubai, it is the obligation of dependents’ sponsors (typically their spouse) to provide insurance for them. According to an insurance broker who spoke to the Vital Signs Partnership, basic private health insurance, excluding maternity, for a spouse starts at 1700 dirhams (US \$463) per year.¹⁴³ Migrant workers earning less than 4000 dirhams per month are eligible for insurance plans that can cost as little as 600 dirhams, but these offer very minimal coverage. “A common thing you will hear about insurance in UAE, as in many other places around the world, is that good insurance isn’t cheap and cheap insurance isn’t good,” she said. “You get what you pay for.”

In 2017, authorities in Dubai announced that they would impose monthly fines of 500 dirhams to any sponsor who failed to sponsor his or her dependents, but workers we spoke to continued to flout the law, due to the high cost of insurance.¹⁴⁴ “I haven’t bought insurance for her yet,” said Farhan, a 29-year old Indian who works in IT and whose wife lives with him in Dubai.¹⁴⁵ “I saw the price range and decided I will start her insurance next year. Just saving a little. And when she gets pregnant, I will take her to India.” He said that his colleagues have urged him to insure his wife in case of costly emergencies. “God willing everything stays fine and she doesn’t need to go to a doctor,” he said. “Only once did I have to take her to the clinic for a stomach flu but it is one nearby and cheap so the total I had to pay was 200 dirhams. Still cheaper than 1700 [the cost of insurance].”

Many South Asian migrant workers in higher-income jobs in Dubai live in the emirates of Sharjah or Ajman, where rent is cheaper, but because their residence visas are for Dubai their insurance policies only cover healthcare in Dubai. “I have bought insurance for my wife and three children,” said Maroof, a 39-year old Indian, living in Sharjah.¹⁴⁶ “I have spent over 5000 dirhams on it and it doesn’t even cover one clinic

138. Ibid.

139. Telephone interview with anonymous healthcare professional, 6 July 2022.

140. Migrant workers who earn more than 4,000 dirhams (US \$1089) per month can bring their spouses and children with them. Those who earn 3,000 dirhams but have employer-provided accommodation can also bring their spouses. See “Sponsoring family residence visa by expatriates”, *The United Arab Emirates Government Portal*, (18 October 2022).

141. Telephone interview with Jeannie, 25 June 2022.

142. Telephone interview with Brian, 25 June 2022.

143. Telephone interview, 28 June 2022.

144. “Dh500 fine if you don’t renew your Dubai health insurance”, *Khaleej Times*, (25 December 2017).

145. Telephone interview with Farhan, 27 June 2022.

146. In-person interview with Maroof, 24 June 2022.

in Sharjah.” Maroof had to move back from Sharjah to Dubai after his wife was diagnosed with Thyroid cancer in late 2020. A 33-year old Indian woman who works in sales for a media company, who had to undergo serious surgery said that race, class and gender play a role in the quality of care that people receive. “It is better if you are well-off and Arab or white,” she said. “And if you are a woman, don’t be single. Have a husband or a father with you to be taken seriously quicker.”¹⁴⁷

In summary, as they do in Saudi Arabia, migrant workers in the United Arab Emirates need private health insurance to access non-emergency medical care in either government or private hospitals or clinics. However, the UAE’s federal government structure, wherein the laws on health insurance are set by each of the country’s seven emirates, has created a patchwork

of regulations that employers can exploit to leave some of the country’s most vulnerable workers- those in its emerging gig-economy- without any formal access to affordable healthcare. This project is primarily directed at the Gulf states’ low-income workers, but the case of higher-incomer migrant workers in Dubai demonstrates that the UAE’s dependence on private health insurance can leave even wealthier migrant workers without easy or affordable access. As in many other areas of migrant workers’ rights in the Gulf, classrace, and gender are intersectional, and it is not only foreign workers at the lower end of the socioeconomic ladder who suffer from policies that appear aimed at generating profit for the UAE’s national elites, but have the effect of discriminating against particular segments of its foreign residents.

147. Telephone interview, 24 June 2022.



Artwork by Appupen

7. QATAR'S WORLD CUP AND ACCESS TO HEALTH

Qatar's hosting of the 2022 FIFA World Cup has placed its record on migrant workers' rights under greater scrutiny than the other Gulf countries. Its population is now 3 million, compared to 1.7 million in 2010, just before it won the right to host the 2022 World Cup.¹⁴⁸ This represents a dramatic 75 percent increase in just 12 years. There are now six clinics to address workers' primary/intermediate health care needs, all located in and around Doha where the overwhelming majority of the country's low-paid migrant workers reside.¹⁴⁹

In 2012, Human Rights Watch issued a detailed report on migrant worker abuses in the country and reported that, "the majority of workers interviewed said that their employers had not provided them with government-issued health cards that would allow them access to public hospitals and clinics for a nominal fee."¹⁵⁰ A survey of 1,189 low-paid migrants in Qatar, published in 2013, found that 56 percent of those surveyed did not have a government-mandated "health card", which they

needed to access subsidized care.¹⁵¹ The report stated that this was "generally assumed to result from employers seeking to avoid the fees and surcharges levied by the government for each of these types of official documentation."¹⁵²

A 2019 policy brief, called 'Improving single male labourers' health', co-published by Georgetown Qatar, the Qatar Foundation, and the World Innovation Summit for Health noted significant improvements in the provision of health care.¹⁵³

Significant investments and developments in healthcare infrastructure in Qatar have taken place over the past three decades. The visible impact of these investments can be seen in the expansion of the largest public health complex in the country—Hamad Medical City—as well as in the burgeoning number of primary healthcare centers, private hospitals, and clinics. Over the past few years alone, Qatar has opened six new

148. "PSA: Population of Qatar Exceeds 3 Million", *Qatar News Agency*, (1 November 2022); Planning and Statistics Authority (State of Qatar), "Population by Sex and Municipality", (April 2010).

149. Fatima Al-Hatimy et al., "A Retrospective Study of Non-Communicable Diseases amongst Blue-Collar Migrant Workers in Qatar", *International Journal of Environmental Research and Public Health*, (17 February 2022).

150. Human Rights Watch, "Building a Better World Cup: Protecting Migrant Workers in Qatar Ahead of FIFA 2022" (June 2012).

151. Andrew Gardner et al, "A Portrait of Low-Income Migrants in Contemporary Qatar", *Journal of Arabian Studies*, (June 2013).

152. Andrew Gardner et al, "A Portrait of Low-Income Migrants in Contemporary Qatar", *Journal of Arabian Studies*, (June 2013).

153. Qatar Foundation, World Innovation Summit for Health, and Georgetown University Qatar, "Improving Single Male Laborers' Health in Qatar: Policy Brief", (2019).

*public sector hospitals, adding more than 1,100 new hospital beds. Additionally, four new Health and Wellness Centers have also been established, sharpening the overall focus on noncommunicable diseases (NCDs), disease prevention, and health promotion. The opening of new facilities and the expansion of existing ones are helping to ensure that the population has better access to higher quality and timely care. However, in a reflection of previous findings, the brief noted problems identified elsewhere in the Gulf.*¹⁵⁴

However, in a reflection of previous findings, the brief noted problems identified elsewhere in the Gulf.

*Workers are highly dependent on their employers and visa sponsors, and must obtain their support and permission when trying to receive medical attention. ... Workers' own reservations and fears of stigma might prevent them from notifying an employer or their supervisor when they are feeling unwell, and this may delay their access to healthcare providers.... There is also the fact that workers complain that they cannot seek medical attention since they do not have medical health cards, and that, frequently, employers delay the process of seeking and having health cards issued for their sponsored employees.*¹⁵⁵

Among the report's key recommendations was that "strict measures of accountability must be in place to ensure that employers issue Qatar IDs and health cards to their employees in a consistent and timely manner."

This is further evidence of a general pattern seen elsewhere in the Gulf, whereby the provision of high quality healthcare facilities is undermined by migrant workers' inability to access the care that should be available to them.

In February 2022, a peer-reviewed article in a medical journal, co-authored by Qatar-based healthcare professionals and representatives of Qatar's Ministry of Public Health and the Hamad Medical Corporation, offered a more optimistic assessment of the situation in Qatar, concluding that "residence in Qatar gave [male blue-collar workers] better access and affordable healthcare for management of [non-communicable diseases]" than in their home countries.¹⁵⁶

The report was based on a retrospective investigation of the electronic health records of 58,342 patients between 1 January 2017 and 30 May 2018. The article's findings are noteworthy, but its conclusion should be set in the context of an inherent sampling bias, which the authors acknowledge when they note that "records of patients with non-availability of valid identification" were excluded from the study. The empirical and anecdotal evidence on migrant workers' access to healthcare suggests that in Qatar, as elsewhere in the Gulf, the problem for migrant workers is not poor quality of care, but rather the inability to access it, with lack of identification the most obvious barrier. Ultimately, the 2022 study makes a more compelling case for migrant workers' access to better healthcare than for the suggestion that they have better access to healthcare.

The only detailed information on workers' possession of health cards since the 2013 survey, which indicated that more than half of migrant workers in the country did not have access to subsidized healthcare, is in the annual audit reports of the Supreme Committee for Delivery and Legacy, the quasi-governmental organisation responsible for stadium construction for the Qatar 2022 World Cup. In 2020, the Supreme Committee's external auditors, Impactt, noted that they found critical issues with two sub-contractors relating to expired Qatari ID cards. At both contractors, workers reported to Impactt that they were afraid of leaving their accommodation site for fear of being arrested.¹⁵⁷ In 2021, Impactt reported that "many high severity issues around passport retention and expired Qatari ID cards were identified."¹⁵⁸ Health cards cannot be issued without valid ID cards.

It should be noted that in relation to workers' possession of their personal documents, including the Qatari ID cards they need to access healthcare, a relatively small proportion of the total workforce on Supreme Committee sites had problems, but it is also true that the rate of workers who reported problems increased marginally year on year - 6 percent in 2018, 11 percent in 2019, 13 percent in 2020, 15 percent in 2021, and 13 percent in 2022.¹⁵⁹ Furthermore, these workers constitute a very small proportion of the total number of low-paid migrant workers in Qatar, and they are subject to project-specific codes of protection overseen by third-party monitors.¹⁶⁰ As such they are a numerically insignificant sub-

154. Qatar Foundation, World Innovation Summit for Health, and Georgetown University Qatar, "Improving Single Male Laborers' Health in Qatar: Policy Brief", (2019).

155. Qatar Foundation, World Innovation Summit for Health, and Georgetown University Qatar, "Improving Single Male Laborers' Health in Qatar: Policy Brief", (2019).

156. Fatima Al-Hatimy et al., "A Retrospective Study of Non-Communicable Diseases amongst Blue-Collar Migrant Workers in Qatar", *International Journal of Environmental Research and Public Health*, (17 February 2022).

157. Impactt, "Annual External Compliance Report of the Supreme Committee for Delivery & Legacy's Workers' Welfare Standards", (February 2020). The reports score compliance based on two factors: 1) Provide workers with visas, Qatar residence permits and health insurance free of charge. 2) Ensure that workers are in possession of their personal documents (identity papers and bank cards), and provide workers with individual, lockable facilities to store their documents. The compliance scores are based on both factors.

158. Impactt, "Annual External Compliance Report of the Supreme Committee for Delivery & Legacy's Workers' Welfare Standards", (April 2021).

159. Data from Impactt, "Annual External Compliance Report of the Supreme Committee for Delivery & Legacy's Workers' Welfare Standards", (April 2021), and "Annual External Compliance Report of the Supreme Committee for Delivery & Legacy's Workers' Welfare Standards", (April 2022).

160. "The Supreme Committee implements a four-tier auditing system against the WW Standards, comprised of contractors' self-audits (first party), comprehensive SC audits and inspections (second party), external monitor audits (third party), and ad hoc inspections conducted by the Ministry of Administrative Development, Labour and Social Affairs (MOADLSA). The SC's audit and inspection regime is complemented by joint health and safety inspections conducted by the SC and Building and Wood Workers' International (BWI)." See Impactt, "Annual External Compliance Report of the Supreme Committee for Delivery & Legacy's Workers' Welfare Standards", (February 2020).

set of the migrant worker population who enjoy significantly better protection than the general migrant worker population. In this context, the finding that 13 percent of workers on the most high-profile projects in Qatar still did not have access

to personal documents required to access healthcare in 2022, despite years of auditing and inspections, gives cause for ongoing concern about the general migrant worker population's ability to access healthcare.¹⁶¹

Case Study - Going Blind in Qatar

Ludra Bahadur Sunar, a 33-year old man from Nepal spent 13 months working in Qatar as a gardener, where he nearly lost his sight due to a lack of health and safety equipment and his inability to access proper medical care.¹⁶² He decided to leave his home in the Pyuthan district of Nepal in order to financially support his wife and five children. He successfully cleared Nepal's mandatory pre-departure health screenings, which included eye tests, prior to his arrival in Qatar in April 2021.

In Qatar, Ludra told the Vital Signs Partnership that he worked as a cleaner for a gardening company. He often worked outdoors in extreme heat, and without access to gloves, masks and safety goggles and was frequently exposed to saw dust due to being in proximity to heavy machinery to cut down trees. When this began to cause irritation in his eyes in September 2021, he approached his foreman, and later a more senior member of staff, and asked them to arrange a visit to a hospital or a clinic, but both told him to arrange a check-up himself. However, due to the fact that his employers hadn't provided him with the Qatari ID that he needed to access public health services, he couldn't access subsidized healthcare and private clinics were too expensive. Ludra also said that he didn't have the confidence to visit healthcare facilities, and he didn't think he would be able to communicate with staff there due to language barriers. Instead, Ludra purchased eye-drops from a local pharmacy to help his condition. These did not improve the situation and by November, he had become blind in his left eye, and was suffering serious loss of vision in his right. He was also in pain.

Ludra was unable to work full time but he continued to work a few days a month to put food on the table. As his condition deteriorated and he continued to receive no support from his company, a Bangladeshi co-worker suggested to Ludra that he fake passing out because, "the company won't take it seriously unless someone is dying." Ludra took his colleague's advice and his employers called an ambulance, which took him to hospital. Ludra spent 12 days in hospital, but said he was unable to communicate with hospital staff and despite receiving some treatment for his eye problems, he said he was discharged before they had healed. He said that the company bore the costs of his 12 day stay, but refused to cover the expenses of follow up treatments scheduled for the next three months and since they had also not issued Ludra with a Qatari ID or a health card, he had to pay out of pocket to access care. He was unable to avail the help of the Nepali embassy as transportation costs to and from were too expensive.

Due to his inability to resolve his medical condition, Ludra requested that his employers cancel his contract and arrange his return to Nepal. However, they refused and Ludra was required to work until June 2022, when a Nepali acquaintance funded his trip home. Ludra has received no compensation from his employer and told the Vital Signs Partnership that although his sight is slowly improving, his dreams of improving the financial situation of his family have been shattered.

161. It should also be noted that the annual compliance reports demonstrate that the Supreme Committee has invested resources into providing mental health services for its workers. In 2019 the Supreme Committee "produced a list of recommended mental health service providers and encouraged contractors to provide these services to their workers" and they also signed "a 'Mental Health Pathway' agreement with Qatar's Ministry of Public Health and the Hamad Medical Corporation to conduct mental health screenings." Impactt, "Annual External Compliance Report of the Supreme Committee for Delivery & Legacy's Workers' Welfare Standards", (April 2021).

162. In-person interview with Ludra Bahadur Sunar, 15 June 2022.



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8. CONCLUSION: ACCESS TO HEALTH AND PREVENTABLE AND UNEXPLAINED DEATHS

As the first Vital Signs report outlined in detail, low-paid migrant workers in the Gulf are subject to a wide range of cumulative risks to their physical and mental health. These risks originate from the workplace, their living conditions (encompassing their accommodation and their broader neighbourhoods), and the environment, and include: heat and humidity, pollution; abusive working conditions, which often include excessive working hours and heavy physical workloads; lax occupational health and safety (OHS) practices; exposure to long-term chronic psychosocial stress; and, in the case of female domestic workers, acute vulnerability to physical, psychological and sexual abuse. The first Vital Signs report noted that despite the shortcomings of the available data on migrant worker deaths, it appears that as many as 10,000 people from South and Southeast Asia die in the Gulf every year (this figure will obviously be higher when migrant workers of other nationalities are included) and that more than 1 out of every 2 deaths is effectively unexplained, which

is to say that deaths are certified without any reference to an underlying cause of death, instead using terms such as “natural causes” or “cardiac arrest”.¹⁶³

Professor Vivekanand Jha, the Executive Director at The George Institute for Global Health, India, and Chair of Global Kidney Health at Imperial College London, outlined to the Vital Signs Partnership why access to health for any population is essential. “Without easy access to healthcare, preventable diseases go untreated and can develop into more serious conditions, and chronic diseases will be detected later. In both cases these place a further burden on health services.”¹⁶⁴ Dr Rashidee Mahboob, the former president of the Bangladeshi Medical Association expressed concern at the high rate of deaths of low-paid migrant workers attributed to natural causes in the context of risks to which they are exposed in the Gulf and told the Vital Signs Partnership that “extra precautions” were required for South Asian workers in the Gulf.¹⁶⁵ Professor

163. The data that is available on the deaths of migrant workers in the Gulf is incomplete, in places contradictory, and it precludes effective analysis of the extent and gravity of the problem.

164. Telephone Interview with Professor Vivekanand Jha, The George Institute for Global Health, India/ Imperial College London, 24 September 2022.

165. Telephone Interview with Dr Rashidee Mahboob, former president of the Bangladeshi Medical Association, 14 September 2022

Jha offered a similar view. “We know that this population is doing dangerous work, and the data is very clear that this can lead to multiple adverse health conditions whether those are cardiovascular or respiratory or other types of disease. They need regular check ups to prevent these adverse health consequences, and more regular check ups than those doing sedentary work. Laws should mandate these types of check ups.” Dr Dennis Batangan, a public health specialist from the Philippines, offered a very similar opinion. “For high risk individuals in need of regular and/or specialized health care, difficulty of access to health care services will determine to a large extent the course of illness for these individuals.”¹⁶⁶

Dr Batangan also drew attention to the risks of migrant workers consistently taking non-prescription medicine in the absence of any medical advice. “In the absence of such advice and monitoring, there might be progression of the disease and/or untoward effects of the medications that may not be addressed”, he said. Professor Vivekanand Jha, the Executive Director at The George Institute for Global Health, India, and Chair of Global Kidney Health at Imperial College London detailed some of the specific health risks associated with overuse of non-prescription medicine. “The general principle is that the indiscriminate use of painkillers is very problematic and can lead to all sorts of health complications such as kidney disease and electrolyte imbalances.”¹⁶⁷

The link between access to healthcare and mortality rates is self-evident, and numerous physicians outlined the clear link to the Vital Signs Partnership. Dr Batangan said that an inability to access care “may also result to non-detection of existing diseases [and] ... as such the disease condition, undetected and hence not managed, can deteriorate and may lead to serious morbidities and/or mortalities.”¹⁶⁸ A senior Nepalese doctor from the Manmohan Cardiac Center, who spoke to the Vital Signs Partnership under condition of anonymity, said that “timely access to health services prevents a large number of deaths.”¹⁶⁹ Dr. Birat Krishna Timalisina, a cardiologist at the Shahid Gangalal National Heart Centre and Metro Hospital in Kathmandu, told the Vital Signs Partnership that failure to provide easy access to health would be a contributory factor in the number of preventable deaths, particularly in an environment where workers are exposed to extreme heat, or other environmental conditions, and high levels of stress.¹⁷⁰

Physicians we spoke to also drew links between workers' inability to access healthcare and the high rate of unexplained deaths. Dr Timalisina noted that if a patient has no medical history and doctors don't see the patient's symptoms prior to death, “they have few clues as to what caused their death ... unless an autopsy is performed.”¹⁷¹ Professor Jha said that in his view the inability of workers to access healthcare was in all likelihood “a critical factor” behind the high rate of unexplained deaths.¹⁷²

166. Email correspondence with Dr Dennis Batangan, 15 September 2022.

167. Telephone Interview with Professor Vivekanand Jha, The George Institute for Global Health, India/ Imperial College London, 24 September 2022.

168. Ibid.

169. In-person interview, Manmohan Cardiac Center, Teaching Hospital, 16 September 2022.

170. Telephone interview with Dr. Birat Krishna Timalisina, Shahid Gangalal National Heart Centre and Metro Hospital, Kathmandu, 14 September 2022.

171. Ibid.

172. Telephone Interview with Professor Vivekanand Jha, The George Institute for Global Health, India/ Imperial College London, 24 September 2022.



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9. RECOMMENDATIONS

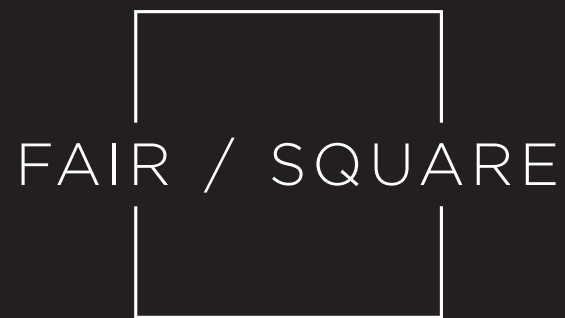
Recommendations to the governments of the Gulf Cooperation Council (GCC) states

- Make all necessary healthcare for low paid migrant workers free of charge at the point of care, irrespective of workers' immigration status or their possession of identity documents.
- Ensure that fully resourced clinics and emergency rooms are in close proximity to areas with large populations of low-paid migrant workers and offer levels of care that reflect the particular needs of these populations.
- Repeal any laws or regulations that require medical professionals to report undocumented or pregnant migrant workers to the authorities and explicitly prohibit medical professionals from doing so.
- Introduce regular and mandatory health check-ups for domestic workers and mandate health workers and other relevant authorities to conduct follow-up visits to employers' homes if domestic workers fail to attend.
- Introduce meaningful sanctions, passing legislation if necessary, for employers and sponsors who, by their actions or omissions (e.g. confiscation or non-renewal of identity documents), prevent migrant workers from accessing healthcare.
- Conduct widespread screening and treatment programs for non-communicable diseases such as hypertension.
- Conduct public information campaigns targeted at migrant worker populations on the health risks associated with the overuse of non-prescription painkillers.

- Ensure that migrant workers have access to mental as well as physical healthcare and that mental health policies, where they exist, are updated to include reference to the specific requirements and vulnerabilities of low-paid migrant workers.

Recommendations to the governments of origin states

- Publicly press governments of the GCC states to improve access to healthcare for migrant workers: highlight existing barriers and urge their removal, and insist that undocumented or pregnant workers seeking healthcare will not be reported to the authorities.
- At a bilateral level, and with the input of public health experts, insist on the inclusion of transparent and explicit healthcare provisions in all bilateral agreements and memoranda of understanding with the GCC states. Establish and activate meaningful and regular review processes for these.
- At a multilateral level, work in coalition with other origin states and outline a detailed position aimed at improving GCC migrant workers' access to health in regional and global forums such as the Colombo Process, the Abu Dhabi Dialogue, and the Global Forum for Migration and Development.
- Conduct pre-departure and post-arrival medical checks and collect information from returning workers on their ability to access healthcare, their general health when abroad, and their working and living conditions, and make this data available to public health specialists.



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