MIGRANT WORKERS - OCCUPATIONAL SAFETY AND HEALTH

JOINT ILO-WHO COMMITTEE ON OCCUPATIONAL HEALTH, SEVENTH SESSION, GENEVA, 5-11 AUGUST 1975
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1. Introduction

1. The Seventh Session of the Joint ILO/WHO Committee on Occupational Health, this time considering the Safety and Health of Migrant Workers, was opened by Mr. J. de Givry, Chief, Working Conditions and Environment Department, who highlighted the fact that safeguarding the safety and health of migrant workers was one of the constitutional obligations of ILO. Speaking on behalf of ILO and WHO he expressed his thanks to the participants and conveyed the good wishes of the Directors-General of ILO and WHO for the success of the meeting.

2. The voluntary migration of workers from one country to another is not a recent phenomenon. To take only one of the many possible examples from various parts of the world, an estimated 35 million Europeans emigrated to the United States of America between 1800 and 1914, attracted by high wages and an abundance of land. These migrants generally left home without any intention of returning. This impulse still operates today, but the corresponding population movements are much smaller than they used to be, since the countries of destination have usually raised barriers to permanent immigration.

3. With regard to occupational health and safety, migrant workers create special problems in addition to those they share with national workers, even where they enjoy the same conditions as the latter as provided for by ILO Convention No. 97 of 1 July 1949, Article 6.1, as follows:

   Each member for which this Convention is in force undertakes to apply, without discrimination ... to immigrants lawfully within its territory, treatment no less favourable than that which it applies to its own nationals ...
4. During the first years of their residence, these special problems are largely the same for temporary migrants and for immigrants settling permanently in the host country. They call for the adoption of measures to safeguard the occupational health and safety of these workers.

5. The purpose of this report is to review the problems involved, to find measures to combat them and at the same time to establish criteria for selecting the order of priority in which they should be tackled.

6. The meeting decided that it would start by reviewing the causes of migration of workers from one part of the world to another, although these have already been considered at great length by ILO, as a preliminary to preparing international standards. The meeting felt that these should be classified into three main categories.

(a) Reasons based on the interests of the countries of employment

7. Many of the highly industrialised countries are short of labour for rapid industrial expansion, while some countries in process of industrialisation find it necessary to import labour, because the expertise and skills needed are not available among their nationals. Another reason is the economic advantage gained by industries in employing foreign workers, because a foreign worker might be willing to accept a lower wage. In some industrialised countries and wealthy countries undergoing industrialisation, the nationals may be highly selective in their choice of work, and thereby create a labour vacuum in many occupations which is then filled by workers from abroad.

(b) Reasons relating to the interests of the countries of origin

8. As a rule governments are not involved in exporting their national labour to other countries. They may, however, allow migration of workers because it is the choice of the workers themselves. They may even encourage some migration for the following reasons:

(i) a surplus of unemployed and underemployed workers;
(ii) economic shortages and low wages;
(iii) the possible return in terms of economic benefit to individual families;
(iv) augmentation of the foreign currency reserves of the government.

(c) Reasons influencing individual migrant workers

9. The main reasons in this regard can be listed as follows:
(i) the expectation of the worker that he will have a better wage and be able to save money for use on his return to his home country;

(ii) being unemployed or underemployed has already been mentioned but it is highlighted again because many migrant workers feel that even though employed, their skills and proficiency are sometimes underutilised;

(iii) expectation of better living conditions, social and medical security and professional and social advancement;

(iv) access to better food resources, water supplies and agricultural and grazing land;

(v) easy availability of supplies of consumer goods and social amenities;

(vi) failure to adapt to social and political changes in their homelands.

2. Scope, nature and evolution of the problem

Critical review of the available statistics and documentation

10. Before taking a look at the problems common to migrant workers in different countries throughout the world, the term "migrant worker" as used in this report needs to be defined. There are two classes of foreign worker that the term does not include, because they do not create the special problems of occupational health and safety posed by all other migrant workers. These are:

- frontier workers, who work on the other side of their national border but continue to reside in their home country;

- seasonal workers, in the strict sense of the term, who go to work in a foreign country for a very brief part of the year, three to four weeks at most, particularly for agricultural work and crop-picking, where there is a temporarily high demand for labour.

In addition, although the migrant workers' families create serious problems in the host country (and in their country of employment when they remain there), these are not the problems that will be dealt with in this report. Hence, unless otherwise indicated, any figures given will refer to workers only, exclusive of any non-working members of their families.

11. It is often difficult to assess migrant workers' problems properly. As Houdaille and Sauvy have pointed out, even when such migration is fully within the law it lends itself less

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easily than any other demographic variable to measurement or even simply to counting. On top of this, there may be massive illegal migration. Accurate assessment of the number of foreigners living in a country is really only possible at times when regular censuses are being taken. In the intervals between two censuses, the only figures available are approximate and vary according to their source. This qualification applies to most of the figures given in this report, but they may be taken as a close enough approximation of the right order of magnitude.

12. Little information can be expected from migrant workers' home countries, for most of them have no facilities for collecting such data. In Europe, the most accurate data comes from Spain, through its Institute of Emigration, and, to a certain extent, from Italy and Portugal. Admittedly, the foreigners in employment in an industrialised country are known to the health and welfare services regardless of the means by which they came into the country of employment. However, in the desire to avoid any discrimination between foreign and national workers, which is rightly rejected, the data for the two groups are merged, with the result that it is often impossible to separate them in the over-all statistics.

13. This uncertainty is compounded by the recognised imperfections of the morbidity statistics in many countries and, in addition, by the reluctance of foreign workers to give information they think may be used against them. For all these reasons, the available documentation is scanty, fragmentary and often incomplete. Recourse has very often had to be made to transposition or extrapolation of reliable data collected by a number of establishments and services specialising in medical and social assistance to foreign migrants. Such establishments and services, however, do not cover all such workers by a long way.

Review of the existing features of the migrant worker in various countries

14. There is a particularly large number of migrant workers in Europe, found mainly in the industrialised countries of Western Europe. As a rule, no migration takes place between the socialist countries of Eastern Europe; however, according to Böhning, the German Democratic Republic has approximately 50,000 immigrants from Czechoslovakia, Hungary and Poland. An estimated 13,541,000 migrant workers and families (representing a working population of 7,783,000) were living in Western Europe in 1974. Table 1 shows the home country and distribution of foreigners in Europe (estimation ILO).
Table 1

Europe: Migrants in population 1974

(in thousands)

<table>
<thead>
<tr>
<th>Countries of origin</th>
<th>Countries of immigration or employment</th>
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<td>FR of Germany</td>
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<td>Africa</td>
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<td>Algeria</td>
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<tr>
<td>Morocco</td>
<td>21</td>
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<tr>
<td>Tunisia</td>
<td>17</td>
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<td>Asia</td>
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<tr>
<td>Turkey</td>
<td>1 028</td>
</tr>
<tr>
<td>Europe</td>
<td></td>
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<tr>
<td>Spain</td>
<td>273</td>
</tr>
<tr>
<td>Finland</td>
<td>(-)</td>
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<tr>
<td>Greece</td>
<td>406</td>
</tr>
<tr>
<td>Italy</td>
<td>630</td>
</tr>
<tr>
<td>Portugal</td>
<td>121</td>
</tr>
<tr>
<td>Yugoslavia</td>
<td>708</td>
</tr>
<tr>
<td>Others</td>
<td>916</td>
</tr>
<tr>
<td>Total immigrants</td>
<td>a 127</td>
</tr>
</tbody>
</table>

1 The estimates (by the ILO) included in this table are based on data which vary widely between countries (census, aliens control, etc.). In the case of the United Kingdom the number of "immigrants" in each case is that of the persons born abroad: it should therefore be reduced by the number of United Kingdom nationals who were born in foreign countries and increased by the number of foreign nationals born in the United Kingdom.
15. Industrial expansion in the host countries has, over the years, created an increasingly urgent demand for foreign labour. Workers have therefore been coming from more and more distant countries and this has increased the various difficulties facing the migrant. The situation is further aggravated by the fact that conditions have recently improved in a number of the closer home countries where wages have risen to levels affording the worker a satisfactory standard of living without any need for expatriation. The Hudson Institute predicts with respect to France, for example, South Europeans will remain in their own countries or will go back there as soon as they are sure of earning 75 per cent of French wages.

16. The migrant population is in a state of perpetual flux since, each year, after stays of very variable lengths, migrants go back to their own countries and their places are taken by newcomers. The annual migratory flow in 1973 was probably between 600,000 and 1 million (ILO, 1974). The economic recession caused by the energy crisis has cut these figures down considerably. Whereas the number of workers coming into France rose by 35 per cent from 1972 to 1973, the 1974 figures were 51 per cent below that for 1973. The proportion of non-working (family) to working migrants varies greatly from country to country.

17. Switzerland (865,000 in 1971), Luxembourg (55,000) and Bahrain (38,000 in 1971) lead the field with regard to the percentage of foreigners among the national population (16.1, 19 and 20 per cent) and of working foreigners among the working population (table 2). As an example, the total number of foreign workers by nationality in Bahrain is given in table 3. In absolute figures, it is the Republic of Germany and France who hold the record for the number of resident foreigners in their countries (4,127,000 and 4,126,000 respectively), and also for the number of working foreigners. These two countries together account for more than half of all the migrant workers. The numbers of such workers have been increasing steadily from 1960 to 1974, with a temporary decline in 1967. For this reason detailed information has been given for migrants in these two countries. Figures for the other countries are fairly similar, apart from the exceptions indicated.

Table 2
Total foreign population and working foreign population

<table>
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<tr>
<th>Total foreign population</th>
<th>Working foreign population</th>
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<tbody>
<tr>
<td></td>
<td>Percentage of total population</td>
</tr>
<tr>
<td>Bahrain</td>
<td>20</td>
</tr>
<tr>
<td>Belgium</td>
<td>7</td>
</tr>
<tr>
<td>France</td>
<td>7</td>
</tr>
<tr>
<td>Netherlands</td>
<td>1.6</td>
</tr>
<tr>
<td>Fed. Rep. of Germany</td>
<td>5.9</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>4.7</td>
</tr>
<tr>
<td>Sweden</td>
<td>5.1</td>
</tr>
<tr>
<td>Switzerland</td>
<td>16.1</td>
</tr>
</tbody>
</table>
There are other migration trends taking place in other countries of South Arabia, Latin America, South East Asia and Africa. Examples of these can be quoted from Kuwait, Saudi Arabia, Bahrain and the United Arab Emirates as host countries which receive migrant workers from the neighbouring countries, like Egypt, Sudan, Lebanon, India, Pakistan, Palestine and Yemen. Even some Europeans and Americans are known to migrate to these new resource countries. Table 3 illustrates the position in regard to Bahrain.

Other known types of migration occur by virtue of causes related to land use for purposes of rearing and grazing cattle and increasing the animal wealth, cotton growing, grading and packing and other agricultural activities. An example of this type of migration affects the Sudan as host country and Nigeria, Chad and some other Central African countries as countries of origin. Although statistical data is difficult to obtain with regard to these agricultural movements, it is known that large numbers of working populations do migrate to large agricultural schemes and settle down. An interesting feature of this type of migration is that it might start as seasonal migration but it soon takes the form of permanent settlement in the host country. Another aspect affecting African countries in respect of migrant labour is the recent change brought about by bouts of drought causing marked ecological changes in the countries of origin and consequent migration of groups of workers and stock breeders to settle in the host country. This type of migration has affected several African countries.

The migration pattern in Asia has been somewhat different. Owing to sharp increases in population in nearly all the countries of South East Asia and the Far East, and the consequent reduction of employment opportunities, even for nationals, the legal migration of workers between the countries of the region has come to a virtual standstill. In the latter part of the nineteenth century

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### Table 3

<table>
<thead>
<tr>
<th>Country</th>
<th>Number</th>
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<tbody>
<tr>
<td>Oman</td>
<td>10,785</td>
</tr>
<tr>
<td>India</td>
<td>6,657</td>
</tr>
<tr>
<td>Pakistan</td>
<td>5,377</td>
</tr>
<tr>
<td>Iran</td>
<td>5,097</td>
</tr>
<tr>
<td>Yemen</td>
<td>1,538</td>
</tr>
<tr>
<td>Jordan and Palestine</td>
<td>1,338</td>
</tr>
<tr>
<td>Other Arab countries</td>
<td>2,753</td>
</tr>
<tr>
<td>Egypt</td>
<td>587</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>2,901</td>
</tr>
<tr>
<td>Other European America</td>
<td>301</td>
</tr>
<tr>
<td>America</td>
<td>272</td>
</tr>
<tr>
<td>Others</td>
<td>279</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>37,885</td>
</tr>
</tbody>
</table>
and the early part of this, India and China were the great reservoirs which provided migrant labour to many parts of the world - the other eastern countries as well as to distant countries like East Africa and the West Indies. These migrants were mainly unskilled and were used as agricultural workers, helping in the opening up of land and the growing of plantation crops. The descendants of these workers have, in many instances, stayed on in the host countries, giving rise to the problems connected with minority groups.

21. A very significant change in the standard pattern of migration has occurred in the last decade in many of the countries of South East Asia - the migrants now are skilled workers and technically and professionally qualified people. Some of these have migrated to work in those developing countries which are in need of their expertise while others have gone to the affluent industrialised countries to find the work and higher remuneration which are not available to them at home. The following tables demonstrate the movement of international migration in South America, Africa and North America.

3. General health problems

22. The impact of the process of migration on the health of migrant workers shows some important features brought about by the new work environment and the psychosocial effects to which they are liable to be exposed. The main features of this impact are reviewed in the following paragraphs.

Endemic diseases in country of origin

23. A number of migrant workers may be carriers of certain communicable and non-communicable diseases that are endemic in their own countries but do not exist in the host country. This causes problems as to which diseases are involved and how they may be detected. Also, when a case is found, should the work concerned be refused admission or sent back in view of the triple question of fitness for work, cost of treatment and risk of transmitting the infection into the host country? Despite their importance, a detailed discussion of these problems and ways of solving them is not possible in this report. We shall restrict ourselves to mentioning those diseases most frequently encountered and commenting on a few important points concerning them.

24. In many cases, clinical examination alone cannot detect such imported diseases, since they are often very well tolerated and clinically inapparent. Recourse must, therefore, be had to laboratory tests. In actual fact, it is difficult to find out the relative prevalence of these diseases without carrying out mass examination or supplementary investigations in the case of other disorders that have led to hospitalisation. Multiple parasitic infection occurs particularly frequently among workers from Central Africa. Most of the important diseases are unlikely to become entrenched in the host countries of the temperate zones owing to the hygienic conditions found there and to the absence of climatic conditions or vectors capable of favouring their transmission.
### Table 4

#### Latin America: Migration by country (1974)

<table>
<thead>
<tr>
<th>Country of employment (host country)</th>
<th>Total Latin America migrants</th>
<th>Country of origin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>1,500,000</td>
<td>From Paraguay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bolivia</td>
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<tr>
<td></td>
<td></td>
<td>500,000</td>
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<td>Chile</td>
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<td></td>
<td></td>
<td>350,000</td>
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<td>Uruguay</td>
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<td>80,000</td>
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<td></td>
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<td>70,000</td>
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<td>Bolivia</td>
<td>45,000</td>
<td>From Peru</td>
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<td>Brazil</td>
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<td>2,000</td>
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<tr>
<td>Brazil</td>
<td>140,000</td>
<td>From Paraguay</td>
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<td>3,000</td>
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<td>Chile</td>
<td>135,000</td>
<td>From Bolivia</td>
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<td>20,000</td>
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<tr>
<td></td>
<td></td>
<td>Bolivia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Miscellaneous</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Paraguay)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,995,000</strong></td>
<td></td>
</tr>
</tbody>
</table>

1 Estimates by ILO.
Africa: Intercontinental emigration up to 1 January 1975¹
(in thousands)

(The first figure in each case is the number of persons who have emigrated, the second - in brackets - is the number of workers.)

<table>
<thead>
<tr>
<th>Countries of emigration</th>
<th>2% of Germany</th>
<th>Belgium</th>
<th>Spain</th>
<th>France</th>
<th>Others</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Algeria</td>
<td>2 (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1016</td>
</tr>
<tr>
<td>Morocco</td>
<td>24 (65)</td>
<td>5 (29)</td>
<td>270 (70)</td>
<td>424 (177)</td>
<td>181 (107)</td>
<td>907 (502)</td>
</tr>
<tr>
<td>Tanzania</td>
<td>17 (11)</td>
<td>2 (1)</td>
<td>0</td>
<td></td>
<td></td>
<td>91 (92)</td>
</tr>
<tr>
<td>Others</td>
<td>2 (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>42 (72)</td>
</tr>
<tr>
<td>Total North Africa</td>
<td>47 (30)</td>
<td>69 (29)</td>
<td>126 (705)</td>
<td>182 (185)</td>
<td>154 (907)</td>
<td></td>
</tr>
<tr>
<td>Mali</td>
<td></td>
<td></td>
<td>40 (36)</td>
<td>0</td>
<td></td>
<td>40 (36)</td>
</tr>
<tr>
<td>Mauritania</td>
<td></td>
<td></td>
<td>30 (27)</td>
<td>0</td>
<td></td>
<td>30 (27)</td>
</tr>
<tr>
<td>Senegal</td>
<td></td>
<td></td>
<td>20 (17)</td>
<td>0</td>
<td></td>
<td>20 (17)</td>
</tr>
<tr>
<td>Others</td>
<td>24 (24)</td>
<td>9 (9)</td>
<td>0</td>
<td></td>
<td></td>
<td>33 (33)</td>
</tr>
<tr>
<td>Total Africa</td>
<td>71 (33)</td>
<td>58 (39)</td>
<td>60 (260)</td>
<td>1356 (785)</td>
<td>242 (190)</td>
<td>1789 (1060)</td>
</tr>
</tbody>
</table>

¹ Estimates by ILO.
Table 6

North America: Intercontinental immigrants by areas of origin

<table>
<thead>
<tr>
<th>Continents and countries of emigration</th>
<th>Country of immigration</th>
<th>Canada (average)</th>
<th>United States (1974)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>thousands</td>
<td>%</td>
</tr>
<tr>
<td><strong>Africa</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>inc. Egypt</td>
<td></td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>Asia</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>inc. Korea</td>
<td></td>
<td>26</td>
<td>23</td>
</tr>
<tr>
<td>India</td>
<td></td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Philippines</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Hong Kong</td>
<td></td>
<td>7</td>
<td></td>
</tr>
<tr>
<td><strong>Europe</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>inc. Greece</td>
<td></td>
<td>77</td>
<td>70.5</td>
</tr>
<tr>
<td>Italy</td>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Portugal</td>
<td></td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>UK</td>
<td></td>
<td>24</td>
<td></td>
</tr>
<tr>
<td><strong>Oceania</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>inc. Australia</td>
<td></td>
<td>0.81</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>intercontinental</td>
<td></td>
<td>109</td>
<td>227</td>
</tr>
<tr>
<td><strong>All immigration</strong></td>
<td></td>
<td>150</td>
<td>400</td>
</tr>
</tbody>
</table>


2 Annual average for 1968-73.

- = figure negligible or not available.
25. This would not apply in the case of migration to tropical countries with areas possessing all the factors for successful development of certain diseases but which have up to now remained free of such diseases through lack of contact with them. Schistosomiasis has given several recent examples of this in the case of large hydraulic or irrigation projects for which it was impossible to carry out stringent ecological and public health surveillance, at the proper time (Lake Kariba, the Volta River Basin, Lake Nasser).¹

26. Some believe that the risk of leprosy ought not to be underestimated, since it is in fact contagious and has a prolonged latent period before onset, even though the number of cases observed among the local population of the host countries is almost nil. Moreover, nationals with leprosy contracted overseas have been living in these countries for many years without spreading the disease. A number of non-communicable diseases are of special significance. Among them are the haemoglobinopathies, of which one out of every four or five Black Africans is a carrier and which can cause severe anaemia or infarctus whenever the blood is deoxygenated (sickle cell anaemia and haemoglobinopathy C). In the same way the prevalence among certain population groups (North Africa, Central Africa, Sardinia, Thailand and Brazil) of a genetic deficiency in glucose-6-phosphodehydrogenase may create problems regarding fitness for certain types of work. Carriers of this deficiency run the risk of severe haemolytic disorders when exposed to a large number of toxic substances and medicaments, particularly benzene, lead and all the haemolytic poisons (methaemoglobinising amines).²,³,⁴ In practice, the difficulties lie more often in the fact that physicians in the host community are unfamiliar with the imported diseases so that when making their decisions they may be too strict or not strict enough. They should therefore seek the opinion of a specialist.

Acquired diseases

27. This concept would be rather vague if it were to cover the whole range of diseases involved, in practice, there is general agreement that primary consideration should be given to tuberculosis. This view is shared both by those authors concentrating on African migration to Europe and by those dealing

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with migration from other continents. A French survey reports that the risk for Italian and Spanish workers is approximately the same as for French workers, for Poles is twice as high, for Yugoslavs and North Africans four to six times, and for Africans it is 20 to 30 times as high.1 The risk of tuberculosis is therefore three or five times more for migrants. A decisive role is played by predisposing factors such as bad working conditions, poor diet, bad housing, overcrowding and poor health education. It has been stated in some studies from Bahrain and Sudan that the risk is the same for migrants as for native workers.

28. The lungs are the most frequent and most progressive site of the disease, which clearly indicates the need for early and frequent screening in migrant communities, by means of both the tuberculin test and mass radiography, particularly during the first two years of residence. Non-pulmonary or glandular tuberculosis is not uncommon and should also be looked for. Such screening should, logically, also be carried out before departure from the home country but the evidence is that the disease is indeed one of acquisition, resulting from weakening of the system and exposure to infection, and implies that screening should be carried out in migrant communities, either at their place of work or at their place of residence. Occupational health services, by their nature and, more particularly, because of their experience in the matter, would seem to provide the best framework for this work. With reference to acquired diseases, a marked increase in acute seasonal broncho-pulmonary disorders is generally observed: these are generally due to the poor housing conditions of migrant workers. One serious disease that tends to increase in prevalence among migrants is venereal disease.

Psychosocial factors

29. Sociologists2 have divided the process of fitting migrants into society into three successive phases, namely: adaptation, integration and assimilation. There is general agreement that emigration is a phenomenon primarily related to sociological and economic problems and is not usually related to pathological behavioural anomalies. However, even in good health, the migrant worker is vulnerable, as he carries within himself various factors that limit his ability to adapt to the environment in which he must live and work and that may undermine his health. A further disadvantage is the frequently deleterious effect of that environment itself.

30. The migrant worker is generally a rural subject abruptly transplanted into an urban society and, what is more, into a foreign one. He would have difficulty enough in adapting to city life in his own country. Abroad, these difficulties are aggravated and become greater the further he is from his own country. Migrants from bordering countries, with similar cultures, adapt easily. The

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same does not apply to migrants from other continents. These have to contend not only with their ignorance of the environment in which they have to live but also with the large differences between this environment and that which they have left. Everything is different: the climate, eating habits, social customs, cost of living, housing conditions and the type and rhythm of work. The migrant is handicapped in dealing with these changes by his inexperience of urban life, his inadequate knowledge or complete ignorance of the language of the country, his frequent illiteracy and his frequent lack of occupational skills. These are compounded by emotional factors: fear of isolation, loneliness, sadness at separation from the rest of his family at home, fear of not finding work or of losing it and sometimes worry about heavy debts which have to be paid back to the organisation of dubious legality that arranged his journey.

31. The cultural background, customs and traditions of the migrant not only no longer represent a comforting framework for his life and a psychological support, but often, on the contrary, create a barrier to his integration into the host country. Such factors have a heavy influence on the migrant worker's behaviour and can predispose him to illness. The same applies to the migrant's realisation that his original skills and experience count for very little when they have no relevance to the requirements of his new activities. The migrant is therefore trapped from the start in a sort of contradiction that may have pathological consequences. On the one hand, he tends to buttress his identity as a foreigner by clinging to his own cultural values and traditions and seeking out the company of his compatriots. On the other, he knows quite well that he must make an effort to integrate himself into the host community if he is to improve his chances, to make his job and his income secure, and to make it possible, if he so wishes, to bring his family to live with him.

32. The prevalence of psychiatric disorders seems to be two to three times as high among recent migrants as among the local population. The aetiology of these disorders lies in the depersonalisation phenomenon in those migrant workers who are unable to adapt themselves in the surrounding cultural environment. They may be disguised as various somatic conditions, particularly of the digestive tract. Acute psychotic states or paranoid reactions appear during the first years of residence in the host country. Such states may appear abruptly and are usually centred on ideas of persecution associated with the casual aggressive situation, which may be either those responsible for taking care of him on arrival (regarding housing or work) or institutions (e.g. responsible authorities, welfare agencies, hospitals, etc.). The poorer the migrant's cultural background and the more unfamiliar his surrounds the greater becomes the problem of integration.

33. The psychopathological reaction to such depersonalisation takes the form of regression in a psychotic, neurotic, somatic or even traumatic shape. An accident is experienced by the victim as something fated to happen and as a harbinger of death by harming the body which is the only guarantee of his identity and which alone is capable of giving him a place in society.¹

Occupational diseases

34. So far as occupational diseases are concerned, it must be admitted that there is insufficient statistical documentation on the subject. This is generally the case even among non-migrant workers. It has been recognised however that, because of their exposure to high risks and to arduous labour, migrant workers are likely to contract more occupational diseases than native workers. The question of occupational diseases in migrant workers presents a field which requires further studies and WHO and ILO are called upon to initiate and augment this research; studies are also required to clarify the picture of occupational diseases amongst migrant workers in the future.

Occupational accidents

35. Not much statistical data is generally available relating to accident, severity and frequency rates amongst migrant workers, as compared with the national working population. What there is has to be treated with care because accurate information and records enabling differentiation between the two groups have not been kept from the start. Another important aspect is that it is known from the existing information that migrant workers are usually allocated to the less skilled types of work characterised by heavy manual labour and hence exposure to a higher risk of accidents. This coupled with the stresses that the migrant workers are exposed to may also increase the severity of the situation.

36. A German study1 which compares rates of accidents at work and accident rates for travel to and from work for various nationalities of migrant workers, and whose findings have also been confirmed by other less detailed studies, estimates the accident rate to be 2 1/2 times as high (1 573 as against 679). This distinction is not maintained, however, in the case of fatal accidents or accidents occurring on the way to or from work. The accident rate varies for different nationalities in descending order as follows: Turks, Italians, Yugoslavs, Spaniards, Greeks, Portuguese and lastly "other Europeans" (Benelux, France, Austria, and Switzerland). However, this order changes in the case of fatal accidents to: "other Europeans", Turks, Yugoslavs, Spaniards, Greeks and Portuguese. The fatal accident rate for the last two nationalities is lower than that for Germans.

37. In the building industry, the highest accident rate occurs amongst Turks, followed by Greeks, Yugoslavs, Spaniards, Italians, Portuguese and "other Europeans". The same order holds for the metallurgical and other branches of industry. With regard to the fatal accident rate, Turks are less at risk in the building industry (sixth place) than in metallurgy (first place). However, in other branches of industry, the first place is held by "other Europeans" with a rate double the average for foreign workers and almost three times that for German workers.

1 Leichsenring, C.: Die Unfälle des ausländischen Arbeitskräfte in der BRD (Hauptverband der gewerblichen Berufsgenossenschaften, Bonn).
REPORT OF THE JOINT ILO/WHO COMMITTEE ON OCCUPATIONAL HEALTH

38. These statistics strongly suggest that the degree of exposure to risk is not the same for different ethnic groups and, more particularly, that the attitude to risk situations springs from a complex of causes not fully accounted for by cultural and linguistic differences. Godard¹ considers that the group factors clearly shown to exist in the etiology of industrial accidents have a particularly adverse effect on migrant workers. Such factors are low level vocational qualification, mobility of employment, age, poor educational background aggravated by language problems, health, housing, diet and social and cultural barriers. As for research on occupational diseases, precise and accurate data are also essential.

Absenteism, rates of absenteeism, comparison with the figures for national workers

39. Many statistical surveys, the data from which unfortunately do not lend themselves to comparative studies, indicate that absenteeism among migrant workers, regardless of cause, is significantly higher, particularly during the first two years of residence in the host country. Sickness and accident are among the main causes of absenteeism and it is estimated that there is a 30 per cent to 50 per cent rise in the incidence during the first year. The same applies to the figures for severity of illness or accident, calculated as the average duration of absence from work. In a survey carried out in the Lyons area, Robert² reports that in several undertakings the figure was about 70 per cent higher in the first year, had dropped to half that in the second year and was on the same level as for national workers in following years. It appears that the conditions of work and the degree of effort made for the reception of migrants play a very significant part in the severity rate. For instance, the index has been noted to drop below that for national workers, although here analysis of the data shows that the age structures of the groups had not been taken into account. It may, however, be stated that the accident rate remains high even when the severity rate has gone down somewhat. There is often incomplete data on absenteeism by cause. Occupational health departments are frequently not in a position to take the causes of absenteeism into account. The following tables illustrate some of the statistics obtained in various studies, but it is necessary to consider them with care.

40. A study conducted in Switzerland³ shows national workers to be at higher risk. The term "minor accident" was applied to accidents that did not involve absence from work. The study was carried out in a building concern in 1970.

Table 7
Occupational accident rates for 1,000 persons covered by social security, Netherlands, 1971

<table>
<thead>
<tr>
<th></th>
<th>Total accident rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dutch workers</td>
<td>32</td>
</tr>
<tr>
<td>Foreign workers</td>
<td>92</td>
</tr>
</tbody>
</table>

(From Report S.EA 18 of the Netherlands Ministry of Social Affairs.)

Table 8
Comparison of lengths of absence from work among foreign and Dutch workers, 1970

<table>
<thead>
<tr>
<th></th>
<th>Foreign workers</th>
<th>Dutch workers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Under 1 week</td>
<td>38.0</td>
<td>34.1</td>
<td>34.4</td>
</tr>
<tr>
<td>1-3 weeks</td>
<td>46.5</td>
<td>48.9</td>
<td>48.7</td>
</tr>
<tr>
<td>3-6 weeks</td>
<td>11.6</td>
<td>12.7</td>
<td>12.6</td>
</tr>
<tr>
<td>6-13 weeks</td>
<td>2.5</td>
<td>2.7</td>
<td>2.7</td>
</tr>
<tr>
<td>Over 13 weeks</td>
<td>0.7</td>
<td>1.0</td>
<td>1.0</td>
</tr>
</tbody>
</table>

(From Report S.EA 18 of the Netherlands Ministry of Social Affairs.)

Table 9

<table>
<thead>
<tr>
<th></th>
<th>Workforce</th>
<th>Minor accidents</th>
<th>Accidents</th>
<th>Total accidents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Swiss workers</td>
<td>9.10</td>
<td>24.1</td>
<td>9.8</td>
<td>14.0</td>
</tr>
<tr>
<td>Annual workers</td>
<td>18.32</td>
<td>25.3</td>
<td>16.3</td>
<td>18.9</td>
</tr>
<tr>
<td>Frontier workers</td>
<td>10.04</td>
<td>10.3</td>
<td>14.5</td>
<td>13.2</td>
</tr>
<tr>
<td>Seasonal workers</td>
<td>62.54</td>
<td>40.2</td>
<td>59.4</td>
<td>53.9</td>
</tr>
</tbody>
</table>

The author considers that these findings are distorted because the administrative difficulties the foreign worker encounters through lack of the right information probably hold him back from reporting accidents to the social security organisation. However, a correction would seem to be necessary to allow for the longer working day of seasonal workers. Resident workers have an accident rate of 1.11 accidents per 10,000 working hours as against a figure of 1.65 for seasonal workers.
Table 10

Absences due to sickness or industrial accident in a metallurgical undertaking at Lyons, with a workforce of 500, including 206 foreigners (Robert, 1969)

<table>
<thead>
<tr>
<th></th>
<th>French workers</th>
<th>Foreign workers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual incidence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- of sickness</td>
<td>13.0%</td>
<td>18.0%</td>
</tr>
<tr>
<td>- of industrial accidents</td>
<td>10.5%</td>
<td>15.8%</td>
</tr>
<tr>
<td><strong>Average duration</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- stoppage of work due to illness</td>
<td>25.5 days</td>
<td>43.5 days</td>
</tr>
<tr>
<td>- industrial accidents</td>
<td>20.8 days</td>
<td>36.0 days</td>
</tr>
</tbody>
</table>

4. **Migrant women workers**

41. Although labour migration principally concerns male workers on account of the very nature of the work most often performed, these migratory movements also concern the family, particularly the wives of migrant workers who may themselves constitute a reserve of clandestine labour; moreover, the importance of the migration of female workers as such is by no means negligible. They usually carry out diversified types of work such as hotel keeping, domestic service or as health auxiliaries. Agricultural work utilises a large proportion of female migrant workers. In industry they often occupy low-grade unskilled occupations. For example, it is estimated that 75 per cent of French migrant workers are in such categories.¹

42. The specific problems encountered concerning migrant women workers are mainly the following:

(i) they may be at a lower educational level than the male migrant;

(ii) their employment is very often "marginal", i.e. part-time, seasonal, undeclared (domestic work, small agricultural jobs);

(iii) they may take more than one job;

(iv) they may have a long working day (office maintenance in the early morning or late evening, piece work in the daytime, combined with personal domestic work);

(v) they may be limited to certain types of employment such as domestic work, tailoring, cleaning and maintenance,

¹ Comité français d'aide aux migrants, Cahier médico-social No. 3 and 4, Paris, 1975.
shop assistance. Moreover, they often have to work in small workshops or the premises they clean are spread over a wide area; their work is often temporary and under poorly controlled safety and health conditions, which leads to abuses and increases the risks associated with clandestine and irregular work;

(vi) to these problems must clearly be added the problems specific to the wife and mother, which loom particularly large among migrant female workers because of their ignorance of the medical and social legislation of the host country concerning maternal and child health. This may present many psychological and health problems.

43. Migrant females especially should be provided with health and social protection, taking into account the very fragmentary and disseminated character of their work. Occupational health could be adapted to play a dominant role in this situation.

5. Factors liable to affect the health and safety of migrant workers

44. Many factors may affect the health and safety of migrant workers: some are personal, others are associated with the workers' environment, his social environment and, more specifically, the usually bad conditions of work. It should not be forgotten that in several instances migrant workers may be considered as "second class citizens". The wages of migrant workers are generally low compared to those of nationals carrying out the same type of work. In addition, some of them try to economise and save by cutting down on food, housing and recreation and therefore aggravate their already poor state of health.

Personal factors

45. State of health. As a rule, the migrant is in good health when he receives authorisation to work in the host country. Official admission of a migrant worker is conditional on his passing a medical examination but this may not be the case for all countries. This examination is designed to ensure that he is fit enough and is not suffering from:

- a progressive disorder, or a disability, likely to debar him from taking up work (or in some cases to engage in the occupation he wishes) and from supporting himself;

- a long-term disorder that is contagious or likely to become so, which may place the community in which the worker is to live at risk.

46. Some countries require further conditions to be met, such as the absence of serious defects capable of being passed on to his progeny (France) or the absence of any recent major surgery (Federal Republic of Germany).
47. In some cases medical examination is generally carried out in the home country before departure and is conducted either by authorised local physicians or by physicians sent for the purpose by the host country. If, for any reason, the examination cannot be carried out before departure, it is performed upon arrival on the territory of the host country. In Switzerland, such medical examinations take place at the frontier posts. However, there are many exceptions to this general rule:

- firstly, nationals of European Economic Community countries do not need work permits within the Community and are only required to hold residence permits. These may be refused in the interests of public order, public safety and public health; reasons which are rather indefinite as far as public health is concerned. In the same way, Sweden, which requires medical examination for Yugoslavs, drops this requirement for Finns and nationals of other Scandinavian countries;

- secondly, bilateral health agreements may be initiated, formulated and continuously reappraised between countries with special interests, in order to assist in the conduct of medical examinations of migrant workers;

- lastly, there is a high level of illegal immigration into all industrialised countries. Exact figures for this are obviously not known (see section 74).

48. As a final point, mention must be made of the diseases that may be carried by migrants. Most migrants from the Maghreb and especially those from Africa south of the Sahara are allowed to work even though they may be suffering from multiple parasitic infections, generally intestinal, but well tolerated and unlikely to spread in the host country. These diseases may, nevertheless, at some point become a factor owing to lowered resistance. The same applies to the fairly widespread intrinsic systematic weaknesses caused by conditions of health and diet in childhood and adolescence which can rarely be detected at the medical examination.

49. It emerges from all these considerations that most migrants are healthy when they start work in the host country. Nevertheless, a not insignificant proportion of them do not, for various reasons, satisfy the criteria of health and fitness required for employment and may therefore respond badly to the new conditions in which they find themselves.

Environmental factors

50. Types of undertaking. Apart from the nature of the work involved, whose possible impact on health is discussed elsewhere, the general characteristics of undertakings, including their size, affect a number of the factors examined in this chapter. Migrants working in large numbers in large industrial undertakings often enjoy many advantages, more than required by legislation, with respect to food (works canteens, sometimes providing special food for the largest ethnic groups), recreation and housing. Facilities for dealing with any health or welfare problems they may have are also made available. They often receive help in dealing with the unavoidable administrative formalities they have to comply with. The same does not apply to migrants in small undertakings or in
agriculture, and as a result the difficulties confronting these migrants are greater. Lastly, the conditions in some undertakings may be positively unfavourable, in cases where unskilled migrants are expected to undertake arduous, uninteresting, dirty or unpleasant work.

51. Climate. Climatic conditions may influence migrant workers' health. Migrant workers, especially in Europe, often come from hot countries to countries with a temperate or cold climate. Low temperatures, fog and lack of sun in winter may represent a debilitating factor during the first months and favour the development of some diseases. Some who come from moderate climates to the hot regions may also suffer from the difference in climate.

52. Diet. Correct diet is of vital importance in ensuring fitness for work and resistance to disease, especially tuberculosis, to which migrant workers are known to be particularly susceptible. The diet of some migrants is often far from satisfactory, both before and after they have migrated. If there is a good variety of food available, taboos become easy to observe. Moslem workers may be affected by the change in meal times brought about by fasting during the month of Ramadam: shift work may be unsuitable during this month and also arduous work. However, this may easily be surmounted if adequate breaks for meals are allowed at the specified times.

53. It is less easy to keep to dietary habits. The traditional diet, which is often well adapted to its particular environment and way of life, is a social fact difficult to alter overnight when the environment and way of life changes. The foods generally used in the migrant's home country are not always to be found, or not at reasonable prices. In mass catering, traditional cooking methods cannot be used when the consumers are a mixed group of nationals and migrants, or migrants of various ethnic origins. It remains difficult to use these methods even when the consumers are of the same ethnic origin; it is not always easy to employ them even in family cooking. It is also difficult for workers or their wives to make a proper comparison between the price and nutritional value of foods. In addition, they are unaware that someone from a hot country coming to engage in physical labour in a cold or temperate climate needs an appreciable extra intake of energy-giving foods, particularly during the period of adaptation to his new situation (WHO, 1974). All these factors mean that the dietary intake of many migrant workers does not meet their new energy requirements.

54. Housing. Housing, like food, is a very important factor for the mental and physical health of the migrant worker. A series of studies carried out by the Council of Europe has found that adaptation and, where applicable, integration of migrants into their new environment in the host country is greatly assisted by proper housing. In most host countries, housing is, as a rule, included as part of the employment contract signed by the employer. In addition, the migrant's family is not allowed to join him until it has been ascertained that suitable housing is available for them. However, such standard procedures are far from universally applied. The free access enjoyed by migrants of certain nationalities and the spontaneous, i.e. illegal, nature of such immigration has adversely affected housing conditions for migrants. Often accommodation is poor and, in some cases, quite insanitary despite the efforts made
by governments, municipalities, undertakings or various welfare agencies. The sanitary standards applied must, of course, be those of the host country. No comparison should be made with housing conditions prevailing in the home country, where general conditions, especially climate, are often quite different.

55. The underlying causes of poor housing are legion. Migrants generally find work in expanding towns, where there is often a shortage of housing, particularly of the low-cost housing which is all they can afford. Lack of time and the language barrier make it even more difficult to find something. But low wages and the frequent wish to save money lead migrants to refuse suitable accommodation and to prefer lodging houses, overcrowded insanitary quarters or hutments, where they are sometimes taken advantage of by owners or managers, often their own countrymen.

56. Family accommodation, like individual accommodation, is often overcrowded. The cultural traditions of some groups, lack of elementary notions of hygiene (more frequent in women than in men) and sometimes large numbers of children add to the factors already mentioned in aggravating the insanitary state of the housing.

57. Language problems. Unfamiliarity with the language of the host country generally does not apply when the migrant comes from a country of origin which shares the language of the host country, e.g. Latin America and Arab countries. Illiteracy, which is common among migrant workers, is an aggravating factor. This means that the migrant cannot correspond with his family except through the intermediary of a "public letter writer", that he is cut off from both his home and his host environment, that his chances of vocational training are considerably reduced and that the likelihood of his having an accident is increased. Difficulties of communication are considered to be one of the most formidable problems confronting migrant workers.

58. The migrant's communication difficulties occur on two levels. He may find himself cut off from his fellows upon arrival because no "colony" of his ethnic group yet exists (this is now rare), or because he is assigned to rural work and is isolated among national agricultural workers. He may, on the other hand, be taken under the wing of earlier migrants and "belong" to a community of his own ethnic group either at work or outside it. The difficulties of communication in these two cases differ.

59. The first case, that of isolation, is the more dangerous and only exceptional persons manage to combat depersonalisation and, at the same time successfully achieve adaptation with the population of the host country. In the second case, the problem of communication is raised, but in another way: it usually tends to occur in the adaptation stage and not during the introduction phase.

60. Migrant workers who come from neighbouring countries generally cope well with the transplantation stage, but still suffer, often after many years, from a feeling of isolation because they cannot communicate fully and probably also because the "cultural content" of communication differs from one society to another, however similar such societies may be, and some aspects remain incommunicable.

61. The migrant who comes from a country more distant or more different from the host country is under an even greater disadvantage in Europe when it comes to making a true adaptation,
for which good communication is essential. At work or in everyday
life, there is a threshold of integration and penetration into the
host society that he is unable to cross and this immobilises him and
turns him in on himself. He is not in a position to fulfill one of
the necessary conditions of good health, i.e., to be in harmony with
his environment.

62. The language barrier aggravates the migrant's
difficulties in all fields: during the administrative and medical
formalities attendant on his entry into the host country and on his
engagement by an undertaking; at work, where his ignorance of the
language has important repercussions, particularly with regard to
accidents, as will be seen later; in the most simple aspects of
everyday life; in his relations with the public authorities; and, as
mentioned below, when he has to apply to the medical or welfare
services for assistance.

63. Access to medical services. Besides the occupational
health service, which offers its facilities equally to all workers
including migrants, it is logical and just that migrant workers
should enjoy all the medical and welfare advantages available to
national workers, especially with respect to social security
benefits and unrestricted access to curative and preventive services
and to private medical practitioners. Where this condition is
fulfilled, which is generally true of most host countries, the
migrant worker should find all the facilities he needs to protect,
restore and promote his health.

64. In practice, unfortunately, foreign workers do not
always make full use of medical services, even though their needs
are generally greater than these of national workers. This is
mainly due to the following four reasons:

- the migrant worker often does not known what services are
  available to him nor what his rights are in the matter;

- if he comes from a country with poorly developed medical
  services, he is not accustomed to using such services, does
  not know how they can help him and will not take the plunge
  and use them unless he is seriously ill. On the other hand,
  this problem will not arise if he comes from a country with
  equal or better medical facilities;

- he fears that if he is found to be sick or is forced to stop
  work, even if only for a few days, he will lose his job. If
  this does not worry him, then he is reluctant to lose part of
  his wages. He tends, for these reasons, not to look for
  medical help, or to put off doing so, as long as his
  disabilities allow him to go on working;

- lastly, even if he does make use of the medical services, he
  does not make the most of them because of his communication
difficulties. Diagnosis is more difficult, particularly in
the case of functional disorders; instructions tend to be
misunderstood and courses of treatment improperly followed.

65. This last restriction also applies to routine
occupational health examinations. In systems where occupational
health is purely preventive, communication difficulties can have
serious consequences if the migrant does not grasp the importance of
the advice given him, especially when he is advised to report to the
curative services.
66. **Welfare and social security.** Migrant workers enjoy the same treatment as national workers in most European countries, North America and some of the developing countries so far as welfare and social security benefits are concerned. In some countries the migrant worker is entitled to benefits and to family allowances if his family is living with him. In others these privileges are not available. It is hoped that these countries will soon follow ILO Convention No. 143 and Recommendation No. 151, the main feature of which is equal benefits to all workers—migrant as well as nationals.

67. Migrant workers should therefore feel reassured about their position with regard to social security and welfare. However, the same factors apply here as in the field of medical services. The migrant's difficulty often lies in exercising his rights, either because he does not know which services he should apply to or what he can ask for and obtain, or because he cannot communicate. The difficulties are greater in relation to welfare services than in relation to social security. It is relatively easy to obtain the payment or reimbursement of social security benefit, especially as the arrangements are generally made by his employers. It is much more complicated to ask for assistance, and to understand the advice given properly, in the many fields in which the migrant feels himself at a disadvantage: seeking work or occupational training, learning the language, housing, the procedure for bringing his family into the country, placing his children, having his rights respected, protecting himself against the exploitation he is occasionally exposed to, etc. Nevertheless, welfare services of all kinds have a vital part to play in the reception, adaptation and integration of migrant workers. As will be seen later, much needs to be done in this field to improve the situation and to relieve anxieties that are not without their impact on health and ability to work.

68. **Social environment.** The migrant already has difficulties, on his own account, in adapting to his new environment. Such difficulties may be considerably aggravated if this different environment is also hostile to him. Reactions in the host country are not always favourable to the migrant worker. The unions, which for a long time were accused of protective practices directed against foreign labour, now admittedly generally show solidarity with such workers and strive to look after their interests. However, the unions have not always been able to get foreign workers to take an interest in their policies or to take an active part in union work. In some countries, however, migrants may become shop stewards and sit on works committees. This is only just, particularly in cases where they form a large proportion of the workforce of the undertaking concerned. Language problems to a large extent probably hamper such initiatives and migrant workers bear a certain degree of responsibility for the present state of affairs through their inability to organise themselves and make their wishes known. Things are beginning to change, however, as shown by the 1972 Belgrade Congress and the European Meeting of Representatives of Migrant Workers' Organisations held in 1973 in Brussels.

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1 ILO (1975): Convention No. 143 and Recommendation No. 151 concerning migrations in abusive conditions and the promotion of equality of opportunity and treatment of migrant workers, **Provisional Record, 34**(a) and 34(b).
69. The situation is not always so encouraging as far as the individual worker is concerned, particularly since the rise in unemployment which followed the crisis produced by the increase in energy and raw material prices. National workers may look on the migrant worker as a competitor and sometimes accuse him of accepting lower wages. The national worker has been enabled to move into more agreeable work because the migrant worker has taken over this former job. He finds this situation normal and is, of course, pleased with his own rise in status. However, as soon as the migrant worker begins to compete with him and perhaps to overtake him with respect to job status, objections and protests will not be long in coming.

70. Lastly, relations with the local population are not always trouble-free. Firstly, the fact that, as is natural, the migrant worker tends to keep together with his fellows often puts the local inhabitants against him as they consider he does not want to become part of their society regardless of the fact that they have generally made no effort to help him to do so. Secondly, as soon as what is referred to as the "tolerance threshold" with respect to the proportion of migrant workers in the community is reached, outbreaks of race hatred sometimes occur. This problem should be recognized now and measures introduced to deal with it at a time when such outbreaks are occurring in countries as traditionally hospitable as Switzerland and France.

71. In addition to the problems created by the social environment, attention should also be directed to those created by the family environment. No one today would deny that it is out of the question to allow large numbers of migrant workers to live without their families in an environment demanding a considerable capacity for adaptation. Having their families with them helps them on the emotional level, reduces homesickness, helps them keep their mental balance and often relieves their tendency to excessive saving. His family may, however, be an extra source of worry to the worker and problems of the family environment be superimposed on those of the social environment.

72. In addition, the children create problems. Admittedly, they usually benefit from the good condition of the medical and social services, and, if the mother is not working herself, their difficulties will not begin until they go to school. At school, they will learn a language different from that of their parents and are likely to forget their mother tongue. When introduced to a different culture they integrate better into the host society than do their parents, but at the same time this separates them from their parents. The conflict between the parents' wish to keep their own culture alive in their children and the children's desire to be as little different from their schoolmates and playmates as possible adds to the other causes of difficulty in adaptation.

73. Each of the factors mentioned varies in impact according to the ethnic group or individual concerned, but the combined effect may constitute a formidable obstacle to adaptation to life in the host country. During his first months the migrant does no more than discover the pattern of gestures and attitudes which will allow him to "get by" in the host society. During this period also he is usually taken in charge quite firmly by the reception agencies particularly by the local immigrant community of his own ethnic group but longer established. It is rare for a foreigner to live in close contact with the local population for the first months, or even years, of his stay.
74. **The special case of the illegal migrant workers.** In most countries there are no precise figures to show the number of illegal migrant workers. It was estimated in 1968 that 82 per cent of all migrant workers entering France entered illegally. Similar approximate figures also give a number of 200,000 illegal migrant entries into Germany and 70,000 into Belgium. In the United States there are estimated to be over 1 million unauthorised foreign workers, nearly half of them Mexicans. In Argentina, before 1974, immigration from neighbouring countries was almost entirely on an illegal basis. It is estimated that about 500,000 migrant workers from Colombia have entered and are working illegally in Venezuela. Illegal migration of workers to Bahrain and Sudan is known to exist, but figures for this are not available at present.

75. All the factors mentioned earlier have even greater repercussions on the illegal migrant, whose lot is often particularly difficult. Because his existence is not legally recognised, he often falls prey to organisations or undertakings that exploit him. As a report to the Consultative Assembly of the Council of Europe points out, the situation of these illegal migrants is particularly disturbing for reasons such as the following:

- their wages have no relation to the work they are doing and their income is likely to be barely sufficient to support them;
- they must often live in hiding under very poor conditions: their children do not go to school;
- they have almost no access to medical and welfare services and as a result any health problems may develop seriously;
- they are almost entirely debarred from integrating in any real way with the host population.

76. This unfavourable situation has a serious impact on the health of migrant workers. Therefore, the Committee refers again to ILO Convention No. 143 on illegal migration and hopes that the situation would be improved if it were ratified by all countries.

### Factors connected with work

77. **Vocational training and language problems.** It has been found that foreign workers have less opportunity for education and training as skilled workers. Since most migrants are in this situation, they are likely to take arduous, low-paid and temporary work. The language barrier creates a serious obstacle to vocational training and is generally recognised as one of the causes of accidents.

78. **Arrangement of the workplace.** Adaptation of migrant workers also depends on the ergonomic layout of the workplace. The organisation of the workplace affects migrant workers and plays an important role in their adaptation which may be associated with excessive fatigue and the likelihood of accidents. It is, therefore, advisable to adapt work conditions to suit physical characteristics of migrants where they differ from those of local workers and also where there are differences among the migrants.
themselves. Pardon has reported the case of a workshop staffed during the day by Portuguese women with an average height of 150 cm and at night by African men with an average height of 172 cm. A height difference of this nature affects working posture, and thus increases fatigue and reduces safety. In addition, migrants are likely to undertake the more strenuous tasks and it would, therefore, be necessary to take this factor into consideration as well. More information is required on the stresses imposed as a result of maladaptation in work processes by these workers.

79. A further problem is that of the unintelligibility of verbal communication in noisy surroundings, in cases where understanding of the meaning depends on learning a code, the mastery of which makes an important contribution to adaptation and safety. Such codes are often based on abstractions expressing measurement of a phenomenon that is not directly perceptible. The ability to grasp an abstraction is very poorly developed in workers from non-urbanised and non-industrial areas. This must be taken into account in the design of control panels and signalling devices. Codes are easier to master when they correspond to established stereotypes and as such are more likely to produce the right reaction in an emergency. Adhering to stereotypes plays an important part in safety. A compatriot who has adapted to the work situation, because of his greater experience, may have a decisive part to play in the adaptation and safety of the newcomer in this respect.

80. Migrant workers should receive appropriate training for the type of work in which they are to be engaged. It is necessary to collect more information concerning the effect on workers of bad adaptation to their work.

6. **Occupational health services for migrants**

81. By extending the definition of occupational health proper, this term may be made to cover all the medical examinations that migrant workers must undergo, namely: occupational health examinations proper (i.e. those provided by national health legislation for all workers) - the examination on which authorisation to enter a country as a worker depends; and those examinations offered to, or sometimes imposed on, migrant workers because of the special health risks to which they may be exposed.

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2 Institut National de Recherche et de Sécurité pour la Prévention des Accidents du Travail et des Maladies Professionnelles, Programme d'activité des services d'études et de recherches, Paris, 1974, fasc. 11.
Medical examinations in the country of origin

82. In some developing countries from which migrant workers come, occupational health services may not be adequately developed. In these instances, no pre-employment medical examination can be made as the services are mainly curative, with low emphasis on preventive services.

Medical examinations in the country of employment

83. Medical examination for admission to the country of employment. It should be remembered that this examination is compulsory in most countries of employment and is carried out either before departure from the home country or upon arrival in the country of employment. The medical examination, if carried out, comprises a general clinical examination, testing of sight and urine, chest radiography and serological tests for syphilis. There are a number of required health criteria that are common to nearly all countries. The following diseases should be given attention in establishing bilateral agreements:

(i) severe infectious or parasitic diseases: diseases subject to quarantine (a theoretical restriction since sufferers are not generally in a state to come forward for emigration), active tuberculosis, syphilis with clinical signs and giving positive serological reactions, trachoma, tinea, leprosy; amoebiasis, malaria, helminthiases, etc. Wide latitude is observed, however, with respect to the last two diseases;

(ii) mental diseases or overt psycho-mental impairment;

(iii) hereditary diseases: myopathies, haemophilia or thalassaemia; or diseases generally incompatible with the normal and regular exercise of an occupation: chronic bronchitis, asthma with respiratory insufficiency, gastro-duodenal ulcer, cardiac disease with poor compensation, severe arterial hypertension, chronic nephritis, severe diabetes, severe haemopathies, or malignant tumours.

84. Illegal migrants unfortunately bypass this medical check, and the procedure for regularising their position in the host country, often applied for humanitarian reasons, is often much less stringent.

85. Pre-employment examination. In certain countries the migrant, when recruited by an undertaking, undergoes a pre-employment medical examination in the same way as national workers. This examination is designed to find out whether he is fit to do the work he has been engaged for. At this point, apart from exceptional cases, there is no question of sending him back home. The examination may, however, guide the migrant towards different work from that originally envisaged. Thus, the higher risk of industrial accident during the adaptation period should lead the occupational health physician to be very strict about declaring a person with a poor command of the language fit for a post in which he is responsible for safety or to a dangerous post where perfect knowledge of, and obedience to, safety rules is required.
If the migrant passes the two examinations described above, he may be taken to be in good health. However, it should not be forgotten that during the first months after his arrival and until he is perfectly acclimatised, he remains vulnerable and there is a high risk of his health deteriorating. He should therefore be kept under periodical medical surveillance. This could be carried out as part of three health activities.

Medical surveillance as part of occupational health. Legislation in some employing countries provides for medical surveillance of workers, generally consisting of periodic routine examinations, examinations when work is resumed after sick leave and sometimes examinations carried out at the request of the worker concerned. Within the framework of such legislation, some countries subject migrant workers to additional medical surveillance for the first 18 months after starting work. The frequency of these examinations is left to the discretion of the occupational health physician and depends on various factors, such as age, origin, individual or ethnic predispositions to disease, conditions of work, and the psychological and material conditions of the migrant's everyday life. During these examinations, physiological indices are carefully monitored; special attention is given to the weight curve and chest radiography is frequently carried out. Repetition of these check-ups, together with the breaking down of the language barrier, creates a climate of confidence which permits the physician to press forward and detect the functional disorders, generally digestive in nature, that often result from difficulties of adaptation.

In countries where the occupational health physician is not entitled to treat the worker, he must refer the patient to a physician or to the public health services. This advisory role is essential in the case of the migrant, who often has no doctor of his own and who is reluctant to accept treatment for fear of losing his job.

Medical surveillance as part of social security. Surveillance carried out by the occupational health physician may be supplemented by the medical examinations carried out in a number of countries under social security legislation. Migrant workers are generally covered by such legislation from the time they start work.

Special medical surveillance. Measures taken in the framework of occupational health are generally properly applied when the worker has a steady job and when he works for undertakings over a certain size. The same does not apply, unfortunately, when he changes his job frequently and is thus likely to miss check-ups. For this reason, routine medical surveillance at the workplace is often supplemented (through the intermediary, among others, of specialised voluntary bodies) by medical examination carried out in migrant hostels. However, this measure, which is considered to be discriminatory, is not always welcomed by the migrants themselves.
7. Preventive Measures

Health protection and promotion

91. The description of the diseases common to migrant workers, brief though it is, shows that the protection and promotion of the health of the migrant worker does not depend on health measures alone but must be ensured by a whole range of social, educational, health and legislative measures aimed both at the direct causes and at the predisposing factors of such diseases. It is along these lines that action may be taken by the special public welfare services, trade unions and the voluntary migrants' assistance associations that do so much good work in receiving, guiding, informing, educating, promoting, housing and providing health education for migrants.

92. What needs to be done for migrant workers may be summed up by saying that such workers should have made available to them:

(a) all the social and medical measures available to national workers. However, these measures should be carried out more frequently, more carefully and more stringently than in the case of national workers, for two reasons: firstly because the frequency and severity of illness is greater among migrant workers; and secondly because the migrant is less inclined to seek medical help (whether from the public or private sector) even when he is given the opportunity to do so;

(b) special medical and welfare measures associated with the diseases common to migrant workers and to the enhanced risks to which they are exposed in the host country;

(c) health education adapted to their needs; and

(d) special educational (education should be aimed not only at the migrant but also at public opinion), welfare and family measures to help migrants adapt to and integrate with their new environment.

93. Furthermore, it may be said that any measures aimed at improving the migrant's skills tend to improve his health both by making integration easier for him and by improving his standard of living.

Measures to be taken in the country of origin

94. The ideal procedure would be for those measures capable of preventing or reducing health risks to be taken in the country of origin. These measures can be augmented in accordance with bilateral agreements.

95. Medical examination. Most of the preventive measures taken are of a medical nature. In many of the home countries those applying to migrate undergo medical examination to check whether they are in good health and fit for work. Such examinations are made on behalf of the host countries or host undertakings and are carried out by authorised physicians belonging to the home country.
or by medical teams sent out by the host country. The competence of
the health personnel to carry out these examinations should include
knowledge of both the diseases common to the home country and of
those common to the host country. The medical examination to be
carried out in the home country should be designed to screen
applicants clinically and biologically for likely diseases, as
indicated by the prevalence and incidence of such diseases in the
home country. The results of this screening should then be compared
with the host country’s requirements. The examination should also
assess fitness for work, but the difficulty of defining the exact
conditions of work at any early stage, creates a problem that is
generally overcome by using the concept of general fitness for work
calling for bodily health and adequate physical and mental
functional capacity. The inadequacy of medical criteria of fitness
for work may be a great disadvantage to applicants since it leads to
the application of very high standards as a basis for selection.
Good co-ordination should be established between the medical
authorities of home and host countries to avoid a situation, which
may be detrimental to the adaptation of workers, and in which they
may also be put to the risk and inconvenience of a new medical
examination upon entry to workplaces.

96. This medical examination, unlike those that the migrant
worker will undergo later on during his stay, is a measure more for
the protection of the country of employment than for the protection
of the would-be migrant. However, in his interests, the health
authorities of his home country should be informed of the findings
of the examination whenever it has led to a refusal of permission to
enter the host country. It is easy to make such a report when the
examination is carried out in the home country before departure. It
is more difficult, but should still be done, when examination is
carried out in the host country. Unfortunately, the health services
of many of the migrants’ home countries would be hard pressed to
undertake the care of persons refused emigration permits,
particularly if the disorders involved were not yet very apparent or
if no more than a general lack of strength (undernourishment) was
concerned.

97. Information to migrants. Little has been done to give
the migrant information. Nevertheless, he could usefully be given
an account of the general characteristics and way of life of the
country he is to go to. He could be informed of the problems that
might arise in relation to his work contract and told of the main
points affecting his stay in a given area. Those who can read
should be given leaflets prepared either by the home country or by
the host country, but in any case, in the migrant’s mother tongue.
This is an excellent measure and is carried out in a number of
countries.

98. Teaching of language. Another desirable step would be
to enable migrants to start learning the language of the host
country before departure and to continue their studies on arrival in
the country of employment. However, little has yet been done in
this area. It would, moreover, be unrealistic to expect countries
that have difficulty in setting up the rudiments of health and
welfare services for their citizens to take up the task of providing
information and language training for their migrants. Such work
could only be done by the host countries. Some countries have,
nevertheless, made a start in prearing workers, and sometimes their
families, for emigration. Yugoslavia is an example and has set up
a body (Federal Employment Board) responsible for recruiting workers who wish to emigrate. This body works with the agencies and local missions of the country of employment. It provides information and gives language courses.

**99. Vocational training.** What has been said about language learning also applies to vocational training. It would be much better if this could begin in the home country, even if it had to be completed in the host country. Since the home countries rarely have the means to do this, it has been proposed that the host countries should help with such training before departure. This, however, is difficult to put into practice and has its drawbacks. The employer in the country of employment would then tend to select skilled workers only and to keep them as long as possible. This steady drain of skilled labour would make it more difficult for the migrants' home countries to industrialise their underdeveloped regions. It is in their interests to let their unskilled labour go and get it back well trained a few years later.

**Measures to be taken in the country of employment**

100. There is no point in referring again to the medical examination for entry, which is a formality that few authorised migrants avoid and which has already been mentioned several times. Regardless of what other preventive measures were or were not taken before his departure, the migrant must, on arrival in the country in which he is to work, be properly received, informed of the problems he will encounter and told of the measures at his disposal for overcoming them. He must, where necessary, be taught the rudiments of the language that will be spoken around him and in general be given supplementary vocational training.

101. **Reception and information.** Improvement of reception conditions, which, as has been seen, leave much to be desired, is the surest way to help the migrant over the difficult period following his arrival and to ease his entry into his new environment, thus preventing the unfortunate consequences mentioned earlier. From the start of his stay, the foreign worker should feel that he has not been abandoned and that his interests are being protected.

102. Apart from a few exceptions, the new arrival is received by his compatriots (family, friends or migrant's association) but the support given in such cases is primarily emotional. Consulates might have been thought to play an important part in such receptions, but many migrant workers complain that their consulates do not pay enough attention to them. These agencies are probably overwhelmed by the ever-increasing numbers of migrants from the countries they represent but they should do more for the reception of their own nationals. It is the host country which ought, and which does, make the most effort in receiving migrants. Effort is most effective when the newly arrived migrant is spoken to in his mother tongue.

103. There is, initially, a rough and ready reception service, a sort of helping hand, offered in the trains bringing the migrants in (bilingual hostesses) and in the stations, ports and airports of entry. This reception service is aimed at providing the
migrant with the initial elementary information he needs and also to prevent him falling into the hands, or rather into the clutches, of exploiters waiting for him.

104. The real work of reception is carried out at free information and advisory centres located near the arrival points, where the migrant will find staff speaking his own language to advise him and give him information leaflets written in his mother tongue. Sweden probably holds the record with information leaflets available free of charge in 14 languages and describing various aspects of life in Sweden, with emphasis on the rights and obligations of migrants. In addition, for nearly ten years the Swedish authorities have been bringing out a very low-cost weekly in five different language editions, which reviews the main events taking place in Sweden and deals with social topics of current interest. Similar literature is distributed in other countries, such as France and the Federal Republic of Germany (six languages).

105. An interesting move has been that of incorporating a temporary hostel into such information centres and also letting them be used as meeting places for cultural gatherings attended by foreigners and nationals. (See for example the Europe Centres recommended by the European Conference of Local Authorities and the Council of Europe's Committee on Population and Refugees.)

106. Besides such agencies, which vary greatly in number and size from country to country (in addition to a few very large centres, there are nearly 200 small reception centres in France)\(^1\), migrants may also apply for other welfare services provided specially for foreign workers and to private voluntary bodies also specialising in such work. Such bodies are generally run by private associations belonging to the host country and usually subsidised by the State, or are run by migrants' associations. Both types can call on the services of a number of people able to speak the languages most commonly spoken by migrants. However, these institutions are less concerned with reception than with medical and welfare work or with welfare work alone, which will be dealt with later.

107. Lastly, some countries finance temporary interpreter services which provide interpreters in most of the languages spoken by foreign workers: these are available, on request, to both organisations and individuals. A service of this kind exists in France where it is often called on by doctors to help them talk to their patients.

108. Learning the language of the country of employment. Poor knowledge, and at times complete ignorance, of the language of the host country, has been seen to be one of the main obstacles to the migrant's adaptation to his social and working environment, to the proper accomplishment of his work and to his vocational training and further training. It is therefore important to improve his knowledge of the language. The host country should undertake this task or continue it, in cases where it has already been begun in the home country before departure, which would be preferable.

\(^1\) Comité médical et médico-social d'aide aux migrants (Paris), Rapport d'activité, 1969 à 1974 (not published).
109. What the migrant mainly needs is to be able to express himself within a short time. He must be given a basic knowledge of the language applicable to his everyday surroundings at work and outside it. In order to achieve this it is out of the question to make him carry out lengthy exercises to assimilate the language as would be done in school. When planning such language teaching, a number of important points should be borne in mind. This type of training should be adapted and geared to the age and educational level of the migrant.

110. Lastly, learning a language after a hard day's work is particularly tiring when the worker is still in the period of adaptation and it is sometimes beyond him. One solution would therefore be to give language instructions during working hours paid for by the employer. This is done in some countries such as Sweden, and is a better method than giving evening classes in hostels or in the districts in which migrants live.

111. It has been suggested that it might be useful to associate language teaching with the vocational training given to provide the worker with skills or to improve the skills he has already. Another desirable aim would be to include in language training some general instructions to familiarise the migrant with the culture of the host country and help him understand it. This would probably help him to solve many of his problems.

112. In recent years, under the auspices of the Council of Europe, annual teaching experiments have been run by national bodies dealing with emigration and immigration in order to find out the most efficient teaching methods and to stimulate public authorities' efforts in this field. In addition to the teaching activities described above, various other efforts have been made. As an initial assistance measure, national bodies have published leaflets in several languages (in Serbo-Croat, Portuguese and French) that give the migrant about 50 words considered essential for him to know. In the same way, migrant workers have been taught the words or phrases most needed for their safety at work, for example, such emergency orders as "Stop!", "look out!", "get out of the way!", etc. However, effort must not stop there. Another interesting, though very limited, initiative has been to give language training (being taught to read in hospital) during medium- to long-term hospitalisation (for tuberculosis, rehabilitation, psychiatric disorders) with the help of volunteer teachers.

113. Vocational training and further training. For the reasons discussed earlier, those migrant workers who have not had satisfactory vocational training before arrival in the host country should be provided with such training. The host country's own interests and the moral obligations it has assumed with regard to a labour force essential to its expansion, combine to provide the migrant worker with the means to acquire or improve his vocational training. As a result of vocational training, the worker is enabled to find more interesting and better paid work, he rises in social status both at his work and outside it and when he goes back to his own country (which is the case with most migrant workers), he enriches it with the skills he brings back with him. Some of the migrants' home countries even make it a condition of emigration that opportunities for vocational training should be offered.
114. Most host countries, at least in Europe, have fully grasped the importance of this problem and offer migrants training facilities, as in the form of in-service training or vocational training courses for adults. However, migrants must be encouraged to take advantage of these opportunities, as they are often unaware of the possibilities offered and do not always realise the benefit they can thereby gain. A survey in the Federal Republic of Germany has shown that only 6 per cent of men and 3 per cent of women attend vocational training courses outside their hours of work. This is explained mainly by inadequate grasp of the language and by ignorance of the fact that such courses exist. In addition, women use family reasons as an excuse, while men refer to the difficulties created by shift-work timetables or say they prefer the extra wages earned by working overtime. Workers' representatives in the undertakings who are responsible for supervising the undertaking's training schedule, should be expected to consider in detail the field in which any particular migrant would do best if he were offered the same opportunities as national workers.

115. Any form of vocational training must, of course, be preceded by adequate language training unless it can be given in the foreign worker's own language. Consideration has been given to establishing equivalences for certificates of vocational proficiency and the diplomas gained by migrants in any given host country in order to facilitate the movement of workers from one European host country to another. However, it would appear that nothing useful has yet been done in this field, despite the Council of Europe's recommendations.

116. Health education. Health education for migrant workers, which is of obvious importance as a preventive measure, forms part of education as a whole which provides a primary and essential means of protecting and promoting the health of migrant workers. Health education should be given at work, in residential hostels, whenever contact is made with medical services, or during hospitalisation. It should be given, using methods and with aims that may not always be identical, to the workers themselves and to those members of their family who have come with them. In some countries it has been found that trade unions can play a most useful role in health and safety education.

117. If it is to have its full effect, the health education given to migrant workers must fulfil certain conditions. As in any other context, health education must be adapted to the understanding, behaviour patterns and needs of the persons to whom it is addressed. As a result, persons responsible for providing this education must be perfectly familiar with the cultural background and mentality of the migrant workers concerned and be aware of the conditions under which these workers are living in the host country. In addition, it would be advisable, at least at the beginning of the migrants' stay, if education were to be given in their own language. For all these reasons, the ideal solution (which is difficult to achieve), would be to employ qualified staff of the same nationality as the group to be educated.

118. Attention should be drawn to the important problem of the relationship between work and nutrition, as far as migrants are concerned. It would be necessary therefore to:

- promote an energetic campaign of information and education among migrants, with the aim of avoiding quantitative and qualitative shortcomings in the intake of food; make use of
mass media in the host countries;
- suggest that the authorities in the countries of origin publish information, in simple language and in the migrants' mother tongue, giving simple rules for sensible eating habits.

119. Ease of access to preventive and curative medical care. It is logical and just that migrant workers should be able to take advantage of all the medical and welfare services offered to nationals, such as social security benefits and free access to preventive and treatment facilities. Where this is the case, as it is in Europe, North America and some developing countries, the migrant working in the foreign country should find everything he needs to protect, restore and promote his health. Two reservations must, however, be made on this head.

120. As has been seen, migrants have greater needs than nationals in the medical and health field. The use that migrants make of medical and health services is limited by their mental attitudes, inadequate adaptation and poor knowledge of the language of the host country. These combine to make the migrants unaware of the opportunities open to them and of their rights.

121. In addition, the disease patterns seen among migrant workers are largely determined by the poor conditions of hygiene, housing and diet to which they are subject and their lack of adequate contact with the national population. They are, in short, caused by bad living conditions and inadequate integration, which cannot be dealt with effectively unless there are special welfare services for migrants. The ordinary welfare services are not well suited to solving the special problems created by such living conditions.

122. There are three methods open for solving migrants' problems:

(a) It has been shown by experience that work in the fields of prevention and treatment of disease and of health promotion is more effective when carried out in reception hostels, in districts where immigrants have found accommodation or in medical and welfare centres, than when it is carried out at the factory. The factory is therefore rarely considered for this purpose, particularly when the worker is accompanied by his family. It cannot be used in this way in countries where the law makes a distinction between preventive medicine and treatment, and prohibits the occupational health physician from treating the diseases or disorders he had found.

(b) There are advantages in having special medical and welfare centres for migrant workers. Such centres often meet a psychological need and respond to the desire for identification frequently shown by people who have attended treatment centres open to the general public. In addition, any steps taken to make these centres more capable of dealing with all the problems of adaptation shown by the migrant population, convenient opening hours, the presence of an interpreter or welfare worker, etc., greatly encourage attendance. The part they play as a place for immigrants to meet and talk gives them a "club" atmosphere that supplements their role as cultural centres. Lastly, the fact that workers' families may also attend greatly helps the preventive work that may be carried out there.

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A third solution, which may be found particularly in Europe and which is of some interest, rejects the idea of a special health service for migrants run in parallel with the national services but proposes to teach migrants how to use the national system and to make physicians and welfare workers dealing with migrants understand the problems of this group.

123. Some countries use one of the last two solutions, some the other and some both at the same time. However, it is obvious that a special medical and welfare centre can only be set up in areas where there are enough migrants to justify a separate agency.

124. Welfare and recreation. If recreational facilities are provided they supplement the other measures and help to create healthy conditions of life. Poor quality and paucity of recreational opportunities mean that migrants have no escape from the lethargy that breeds so many psychopathological disorders. It is found that migrant workers spend a large part of their free time in sleeping, in meeting their compatriots or in looking at films or television programmes without understanding much of what is going on. Taking part in excursions or educational outings in the host country meets the need of the younger age groups to take advantage of cultural facilities.

125. It is not enough to give migrant workers and their families complete freedom of access to the welfare services provided for nationals. Moreover, the ordinary welfare services are not very well equipped to solve the very special problems of the migrant population. Lastly, migrant workers and welfare services often have great difficulty in communicating with each other. While it is possible, in spite of some difficulties, for migrants to use the ordinary medical services, it would be better, and is often essential, to provide them with special welfare services.

126. This problem has generally been recognised by the host countries, which have established or encouraged the establishment of welfare services for migrants, with people on their staff who are well acquainted with migrants' problems and know their mother tongues. Some of these services even employ social workers sent from the migrants' home countries.

127. Measures to be taken by the undertaking. One whole aspect (technical objective) of migrant worker safety obviously merges with the question of safety for the whole workforce of an undertaking. If the undertaking has a well-designed safety policy and if an efficient and diversified system already exists with regard to information, training, techniques and responsibilities, the risk of accident will be lower for all. The undertaking should already be safety-oriented, regardless of whether the national or migrant worker is involved. However, the migrant should also make the effort to integrate himself in the different types of safety work, and this is where his difficulty lies. The special measures that must be taken to ensure the safety of migrant workers, i.e. those that have not yet adapted to the host country, are directly connected with the causes of accident specific to them. These causes obviously originate in various shortcomings in adaptation.

128. The migrant cannot therefore merely be subjected to the same safety precautions as a national worker, even where such precautions have been well thought out. It must be ascertained that
he has understood what the risk situation is and has taken in the sense of his instructions not just superficially on the theoretical level but on the deeper level of action so that he will make the right movement or have the right reaction in an emergency. Such knowledge can only be absorbed and make concrete through practical training given while he is learning his job under supervision and cannot merely consist of a few theoretical recommendations. Difficulties of communication and radical differences in basic behaviour patterns make it impossible to know for certain whether a migrant has really absorbed safety instructions unless he has had a practical training in them and practised them repeatedly in real-life situations. For this reason a number of German undertakings often spend two whole days in "teaching" safety to immigrant Turkish workers immediately upon their arrival.

129. Of course, the "real-life situation" should be supplemented by theoretical instruction using audio-visual methods, pictures and films. It must also be ensured that the pictures and symbols used (as in road safety signs) as a means of universal communication have been properly understood. Training migrant workers to be safety conscious is more easily done at the undertaking, provided too many of them do not arrive at the same time and provided that they can be trained in small groups. In the same way, when work is in progress at the factory or on construction sites a large influx of new arrivals is not good for safety, nor is a single newcomer.

130. It would seem possible to make those responsible for safety in an undertaking understand what the migrant lacks on his arrival, what he must be made to assimilate and how this should be done. However, the principal need is for the undertaking to have a general policy allowing an apprenticeship in safety methods to be carried out and giving newcomers and those responsible for safety the means and, in particular, the time for practical and effective training. It is now generally realised that accidents occurring during the first week or at the first workplace make up more than half the accidents occurring during the first month. A strict policy of safety instruction is therefore necessary and also a policy of stable employment.

131. Something should be done in any undertaking to make it easier for the migrant to stick to the same job, using various means and benefits to give him more interest in his work; and trying to reduce too high a turnover (which itself is not a sign of sound management). For various reasons already mentioned, the undertaking is probably not a suitable place for the promotion of health and well-being among migrants, even where occupational health physicians keep them under surveillance - a requirement that is too obvious to need stressing.

132. Nevertheless, close contact must be kept between the medical and welfare unit and the occupational health service. The sequence "case-finding - treatment - prevention" should not be split up in the case of a group that is in the process of adaptation, particularly as the action to be taken falls into many different fields ranging from the guidance to be given in the case of lengthy treatment to the problem of housing or contacts with administrative authorities. Such action plays a large part in helping the migrant to adapt and in keeping him mentally healthy. Where an undertaking has its own canteen, this will assist in dietary adaptation and in
avoiding dietary deficiencies. It will also help in making the changes of diet made necessary by climatic and occupational conditions, while at the same time allowing customs and religious rules to be followed. Medical surveillance of the workforce also helps to make sure that the rules of food hygiene are observed and that parasitic infections are now allowed to spread.

133. Legal, social and welfare measures. It has often been said that equal treatment for national workers and for migrant workers now needs to be put into practice rather than into law since, at least in Europe, legislation in most countries now accords such equality. This report will not discuss the problems concerning the effective exercise of the right to work, but it should not be forgotten that uncertainty of job tenure is a very important predisposing cause of deterioration in physical and mental health.

134. Access to the same facilities, services and benefits as national workers. Considerable effort has been made on a world-wide scale (ILO international social security Conventions) at regional and subregional levels (for example, the European Social Security Convention of the Council of Europe, regulations concerning the social security of migrant workers of the European Communities, etc.) as well as on a bilateral level to ensure that migrant workers and their families benefit from the same rights as nationals of the countries of employment with respect to the various branches of social security.¹

135. The results which have been achieved depend on the level of development of the various national social security schemes. Generally speaking, equal rights have been achieved with regard to work accidents and occupational diseases. As for other areas, there are complex technical problems, especially as regards the preservation of acquired rights and the maintenance of rights in the course of acquisition. Finally, where possible, there is an attempt within the framework of the ILO's international social security Conventions to ensure that the allocation of social security rights are neither based on reciprocity nor made subject to this condition except in a limited way.²

136. With regard to continuing occupational training, migrants also have the same rights as nationals in most countries.

137. Reunification of families. By breaking up the family unit even temporarily, emigration is liable to lead to permanent separation, the establishment of illegitimate families and the abandonment of children. Every effort should therefore be made, both in the migrant's home country and in the host country, to allow the migrant worker and his family to come together again as soon as possible when, as often happens, the head of the family emigrated on his own. Different host countries vary greatly in their policy in this matter, as is shown by the following figures: the proportion

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² All of these problems are analysed in "Sécurité sociale des travailleurs migrants" (Social Security of Migrant Workers), International Labour Office, Geneva, 1974, 149 pp. (in French only).
of family members in the total number of migrants ranges from 55 per cent in France to 13.5 per cent in Switzerland. Bahrain allows the entry of all members of a migrant's family, without any restrictions.

138. Some migrants, whose main aim is to save as much money as possible with a view to going back to their own country at some time, do not want to bring in their families because it costs less to support them in the home country. However, many do want to have their families with them and react badly to the conditions exacted by the host country. There seems nowhere to be any recognition of a genuine right for families to keep together. Even in the most lenient systems of regulations this is made conditional upon:

- possession of a steady job, proof of sufficient income to support a family and the availability of proper accommodation;
- proof that the family members are in good health (wide latitude is generally allowed in assessing this). Some countries also insist that the migrant should first have completed a given period of residence in the country.

139. A disquieting trend has appeared in some countries (France, West Germany, Switzerland, etc.) which may have very serious affects on family unity: this is partial reunification of the family. The father brings his wife in with the youngest children (those still dependent on their mother) and the children of school age but leave those children aged from about two to six in the home country. Difficulty in finding accommodation is the reason usually given for this.

140. Family reunification creates difficult problems for the host countries. Nevertheless, administrative or legislative measures should be taken to ease the procedures for entry of family members, to reduce the amount of time that must elapse before the family can be brought together again (12 months at a maximum) and, an essential condition, to make it easier for the migrant to obtain low-cost accommodation. Unfortunately, conditions in the housing sector are not very satisfactory in many host countries.

141. Proper accommodation facilities. Throughout this report, migrants' housing has been shown to be one of the most important problems and one of the least well tackled. For migrants living on their own, accommodation in a hostel is one solution, particularly when it plays a real part in the life of the district and provided that the privacy of the worker is respected. As far as families are concerned, suitable accommodation is difficult to find and sometimes cannot be afforded on the worker's wage (or on that part of his wage he wishes to spend on accommodation).

142. An attempt to solve the housing problem should be made through the following:

- allocation of accommodation should form part of the work contract, which should clearly specify the conditions to be fulfilled by such accommodation: i.e., place and type of accommodation and conditions under which occupation may be terminated. If not, the employer should undertake to obtain rented accommodation as soon as the worker has completed an unbroken period of work, such as after the trial period, when the contract is due to be renewed;
governments should allocate a proportion of low-cost accommodation for migrants. There should be no direct or indirect discrimination exercised through the criteria applied by the local authorities responsible for allocating low-cost accommodation or in the allocation of other means to facilitate obtaining accommodation;

undertakings employing a large proportion of foreign labour should assist in financing the building of housing for migrants, either directly or, preferably, indirectly to avoid the worker having the uncomfortable feeling that even his private life is under his employer's control.

1.3. EducatiaN. national workers on the migrant worker problem. Relations between migrant workers and the local population have created serious problems in recent years. Whenever the flow of immigration passes a certain threshold in any given country or area, an instinctive self-defence mechanism begins to operate in the local population, which takes up an attitude of rejection under the impression that its collective personality is under attack. Such difficulties usually arise because the local population knows little about the social and cultural background of the migrants or the reasons that have led them to leave their country and do not realise the vital contribution these workers make to the growth and prosperity of the host country, including their own prosperity.

143. A campaign should be launched to educate all sectors of the people of the host country on all these points, using modern mass media techniques. In addition to providing information on migrant groups to create a better understanding of them and to explaining how the community benefits from migrant labour, it would be helpful to deal also with the human aspect of the problem. The migrant worker does not want just to earn money, he also wants to live in a society as a human being among other human beings who regard him as a fellow citizen and who consider it natural to share their civic rights and responsibilities with him. This has been pointed out by Mrs. Cattaneo Petro and Mr. Auders in a report to the Consultative Assembly of the Council of Europe (1973), from which much has been borrowed.

144. General education of the public at large should be supplemented by special information for those who are in close contact with migrant workers and their families as part of their job, their workmates, employees of the relevant public services, and particularly, health and welfare workers. These workers, whose devotion to duty is without question, should be brought to understand the mentality and social and cultural background of migrants so that they will know how to deal with foreigners applying for help, especially as these people will be even more lost and frightened when they are ill.

145. Co-ordination with the migrants' home countries. For a long time migration of workers was uncontrolled. However, over the last 15 years it has become increasingly organised and even where it is not governed by conventions of a strictly legal nature it is covered by agreements between the home and host countries. The home countries have come to realise both the considerable advantages this migration brings to the host country and the benefits they can themselves gain from it, such as the immediate benefit of reducing a surplus unemployed population, the inflow of hard currency sent home by migrants from their wages, and the longer-term benefit of trained manpower returning in a few years' time.
147. The limited amount of co-ordination so far accomplished has mainly been in the economic sector. Even here, there is room for further progress. The migrants' home countries might have regular meetings with the host countries to discuss matters relating to the departure, residence or return of migrant workers. The host countries might draw up long and short-term migration policies with the home countries to take account of changing trends in the industrial and economic development of their two types of country. Close co-operation would also make it possible to assess the capacities and capabilities of those applying for emigration, before signature of the work contract, by means of functional criteria corresponding to the various levels of skill commonly recognised in the host country. This would have its effect on the future well-being, and sometimes, the health of the migrant.

148. It would be as well if this co-ordination were to tackle a number of problems of a more particularly medical and welfare nature, such as that of preparation for emigration, participation of staff from migrants' home countries in measures provided in the host country to help adaptation (and training them for this purpose), exchange of medical information, etc.

National health services and health workers and their relations with foreign workers and their families

149. It is essential that all medical and paramedical health personnel who deal with migrant workers be sufficiently informed of the particular characteristics of their disease entities. Because of the general tendency of sick workers to return to work prematurely, there should be effective collaboration between curative and preventive health services. This is particularly essential for the appropriate placement of the convalescent migrant worker.

150. It is considered appropriate that migrant workers, who arrive in the host country past the age at which certain vaccinations are compulsory, should be advised to submit themselves for the vaccinations usual in the host country. Examples of these are antitetanus vaccine, and for those migrants who show a negative tuberculin reaction, vaccination by BCG.

151. All these measures would be facilitated by the existence of migrant medical and welfare centres staffed by physicians, social workers and interpreters well acquainted with the special problems of prevention, adaptation and self-education that have already been discussed.

152. It must be recognised that hospitalisation creates many difficulties for the migrant, owing to the language barrier, the complexity of administrative procedures and the difficulty of finding somewhere to live on discharge from hospital and during convalescence. Later on, when the question of the immigrant's fitness for work comes up, differences of medical opinion and the difficulty of getting vocational training for another type of work because of inadequate educational background have particularly harmful repercussions on the mental balance of the migrant. Re-employment procedures should lead to opportunities for vocational training adapted to educational background. The difficulties encountered by hospital and re-employment services would be simplified by the provision of interpreters.
153. The same sort of conclusions apply to keeping the migrant worker's family in good health. The high morbidity often found among the children is a direct result of the mother's lack of health education and the high fertility of such families makes it particularly serious. Appropriate instruction should be given by staff with special knowledge of the problems faced by the ethnic group concerned, and provided in a place near where the families are living. Measures of this kind are particularly important where immigration has a noticeable effect on the birth rate in the host country.

154. Since lack of co-ordination between the various medical and welfare organisations in the host country may have harmful repercussions on the health of the migrant worker, and because of the language barrier, it has often been suggested that the migrant worker should be provided with his own health record card listing illnesses, the treatment he has been given and the laboratory tests and vaccinations carried out. It has been found that, through either carelessness or deliberate concealment, health record cards introduced in the past did not last very long. Seafarers' health booklets have been accepted and reasonably well used because they are issued to all sailors. The Commission agreed, in principle, that a card of this kind would be very useful but considered that the practical difficulties involved in its issue and use would limit its value.

Some economic and social implications

155. The countries of immigration or employment draw considerable economic benefits from employing migrant workers, who accept work that national workers refuse because it is arduous, dangerous or badly paid. In addition, this group of workers constitutes a pool of temporary labour available for seasonal work or to meet a temporary rise in production. It is an active group in the economy because of the high proportion of working to non-working members. In addition, lack of skills, and shorter time on the job, linked to frequent changes of employment, keep migrant wage rates down.

156. In addition, because of the age at which immigration takes place, the financial burden incurred while the immigrant is growing up and being educated is not borne to any extent by the people of the host country and represents a sort of hidden subsidy. The financial burden of welfare is directly distributed in accordance with the conventions between the migrants' home countries and the host countries, depending on whether or not the worker's family comes with him. Only a very small part of the contributions made to pension funds comes back to the contributor in the form of a pension paid when he is back in his own country. Lastly, in spite of all the efforts in this field, a considerably lower proportion of the community's financial burden for housing is spent on foreigners. For these reasons and because of the economic advantages accruing to countries and employers using migrant workers, a greater contribution to their interests could be afforded. Such a contribution would allow a great many of the problems of adaptation mentioned to be solved and would make the social cost of immigration less burdensome for the community and reduce prejudice against migrants.
The health problems of migrants in small industries

157. Although a good deal of what has been said about the responsibilities of establishments regarding migrant workers applies to both small and large industries, the Committee recognises the special situation of small industries, particularly in certain regions of the world. Migrant workers may be employed by contractors or small enterprises with serious economic, technical and health disadvantages. Supervision may not be possible and sometimes legislation does not cover small plants. A special approach is therefore required in view of the fact that migrant workers may suffer most from exposure to hazardous conditions in uncontrolled small enterprises in certain regions. Governments should take an active role in ensuring the health protection of migrant workers employed by contractors and small industries. The Committee refers to the WHO Report on the Meeting of Organisation of Health Care for Small Industries that took place in July 1975.

8. Research and studies

158. Temporary migration by workers and their families, as has been seen, creates serious health problems that have not yet been adequately dealt with and which warrant study and research. Some of this study and research should be carried out by the countries concerned; ILO and WHO, the responsible international organisations, should encourage these countries to carry out such work and given them any advice they may need. Other studies or research may be more efficiently conducted and lead to earlier useful results when carried out by, or under the auspices of, and with the participation of, these international organisations. The most important aspects of both types of work will be considered in this chapter. All such studies and research, with the exception of one project aimed at safeguarding the health of host country populations, have the improvement of the health of the migrant worker (or his family) as their ultimate aim. If his productivity is also improved thereby this may be a useful by-product but it is not the object of the exercise.

Long-term studies to provide more information on all medical and social problems encountered by migrants

159. Suggestions for these studies have already been made by a WHO working group (Algiers, November 1973) on health aspects of labour migration. These were:

(a) intensive studies of specific migrant groups from departure to return home;

(b) intensive, or longitudinal, studies of migrants in specific geographical areas;

(c) intensive study of groups entering large enterprises.
Proposals for health research needs

160. Among the many topics for medical research, the most important at the present time seem to be the following:

(a) research into the risk of spreading diseases endemic to the migrants' home countries in the host country and the subsequent establishment of valid and well-supported criteria for the temporary prohibition of migration as a result of such risks;

(b) research into ways of improving the health statistics of the host countries so as to give a more accurate indication of morbidity among migrants (illness and accident, including industrial accidents and occupational diseases), with the aim of introducing whatever preventive measures may prove necessary;

(c) periodic review, in the light of scientific advances, of the medical criteria for according migration permits and medical criteria of fitness for the main classes of work for which migrants may be employed;

(d) research into the best methods of screening to be used, according to the migrant's home country and ethnic origin, in order to comply with the medical criteria required by medical examination for immigration permits or the assessment of fitness for work;

(e) epidemiological studies on morbidity among migrant workers (including occupational accidents) and their families, including the predisposing or direct causes of such morbidity;

(f) studies on the causes and prevention of mental disorders among migrant workers; these are necessary in view of the high incidence of such disorders;

(g) research to find out whether it is possible, and on the basis of what criteria, to determine a would-be emigrant's potential for adaptation to the climatic, occupational, social and cultural facets of his future environment before he leaves his own country;

(h) the effect of migration on family health, in cases where the family accompanies its head or in cases where it remains in the home country. The problems of migrant children accompanying their parents have already received fairly extensive study. This is not so with the problems encountered by the family as a whole, including the case of children left behind in the home country;

(i) ways and means of providing migrant workers with information on safety at work and the prevention of industrial accidents;

(j) ways and means of providing health education, including instruction in nutrition, adapted to the needs of the migrant worker and his family.
Research and studies on non-medical problems with an important impact on migrant health

161. There would be a large number of these if mention were to be made of all the administrative, economic, cultural and social problems whose solution would have a beneficial effect on migrant health and which need to be studied, either because little is known about them or because no satisfactory solution to them has yet been found. Indeed, all research aimed at improving the migrant's adaptation to his new environment should be mentioned, but here only the main topics of most direct concern for solving health problems will be given:

(a) research into the process of providing would-be immigrants with information to prepare them for emigration, including the content of the information provided and the ways and means of applying it;
(b) research into the process of providing information for migrants on their arrival in the host country;
(c) studies on the organisation, operation and role of the social services at the disposal of migrants and their families;
(d) language training: research into the migrant's basic needs and into the best methods of instruction;
(e) studies on how nationals from the home country can assist in solving adaptation problems in the host country, with reference to social services, language instruction, instruction in occupational safety, interpretation services and child education;
(f) studies on what needs to be done, and by what methods, to prepare host country populations for the reception of migrants and in facilitating their adaptation;
(g) studies of the health problems linked to return to the home country.

9. Determining priorities

162. As this report shows, the protection and promotion of migrant workers' health calls not only for health measures, but also for the introduction of a whole range of economic, social, educational and health measures to deal both with the direct and with the predisposing causes of disease among such workers. All aspects are important, starting with wages, and it is difficult to establish any order of priority in the work to be done to improve health.

163. In so far as they can be determined, priorities are not always the same in all circumstances. They vary according to the nature of the migrants' home and host countries. In some cases the languages involved are the same or very similar or the cultures involved are very close to one another; these are the simplest cases. At the other extreme there are cases where everything
differs between the host country and the home country, so far as climate, language, culture, customs and social life are concerned. There are many risk factors as a result and much work to be done.

164. The Committee has recognised that certain items require very special attention. These include control of organised migration by competent authorities, which should be based on bilateral or multilateral agreements. Countries should ensure that there is a valid labour contract before migration. It is highly desirable that families of migrants should join them in the shortest possible time following migration.

165. What should not be lost sight of, in the final outcome, is that the migrant worker is an individual human being who should be treated with due consideration, sympathy and understanding. It is important to call on the different countries to take the migrant worker into account as a human being and not as a mere producer or element to produce wealth. Man, as a superior being, has the right to equal consideration and treatment without discrimination by race, country or any other factors.

10. Conclusions and recommendations

Conclusions

166. Migration of workers has always been an important phenomenon in the world. There is every indication that this will continue in the coming years, perhaps with some difference, despite the economic difficulties of today.

167. Migrant workers are much more exposed to diseases and accidents than national workers in the same environment. The reasons may be attributed to:

(a) the high morbidity and the prevalence of malnutrition in some countries of origin, bringing with them endemic diseases, or inherent weakness caused by general health conditions and nutrition in childhood and adolescence.

(b) the conditions in the host countries are usually new to them and often poor and therefore reduce to some extent their tolerance to the diseases to which they are exposed there;

(c) the difficulties of migrant workers are mainly those of adaptation to a new environment which is frequently detrimental to physical and psychological conditions;

(d) in some countries one may find that migrant workers are treated as "second-class citizens" and given jobs in which the health hazards are higher.

168. The principal factors which may influence the health of migrants and make them more susceptible to diseases are mainly in the following conditions:

(a) the migrants undertake arduous labour, often dangerous and at low pay;
(b) despite the low pay they have always a desire to economise on a budget which is normally insufficient;

(c) because of these reasons and as they lack information on their new physiological needs in the countries of employment which are different from their countries of origin, they may often live in overcrowded and insanitary housing, and their nutrition may be inadequate;

(d) the cultural and social conditions in their family environment reflect also on their psychological adaptation which may be aggravated by language barriers.

169. In order to protect and promote health of migrant workers, it is not enough to resort only to sanitary measures, it is also necessary to deal with a set of variables which are legislative, economic, social and educational, and with health measures of direct influence, particularly on migration; these will be of relevance to migrant workers. It is therefore hoped that nations will ratify Convention No. 143 applied in Recommendation No. 151 of the ILO concerning migrant workers.

Recommendations

170. The Committee recommends that the lines of action indicated in this report be carried out by countries of origin, host countries and work enterprises, and be produced as a guide; it is therefore necessary:

(a) to establish precisely the health standards which are mentioned in this report, adapting them to different conditions in different regions;

(b) to communicate these standards for trail and adaptation allowing for bilateral agreement between countries of origin and host countries.

171. As statistical data about health conditions of migrant workers is seriously deficient in all countries, the Committee recommends that countries of origin and of employment establish and promote health statistics concerning migrant workers. Adequate health statistics should augment efficient measures to prevent or reduce the health problems of migrant workers.

172. It is the duty of the host countries and also in their interest, to avoid causes of disease among migrant workers and their families. For this, countries should:

(a) organise migration in collaboration with the countries of origin;

(b) arrange suitable placement of migrant workers at the same level of wages, work, health and social protection, as national workers;

(c) take measures aiming at the elimination of disease, particularly those connected with housing, diet, language problems and language difficulties;
173. It is important that labour unions recognise the risks at work and that they participate in an active manner in the application of preventive measures in the employment of migrant workers.

174. The Committee felt that special attention should be given to the problem of malnutrition and undernutrition of migrant workers. This could be resolved in a number of ways, including their education, better pay and organisation of the supply of an adequate diet to enable them to perform their work properly and allow them the energy requirements of their particular work.

175. Governments are called upon to establish bilateral and multilateral agreements and to develop adequate legislation aimed at the control of illegal migration of workers.

176. Joint action by ILO and WHO should be developed in the following areas:

(a) the establishment between the two secretariats of a Joint ILO/WHO Permanent Committee to study the problems of health of migrant workers in different countries and suggest solutions and preventive measures;

(b) to inform governments of the countries of origin and host countries of the measures necessary for resolving these problems;

(c) to facilitate the exchange of information and to collect and disseminate information on the health of migrant workers and also to organise joint seminars, work groups and conferences, bringing together all interested parties. It is hoped that the first meeting will take place at the earliest possible opportunity;

(d) to assist and encourage the development of bilateral and multilateral agreements relating to the particular problems relating directly and indirectly to the health of migrant workers;

(e) to establish or co-ordinate the development of health standards relevant to migration, taking into account regional differences. Such standards should be adaptable in application, particularly where migration occurs between neighbouring countries;

(f) to initiate or assist in carrying out research, particularly those long-term studies that will help in the development of adequate information and in the solution of the problem at the international level (some proposals are indicated in Chapter 8).
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PREVENTIVE MEASURES:
MEDICO-SOCIAL CARD

The question of a medical card or health book for migrant workers was raised several years ago. Two initiatives at the international level should be mentioned.

The first was made by the International Catholic Migration Commission, which requested the WHO early in 1967 and the ILO in March 1969 to take action towards the introduction of an international medical card for migrant workers.

The second initiative was taken in July 1969 at the International Occupational Safety and Health Congress organised by the ILO, and took the form of a resolution recommending that the ILO, in collaboration with the WHO and any other international or regional organisation concerned, should consider the introduction of a medical card for migrant workers.

These initiatives were inspired by a desire to help migrant workers; they recognised the difficulties involved in administering first aid and emergency medical treatment to these workers because they are usually unfamiliar with the language of the host country and are rarely able to provide information on their pathological history and the immunisations they have had.

One of the methods considered by the above-mentioned Commission was the introduction of a coded medical card with a wide circulation among doctors who might have occasion to treat migrant patients.

Since then the question has been discussed repeatedly at various national and regional social and medical meetings.

None of these discussions and initiatives has had any practical outcome or led to the introduction of a medical card for migrant workers.
WHilst recognising the fact that migrant workers and doctors in the host country experience great difficulty in understanding one another, and that this can frequently reduce the efficacy of the treatment to be followed, especially following an accident or an acute illness, objections have been raised to the introduction of such a card, including the following:

- producing a medical card and keeping it up to date conflicts with the principle of medical secrecy, as the card may be asked for by persons who are not members of the medical profession (customs officials, policemen, employers, etc.);

- next, it is claimed that this is a discriminatory measure against migrant workers and that it should be made compulsory for nationals as well;

- it is yet one more document among a host of others and this leads to inconvenience;

- it is also thought that a card of this kind is useful only if the information provided on it is complete and clearly set out.

On the other hand, it is worth noting that agreement has been reached among the six member countries of EURATOM in respect of workers and technicians exposed to ionising radiations with a view to exchange of information in these countries about the radiation doses absorbed by the workers. Some automobile clubs, particularly in the Federal Republic of Germany, have requested their members to carry a standardised club card indicating their blood group, any allergies and vaccinations. The Swiss Medical Commission for First Aid and Rescue Operations (CMSS) has brought out a certificate for emergencies which contains social and medical information.

It would appear - particularly in the event of an accident when the victim might be incapable of speaking - that a card of this kind could be extremely useful, not only for foreign workers, but also for nationals. Apart from any other considerations, its introduction would be particularly useful for all workers employed in certain economic sectors where there are greater risks of accidents such as, for example, the building, civil engineering, transport, mechanical and food industries. These are precisely the sectors in which there is a high concentration of migrant workers. Moreover, this card should not be needlessly encumbered with details which, in cases where emergency treatment is called for, would be of secondary importance and which would involve a loss of valuable time for the doctors who would have to fill them out.

Consequently, consideration might be given to the introduction of a medical social card for nationals as well as for foreign workers. An example of the way in which such a card might be prepared is shown below.

The first section could contain information of a social and family nature, including the address of a member of the family or other person to be contacted in an emergency. This would enable additional information about the injured person - such as whether he is a diabetic, suffers from high blood pressure, is an alcoholic, is undergoing treatment, etc. - to be obtained promptly.
PREVENTIVE MEASURES: MEDICAL SOCIAL CARD

The second section could give details about the cardholder's job or the type of work he does. This would aid the doctor in identifying the causes of the accident (or poisoning) and enable him to take rapid appropriate action.

The third section could contain medical information which must be filled out by the medical services and which would facilitate the doctor's task in an emergency.

MEDICAL SOCIAL CARD

No. _________

1. Name ____________________________________________

2. First name ___________________ 3. Date of birth _________

4. Place and country of birth ____________________________________________

5. Nationality ____________________________________________

6. Civil status _____________ 7. Sex ______________________

8. Children: 1. ________ born ____ 2. ________ born ____

3. ________ born ____ 4. ________ born ____

9. Home address ____________________________________________

10. Address for emergencies ____________________________________________

11. Profession ____________________________________________

12. Present job ____________________________________________
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>13. Blood group</td>
<td></td>
</tr>
<tr>
<td>14. Sensitisation, allergy</td>
<td></td>
</tr>
<tr>
<td>15. Vaccinations: smallpox, tetanus, tuberculosis, polio, diphtheria, measles, typhoid fever, other</td>
<td></td>
</tr>
<tr>
<td>16. Revaccinations:</td>
<td></td>
</tr>
<tr>
<td>17. Tuberculin test</td>
<td></td>
</tr>
<tr>
<td>18. Antitetanus seroprevention:</td>
<td></td>
</tr>
<tr>
<td>1. date</td>
<td>type of serum</td>
</tr>
<tr>
<td>2. date</td>
<td>type of serum</td>
</tr>
<tr>
<td>3. date</td>
<td>type of serum</td>
</tr>
<tr>
<td>19. Observations</td>
<td></td>
</tr>
<tr>
<td>20. Date of issue</td>
<td></td>
</tr>
</tbody>
</table>
MIGRANT WORKERS
IN THE CONSTRUCTION INDUSTRY

Dr D. Djordjević, International Labour Office,
Dr G. Lambert, World Health Organization.

Introduction

While sharing the views reflected in the report of the Meeting of Experts regarding the criticisms to be made of the available statistics and documentation on migrant workers, the authors felt it would be useful to supply some additional information on occupational accidents and health within a specific group.

The choice fell on foreign workers in the construction industry because of their large numbers and the high risk of accidents in this area of activity.

The data were mainly collected in two European countries, France and the Federal Republic of Germany, where foreign workers in the construction industry are particularly numerous.

Some characteristics of foreign manpower in the construction industry

In addition to the general comments made on migrant statistics, great caution must be observed in interpreting the data for this area of activity because of the very high mobility of foreign manpower and the considerable seasonal fluctuations in their numbers. Despite all this, an over-all picture of the basic characteristics of this manpower group can be given.

In France, a higher proportion of foreign workers is found in the construction industry than in any other area of activity. In this sector they represent one-third of all wage earners,[1]

Moreover, half the foreign labour force is employed in the construction industry (about one-third) and the metal processing industries (about one-sixth). The same applies to the distribution of the first jobs offered them on their arrival: 35 per cent and 15 per cent respectively.[2]
MIGRANT WORKERS IN THE CONSTRUCTION INDUSTRY

In the Federal Republic of Germany, 21.6 per cent of all foreign workers were employed in the construction industry in 1970, and foreigners represented 29.3.

In Switzerland (including seasonal workers) the construction industry is the leading employer of foreign labour with 43 per cent, while in Belgium it occupies fourth place with 12 per cent.

Roughly, one foreign worker out of five is employed in the construction industry in Luxembourg.

While the construction industry absorbs the greater part of foreign labour, it also pays these workers better than the other sectors. Thus the average monthly wage for immigrants employed in the construction industry in France in 1970 was around 1,091.90 francs; in the other sectors it was around 836.30 francs and for all sectors together it was about 985.06 francs; the lowest monthly wages were paid in the mining industry.

In the construction industry and the metal processing industry, nationals of the Maghreb countries represent a substantial proportion of unskilled labour: 77.5 per cent in the former sector and 94.1 per cent in the latter - these figures are relevant to the occupational accident rate.

In a survey carried out in France among the Moroccan working population, 40.5 per cent of this group stated they are ill more frequently in France than in Morocco; 49 per cent were not ill more frequently and 10.5 per cent did not know. By way of comparison, the largest proportion of migrants - 52 per cent - stated a greater frequency of disease in France than in their country of origin is found in the motor industry.

The same survey shows that work in the construction industry is classified by Moroccans as: fairly tiring (50 per cent), very tiring (26 per cent), not tiring (24 per cent). Mining is regarded as offering the most tiring work (56 per cent).

In the construction industry 68.5 per cent of workers wish to work overtime, 11.5 per cent already do so, and 20 per cent do not wish to do so. By way of comparison, the motor industry has the largest number of foreigners working overtime (14.5 per cent).

Occupational accidents

According to the statistics published in France by the National Sickness Insurance Fund, nationals of Algeria, Morocco and Tunisia, who in 1970 made up 6.6 per cent of the working population, suffered 16 per cent of the accidents causing absence from work and 13.8 per cent of the serious accidents. In the same year they accounted for 16.1 per cent of working days lost through temporary disability and 12.9 per cent of the permanent disability rate in the construction industry.

At the same time nationals of other foreign countries, who made up 14.5 per cent of the working population, accounted for 20.5 per cent of accidents causing absence from work, 22.2 per cent of serious accidents, 21.8 per cent of days lost owing to temporary disability and 22.6 per cent of cases of permanent disability. French nationals, who made up 78.9 per cent of the working population, accounted for 63.5 per cent of accidents with absence
from work, 64 per cent of serious accidents, 62.1 per cent of days lost owing to temporary disability and 64.5 per cent of the permanent disability rate.

However, a more thorough and precise analysis shows that these difficulties are not as great as they appear at first sight. Thus the proportion of foreign workers is found to be almost 35 per cent, made up of 13 per cent from the Maghreb countries and 22 per cent of other nationalities. The 13 per cent from the Maghreb countries account for 17 per cent of accidents and the other 22 per cent account for 20 per cent of accidents. Altogether, the 35 per cent of foreign workers suffer 37 per cent of accidents; although the Maghreb nationals have a high proportion of accidents, "it even seems that the non-Maghreb workers have proportionately slightly less accidents than the French".[9] Estimates made in France of serious accidents and deaths show that in 1970, out of the total number of deaths per industry, immigrants accounted for:

- 34 per cent in the construction industry;
- 25 per cent in the refractories industry;
- 19 per cent in the metal processing industry;
- 13 per cent in the chemicals and related industries;
- 10 per cent in transport and handling.[8]

A study carried out in Belgium (Halewyck Heush) shows that "in two comparable groups of building workers who suffered accidents, the length of temporary disability is 84 per cent higher among foreigners than among nationals and the disability rate is 65 per cent higher. These figures rise to 137 per cent and 112 per cent respectively for foreigners of Mediterranean origin only".[10]

As the following table shows, the frequency of occupational accidents during a seven-year period in the Federal Republic of Germany was consistently substantially higher in the building trade than in the metal processing industry or other industrial sectors. The rate was also very much higher for foreign workers than for nationals in all sectors.[3]

<table>
<thead>
<tr>
<th>Year</th>
<th>Building</th>
<th>Metallurgy</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Foreigners Nationals</td>
<td>Foreigners Nationals</td>
<td>Foreigners Nationals</td>
</tr>
<tr>
<td>1964</td>
<td>320</td>
<td>172</td>
<td>273</td>
</tr>
<tr>
<td>1965</td>
<td>312</td>
<td>162</td>
<td>260</td>
</tr>
<tr>
<td>1966</td>
<td>312</td>
<td>160</td>
<td>254</td>
</tr>
<tr>
<td>1967</td>
<td>308</td>
<td>151</td>
<td>189</td>
</tr>
<tr>
<td>1968</td>
<td>345</td>
<td>155</td>
<td>208</td>
</tr>
<tr>
<td>1969</td>
<td>330</td>
<td>155</td>
<td>250</td>
</tr>
<tr>
<td>1970</td>
<td>318</td>
<td>148</td>
<td>221</td>
</tr>
</tbody>
</table>

As regards fatal occupational accidents in the Federal Republic of Germany, it is once again the building trade that presents the highest risk for foreign workers (see table below).
Finally, without prejudging the reasons that may be put forward, it can be stated that foreign workers in certain host countries of Europe particularly workers from the Mediterranean basin—are at greater risk of occupational accidents than nationals and that this risk is greater in the construction industry than in other industries.

**Morbidity**

The criticisms made of occupational accident statistics are not nearly as severe as those of statistics on morbidity among migrant workers.

As regards pathology in general, there are many factors that may introduce serious errors into the statistical comparison of the various groups, by either overestimation or underestimation. The main sources of error are primarily due to the fact that the age pyramid is not the same for migrants as for nationals. The migrants constitute a younger population.

Moreover, migrant labour represents a selected sample of the population, and attendance at medical clinics often results from an occupational medicine examination to determine fitness.

Furthermore, the figures for attendance at medical clinics do not take into account failures to attend for occupational medicine examinations which, according to a study carried out in health centres in the construction industry[12], may amount to as many as 25 per cent of appointments.

Consequently, in the study mentioned above, from which the main data concerning the morbidity of migrant workers in the construction industry have been drawn, it was preferred to analyse attendance at health centres for the construction industry in the Paris region, which in 1974 covered 380 000 wage earners, 41 per cent of whom were foreign workers.

The data were based on a sample of 8 000 patients out of the 59 000 who were examined at these centres in 1974; the distribution of the foreign workers was as follows:

- Iberians (Portuguese, Spaniards) 44 per cent;
- North Africans (Algerians, Tunisians, Moroccans) 38 per cent;
- Others (Italians, Turks, Yugoslavs) 18 per cent.
The results of this study are shown in the following table:

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Migrants (%)</th>
<th>French (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatology</td>
<td>65</td>
<td>35</td>
</tr>
<tr>
<td>Diseases of the respiratory tract</td>
<td>65</td>
<td>36</td>
</tr>
<tr>
<td>Diseases of the digestive tract</td>
<td>64</td>
<td>36</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>53</td>
<td>47</td>
</tr>
<tr>
<td>ENT</td>
<td>52</td>
<td>48</td>
</tr>
<tr>
<td>Cardiology</td>
<td>48</td>
<td>52</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>37</td>
<td>63</td>
</tr>
</tbody>
</table>

The proportion of migrants averaged 54.86 per cent and the proportion of French nationals 45.14 per cent.

Examination of these data calls for a number of comments.

In the first place, the type of clinic most frequently attended varies by ethnic origin: cardiology and dermatology clinics predominate among the Iberians, while among the North Africans there is an even greater predominance of clinics for ophthalmology and diseases of the respiratory tract.

Moreover, the relative attendance rate shows a downward trend from the Iberians towards the "others". Finally, some remarks can be made regarding the different types of disease recorded.

Heart disease

Heart disease is more frequent among migrants than among members of the local population in the same age group.

If this comparison is limited to physically arduous occupations, the difference in frequency becomes even greater; there are four times as many migrants as national workers with heart disease - of course in relative terms.

The nature of these heart diseases among migrants also displays special features.

Above all, there is a surprising frequency of congenital heart disease (in the two years 1972 and 1973, 30 of the total of 37 cases of congenital heart disease occurred in migrants); the actual
nature of these heart diseases is much the same as is encountered in the local population; there is surprisingly good habitual functional tolerance of these conditions, which are almost always unknown to the patient who has reached adult age and practises an arduous trade. Nevertheless, it should be noted that only non-cyanotic heart diseases were encountered.

"Acquired" valvular heart diseases are also common. The "acquired" origin of these conditions is always difficult to confirm since the patient often does not know his previous disease history (rheumatic fever, chorea, scarlet fever, sore throat).

Diseases of the digestive tract

It is well known that the digestive tract is an area where functional disease is particularly common among migrants. The abdominal fixation of "the various stresses" provoked by everyday difficulties, separation from home, dietary changes, and any communication problems in the psychiatric sense (language, customs, education) seem to be the main factors involved.

These diseases present difficulties for the industrial physician and the specialist because they often require a more thorough investigation than that required by an organic disease; moreover, it is very difficult to follow up this investigation with effective therapy because of psychosomatic implications that are hard to deal with in an occasional consultation; in addition there are very often language difficulties.

In view of the above facts, organic digestive pathology is lower than in the local population. Nevertheless, the same isolation and adjustment difficulties lead to organic digestive complaints such as gastro-duodenal ulcer.

Dietary factors (tobacco, alcohol, irritant foodstuffs) are well-known factors favouring the development of these diseases; there is not much difference from the pathology of the French worker.

Diseases of the respiratory tract

These diseases are particularly important among North Africans. Apart from the high frequency of tuberculosis, diseases of the respiratory tract are frequent during the first years in the new country, particularly in the winter, because of the unfamiliar climate, the considerable humidity, and the outside work normal in the construction industry.

Although this study is limited to workers in the construction industry in the Paris region, it shows that, as with occupational accidents, migrant workers have higher morbidity for specific diseases, and their living and working conditions are no doubt very much involved in this.

Specificity of this manpower group for occupational accidents

Despite the inadequacies of the statistics migrant labour, particularly in the construction industry, has a higher accident
rate. However, it is of fundamental importance to assess this risk at its true level and to seek to explain it in terms of the specific characteristics that make these workers a vulnerable group.

The most obvious fact is that the migrant worker in this industry is not only exposed to the same risks as those faced by the national worker but that he is almost inevitably exposed to these risk factors, which in his case may combine, may supplement each other, or even act synergistically. Listing the specific situations of the migrant can in itself largely explain the increased risk of accident and even of disease:

- the migrant is above all a displaced person, which always creates physical and psychosocial insecurity;
- by their very nature the construction trades are characterised by insecurity because of their impermanence, their seasonal nature, and the short-term employment frequently encountered;
- on building sites the presence of different trades and different firms of varying quality is a risk factor that is particularly serious when the workers concerned have few or no skills;
- work on building sites is most frequently physically demanding and exposes the workers to severe climatic conditions (heat, cold, rain); even if they are in good physical condition, recent migrants are undergoing an adjustment period and their nutritional status is sometimes delicate;
- the language barrier affects both the working environment and social life and can only aggravate the isolation of the migrant, particularly when he is separated from his family, as frequently happens in the construction industry;
- finally, the remote location of some building sites does not make it easy for the medical and medicosocial services to operate.

Conclusion

All these factors which, it must be repeated, may converge on the same individual, obviously create serious insecurity and hazards.

A study of these factors leads to an appreciation of the need for an over-all approach to the problems of the migrant worker as the only way of successively or simultaneously correcting the most critical points, by lessening and eventually removing the obstacles confronting him.

The construction industry, by virtue of the critical situations it presents for migrant workers, provides a particularly telling example of the variety and complexity of the factors involved.
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THE MIGRANT WOMAN AT WORK

General comments

Labour migration principally affects male workers by the very nature of the work usually performed and the sociocultural structure of the countries providing manpower. Nevertheless, these migratory movements also affect the family, particularly the wives of migrant workers who may themselves constitute a reserve of clandestine labour; moreover, the importance of female migration of labour as such is by no means negligible. In France, for example, there are 350,000 immigrant female workers, 75 per cent of whom are semi-skilled or unskilled.¹

The interest taken in the general problems of the feminine condition was recently shown with regard to migrant female workers, and for information a brief bibliography mainly concerning European migration is given below. It also seems worth while to summarise the proceedings of a congress on the migrant woman at work¹, ² and make a series of comments that could provide a basis for further thought on this subject.

Specific problems

First, the ambiguity of the term "migrant female worker" must be noted. Where the problems concern the work of the woman, migrants and local workers are on the same footing. Where the problems concern migration, men and women are often confronted by similar difficulties.

¹ Comité français d'aide aux migrants, Cahier Médico-social, No. 3, April 1975.
² Ibid., No. 4, July 1975.
Despite this ambiguity, however, it seems that some characteristics of the conditions of employment of the migrant woman can be identified:

- she has a lower educational level than the male migrant;
- her employment is very often "marginal", i.e. part-time, seasonal, undeclared (domestic work, small agricultural jobs);
- she has more than one job (janitor plus domestic work);
- she has a long working day (office maintenance in the early morning or late evening, piece work in the daytime, combined with domestic work);
- she is limited to certain types of employment such as domestic work, tailoring, cleaning and maintenance, shop assistants. In addition, these women often have to work in small workshops or the premises they clean are spread over a wide area; their work is often temporary and conducted under poorly controlled safety and health conditions; this leads to abuses and increases the risks associated with clandestine and irregular work.

To these problems must obviously be added those specific to the wife and mother; these loom particularly large among migrant female workers because of their ignorance of the medical and social legislation of the host country and because of cultural and linguistic barriers.

**General guidelines**

These very brief considerations lead to some general guidelines:

Information should be developed in both form and content, taking into account the two aspects of the problem, that of sex and that of work.

Health and social protection, taking into account the very fragmentary and disseminated character of the work of female migrants. Occupational health could be adapted to play a dominant role in this situation.

Over-all policy on female migrants, bringing together the occupational health and safety aspect, the medico-social and family aspect, and the training aspect.

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THE MIGRANT WOMAN AT WORK


Éducation - Promotion


THE MIGRANT WOMAN AT WORK


Health


THE MIGRANT WOMAN AT WORK


Health Education


The migration of Portuguese workers to European countries in need of manpower has led to marked changes in the "ecosystem" of vast numbers of people. This flow of manpower has caused alterations in the basic unit on which the combination man-and-environment rests. The upshot has been the creation of "biotic communities", leading to the emergence of detrimental phenomena and difficulties on the part of the individuals concerned in adapting themselves to an ecological setting very different from the one they have been used to. Such phenomena are fundamentally inter-dependent. In interaction with problems of health, living space, hygiene and human contacts, they eventually find expression in psychosomatic disorders.

As regards nutrition, more particularly, it is a fact that certain communities of immigrant workers - and especially in France - contain a high proportion of men and women suffering from malnutrition and avitaminosis. The following phenomena are discernable:

- people clearly do not have enough to eat, or eat unsuitably; they are, quite evidently, physically exhausted, and frequently suffer from stress;

- hypovitaminosis, especially as regards vitamins A and B, and ascorbic acid.

Malnutrition almost always affects:

- unskilled workers doing heavy manual work;

- emigrants, mostly from the countryside, where social and economic conditions combine with ignorance and tradition to produce faulty eating habits, i.e. excessive consumption of carbohydrates, too little in the way of fats, and absence of protein.
Furthermore, the people affected have an excessively narrow idea of what constitutes thrift. They tend to cut down on the purchase of food, erroneously believing that what they eat is sufficient, whereas in fact it is not. This being so, a man does not get a satisfactory daily ration of protein. The body cannot make good normal wear and tea: and hence tends to run down. At the same time, even though the body is receiving energy-producing foods in substantial quantities - in this case, such foods being largely restricted to carbohydrates - a state of metabolic imbalance is brought about in which the many complex biochemical operations of the body are less efficiently performed. This is exceedingly harmful when hard physical labour is to be done and much energy has to be expended. Whence a "negative balance" in nutrition as the end result of maladjustment between the energy which has to be expended in work and the amount of energy which ill-chosen food can provide. The upshot is a state of secondary malnutrition, described and denounced by us above. Inadequate feeding is complicated by an inadequate intake of trace elements - biocatalysts - and the upshot is the very evident hypovitaminosis of such workers.

Thus the delicate balance between labour and nutrition cannot just be left to chance. There are definite rules to be observed if we wish to avoid quantitative or qualitative errors which might lead, in the short or long run, to irreparable damage.

There is one problem with regard to nutrition and the single immigrant worker. But the position changes when he is joined by the rest of his family and the original family unit is restored. When that happens, we are faced with a whole range of problems, and they can by no manner of means be neglected, especially if we bear in mind that very large numbers of people are involved. And firstly, many of these secondary immigrants will be females, so that we shall have to consider ways and means of preventing malnutrition during pregnancy and immediately after confinement, if the offspring of such women are not to suffer physical underdevelopment which may be irreparable.

The author of these lines is persuaded that the problem of imbalance between the work done and the food ingested is common to migrant workers other than Portuguese who have taken root in Europe, and hence feels obliged to make the following recommendations: a campaign of information and education should be launched among migrant workers, to persuade them to eat sufficient food of adequate quality; workers must be made to understand that it is by virtue of the food they eat that they can continue to lead a normal life, with sufficient surplus energy to spare for the work they do; such a campaign might suitably be launched by direct contacts with the very poorest migrants, amongst whom secondary malnutrition, brought about by faulty eating habits, is most frequently observed; advantage should be taken of the mass media, such as television, the wireless, and the local press, and of meetings of migrant workers, to which meetings encouragement could suitably be given; it might be a very good thing to produce a little handbook, simply written, in the immigrant's mother tongue, with abundant illustrations. This would be distributed in immigrant communities wherever they might be. This little handbook would impart elementary knowledge about nutrition; give a list of common foodstuffs, with their nutritional value and an indication of the energy they provide; describe and classify the various kinds of work done by immigrants, with an indication of the energy expenditure involved; and give advice as to rational eating habits, making due allowance for the energy-output required, the need to maintain health, the intensity of the energy expended, age, and the individual's physical fitness.
Migration of workers takes place in Latin America for much the same reasons as those which explain movements of population in other parts of the world. That this is so becomes evident if we observe the economic imbalances between adjacent countries which exchange population in this way.

Certain privileged countries are highly developed economically and have a stable currency, and hence act as magnets to people living in less-favoured, less-developed areas, where unemployment and underemployment are endemic and the purchasing power of the currency is low. We can see this happening in South America today; countries such as Brazil, Venezuela, and now Ecuador, which are developing apace, are attracting immigrants. Paraguayans and Bolivians go to Brazil, Colombians and Central Americans to Venezuela, and Colombians and Chileans to Ecuador. There has been, as is well known, an increase in the movement of Mexicans towards the southern States of the United States.

Certain features peculiar to the subcontinent will become evident in this paper, although it deals exclusively with migration between Colombia and Venezuela. Such migration is now on a scale such as to cause concern to both these countries. Moreover, it constitutes a problem about which the author of these lines can claim a more direct knowledge.

The background

Until about 1950 or thereabouts, Colombia offered a higher standard of living and better educational facilities than Venezuela, and hence labour tended to move from the latter to the former country. But the Venezuelan economy, founded on vast oil resources, then began to expand at a great pace, with the result that the current began to flow in the opposite direction, and this new trend was powerfully encouraged by what happened in Colombia between 1948 and 1957 - political persecution of an especially violent kind in
the countryside, causing a shift of population to the towns. In areas close to the Venezuelan frontier, violence was such as to force the peasants to seek peace and work across the border.

**Features peculiar to migrants**

Colombian emigrants at present fall into two main groups:

(a) professional people, technicians and highly skilled workmen, much in demand to man the expanding industries of Venezuela. They enter perfectly legally, having performed all the requisite entry formalities, but are not very numerous (something like 100,000 in 1972);

(b) persons whose documents are not in order. These comprise -

(1) people who entered Venezuela with a valid tourist permit or frontier pass and thereafter settle down to earn a living without complying with the requisite formalities, and

(2) unskilled workers and peasants who have entered the country illegally thanks to the complicity of go-betweens and middlemen, the men to work as agricultural labourers and the women as domestic servants. The latter are frequently attracted by the prospects of high pay, but are cheated by the middlemen involved, who force them to practice prostitution.

The people described under (b) above are more numerous, although exactly how many of them there are is difficult to say, since by definition they escape all official censuses. Estimates vary from 300,000 to 700,000. In Colombia and Venezuela, there seems to be general agreement to the effect that they number perhaps half a million.

**Reasons for migration**

In preliminary inquiries amongst illegal migrants the following reasons for emigration have been adduced:

- higher standards of living because of higher incomes, paid in a stable currency;

- unemployment or underemployment in Colombia;

- movement for political reasons of recent origin, with the result that persons already settled in Venezuela try to attract their families still in Colombia;

- pressures due to the rate of population growth in Colombia;

- shortage of manpower for agricultural and cattle-raising, domestic service and other arduous occupations in Venezuela, and hence a demand for foreign workers willing to accept a 50 per cent cut in normal Venezuelan wage rates.

There are other factors, of course, which tend to facilitate and increase migration:
Spanish is spoken in both countries;
the people are much the same on both sides of the border;
ecological similitude: the migrants come from the countryside and settle down easily in the Venezuelan countryside, where geography and weather are very much the same;
social and cultural patterns are very similar on either side of the border;
when there is selective migration of the highly skilled, the more developed cultural traditions of the country of origin seem to play a part as well.

From inquiries among illegal immigrants deported from Venezuela, Mossman has discovered that the following motives carried weight:

(1) "To get a better standard of living, look for work or have a better chance of finding it" .......... 73.1%
(2) "To find out what it's like and for the adventure" . 12.4%
(3) "To rejoin my family in Venezuela" ................... 7.0%
(4) "Put up to it by others" ............................... 3.3%
(5) "Family reasons" .................................... 3.1%
(6) Other reasons ........................................ 0.9%

Amongst these illegal migrants, migration is a kind of spontaneous flow which has nothing to do with whether there actually are employment opportunities at the place of destination. This does not hold good of technicians and skilled workers, for whom the demand is selective and well organised in Venezuela itself.

Factors affecting the health and welfare of the migrant

Factors connected with the individual

(a) Selective immigration: Generally speaking, the technician and skilled worker stands a good chance of adjusting himself satisfactorily to his new environment. His reasons for moving were that he wanted a better wage and hence a higher standard of living. He will usually be fit and better educated than his counterpart in Venezuela, and with ample occupational experience. Besides, Colombia is a country of marked geographical variety; internal movements of population are frequent, and it may well be for this reason that Colombians are highly adaptable to all sorts of environments.

(b) Illegal migration: The position is not at all the same with regard to the illegal migrant, who usually comes from the poorest classes in Colombia, is often none too fit, and frequently undernourished. He tends to be ill-educated too, although in this respect he differs but little from most of the country-dwellers among whom he settles.
Factors to do with the environment at the receiving end

(a) For selective migrants: As a general rule, there is little difference as regards housing, habits, and welfare facilities in the two countries. The migrant settles down in towns or industrial centres where there are no dissimilarities in language, climate and eating habits such as complicate the lot of migrant workers elsewhere (in Europe, for instance).

One unfortunate fact is that there exists in Venezuela a widespread dislike or distrust of Colombians, leading to discrimination against them. This may be attributable to the behaviour of certain illegal immigrants who have gone in for crime; their ill repute may have rubbed off on all their compatriots.

(b) For illegal immigrants: Although, geographically, differences between areas of immigration in Venezuela and those of emigration in Colombia are not marked, there are social factors which have a most serious effect on the illegal immigrant:

- the illegal immigrant may have to pay a very high price (1,500 to 2,000 Colombian pesos, or more than a month's wages) to the middlemen in both countries who organise clandestine migration;
- he earns less than half what a Venezuelan worker gets for equal work. Even so, he earns more than he would have done in Colombia;
- he is entitled to no medical care and comes under no social insurance scheme;
- housing and working conditions are alike deplorable;
- he loses his elementary human rights and the right to property. He cannot marry, cannot acquire real estate (and personal estate or chattels only within limits), and cannot bring an action at law;
- should he claim the wages and benefits which are his due he may well find that he has been denounced to the authorities by an unscrupulous employer, in which event the police will usually deport him at once, without even giving him time to collect his belongings. In such circumstances, he will be unable to demand payment of the wages due. Exploitation of this kind causes much distress, and because of it deported workers frequently try to re-enter the country to collect their belongings, assemble their families, and claim their pay. Rocheau, in 1972, estimated that between 8,000 and 10,000 persons were expelled every year. Restricted and fragmentary data led Mossman, in 1973, to reckon that between 10 per cent and 50 per cent of those expelled sought to enter Venezuela again.

From the above, it will be clear that Colombian migrants in Venezuela fall into two main groups. Firstly, there are the highly skilled, whose entry is not only agreed to but actively encouraged by the host country. Their conditions of life and work are such as to enable them to settle down satisfactorily; in addition, they
receive medical care, preventive and curative, and other social security benefits not inferior to what Venezuelans are themselves entitled to. These people are readily acceptable in local society and their contribution to Venezuelan economic development is readily acknowledged.

Then there are the illegal migrants, about whose motives for moving it is difficult to generalise. Such illegal migration creates severe problems for both countries, even though it provides a natural solution to economic and social problems on either side of the frontier. In Venezuela, a void has been created by the drift to the towns and centres of industrial development, where pay is better; the influx of Colombians helps to fill this. Such movements of population create difficulties for agriculture and stockbreeding, which lack labour and hence employ Colombian immigrants; the latter put up with lower pay, while enabling local agriculture to avoid a slump. They do not compete with Venezuelan labour. On the other hand, Venezuela provides a natural outlet for the Colombian unemployed.

As regards, more particularly, the question of occupational health, facts and figures are in such short supply that estimates are impossible.

In Venezuela, legal immigrants enjoy equality of treatment, so Colombian immigrants in this category encounter no special problems. But precisely because the immigrant worker whose papers are not in order is present illegally, it is difficult to attempt a serious investigation of occupational health and safety amongst such people. In neither Venezuela nor Colombia are there medical services specially designed for migrants.

Courses of action envisaged

Since 1959, many attempts have been made to reach bilateral and multinational agreement to meet the problems caused by illegal migration. The highest government authorities in Venezuela have displayed a sincere interest in co-operating with the Colombian Government with this in view.

In 1959, the Ministers of Foreign Affairs of the two countries signed an agreement reaffirming the friendship between Colombia and Venezuela, and defining certain action to be taken. More recently, commercial agreements and agreements for bilateral economic development have led to joint decisions taken under the auspices of the Andean Subregional Pact, and it is hoped that action will shortly be taken as a result. Very recently (in June 1975), the Government of Colombia signed an agreement with the Inter-Governmental Committee for European Migration, with a view to obtaining technical assistance and to the drawing up of a co-operative programme to regulate migration. While this paper was being written, the Presidents of the Republics concerned are meeting, and one of the items on their agenda is this problem of migration. The highest circles of Government in both countries are clearly interested in finding a way out, and it is therefore legitimate to hope that action will be taken very shortly.

Such action would include the following:
- breaking up of the clandestine organisations which run illegal migration;

- punishment for employers exploiting illegal immigrants;

- creation of official centres in both countries to co-ordinate the supply and demand for labour;

- action to facilitate the issue of documents to allow workers to cross the frontier;

- co-ordinated action against offenders;

- decision as to policies and legislation on migration, which are compatible with the mutual requirements of the countries concerned, while providing adequate standards for the protection of the worker and his well-being.
In Bahrain, as in many other countries of the world, new migratory movements are occurring, either to settle in land recently opened up or reclaimed or to seek employment. The first category of this migratory movement is usually accompanied by organised health services, both curative and preventive. This report deals with the second category which is generally drawn towards construction projects needed for development of the country and for urgent industrial projects. These projects require a large labour force, and most of it is usually brought into the locality from other countries.

Bahrain comprises a group of over 30 islands of which only five are inhabited: Manama Island is the largest and the most important. The density of population is 935 persons per square mile. The population in the last census (1971) was 216,078 of whom 18 per cent were reported to be expatriates. In 1974, it was estimated to be 240,000 with about 20 per cent non-Bahrainis.

Since the discovery of oil almost two decades ago and the construction of a large refinery, considerable infrastructural facilities have been built in the country. More recently, a large-scale aluminium plant was established and resulted in a sharp increase in international traffic. Plans are being drawn up for the development of other large-scale industries such as a shipyard with an estimated labour force of 20,000 - of whom a considerable number would be expatriates.

Bahrain has an active private sector running a considerable number of small-scale industries (95 per cent of the industrial enterprises are in the private sector). With the rapid progress in Bahrain in the last few years, many new trades have been introduced and many industrial processes have been built up rapidly without up-to-date measures for the protection of workers' health or due concern for occupational health. No doubt, the health of workers, whether local or migrant, is affected by this rapid change as well.
as by the exposure to new risks, stresses and strains and by the problem of adaptation.

There is a fairly large expatriate labour force in Bahrain as indigenous labour falls short both in quantity and quality. The shortage in quantity is mainly caused by social factors which prevent females from playing their part: only 3.8 per cent of females, aged 14 and over are included in the labour force. Shortage of quality is found mainly among skilled and unskilled workers. The average Bahrain share of the total labour force is 63 per cent but this does not apply equally to all types of economic activity; over half of all non-Bahrainis are employed in construction or in community services. This may suggest that Bahrainis avoid working in these particular occupations but the fact is that the employers in the private sector prefer not to employ Bahrainis. This can be attributed to many reasons - such as:

1. Migrants accept lower pay, and have to compensate by living in inferior and unhealthy accommodation;
2. No pre-employment or preplacement medical examinations are necessary;
3. Migrants accept unsatisfactory working conditions and the complex health problems which are usually found in the construction division or in small industries;
4. Employers recruit migrants on a contract basis and, if they prove to be unsatisfactory or unfit, terminate their contracts with hardly any compensation;
5. Employers provide few health or welfare services;
6. The administration of the labour law can barely cover them. The Occupational Health Act has not yet seen the light of day.

Usually the migrants arrive without their families and have to remit most of their income to support their dependants at home. This, together with the living and working conditions in the recipient country, often badly disturbs their feeding habits and consequently their nutrition and performance at work.

In spite of the fact that the health services are available free of charge in all health centres for any resident of the island, migrants are usually reluctant to report sickness unless they are gravely sick and need hospitalisation.

Migrants are more exposed than nationals to occupational hazards, diseases and accidents owing to their ignorance of the language and to their placement in arduous or even dangerous jobs.

Among migrant workers there is usually a high rate of sickness absence caused by tuberculosis. This high incidence can be explained both by their living conditions before leaving home and by their living and working conditions in the host country. Migrants also suffer from relapses of malaria; both this and tuberculosis are aggravated by malnutrition and parasite infection.

The socio-psychiatric problems of the migrant worker have not yet been explored here and the complexity of factors involved makes further studies necessary.
Manpower movements from one country to another raise important health and social problems. Migrants need protection against any occupational hazards to which they are exposed before they become adapted to their new conditions and also against those social and health problems that may accompany migrant existence in a foreign country, some caused by differences in customs or prejudice. At the same time, the population of the recipient country has to be protected against imported diseases. This dual protection calls for co-ordination among the countries concerned to provide social, medical and health supervision.

Accommodation for migrants should, at least, offer an elementary standard of comfort and hygiene; they should not be left to find accommodation on their own as they tend to live together in inferior houses and to be isolated from the surrounding community.

Linguistic communication is very important and special attention should be devoted to teaching them the recipient country's national language or to selecting migrants from other countries speaking the same language. It is important that training in safety methods should be given either in the language of the migrant workers or in another language, equally understood by both parties.

Medical control and supervision should start before migration in the country of origin and be followed by the national health authority after the migrant's arrival in the recipient country. Before migration, they are mainly to ensure that the migrant is in a good state of health, both physically and mentally. Medical and occupational health services should join in supervising the migrants when they arrive in the host country.

In Bahrain, where no occupational health services are available at workplaces, our new policy is to integrate all the health services under one roof in health centres. Health centres of different sizes will provide occupational health services, such as medical examination, environmental-monitoring of workplaces, health and safety education, etc. This will follow the policy laid down by the central occupational health services section of the Ministry of Health, which will plan, supervise and co-ordinate policy with other national agencies for the health and welfare of the gainfully employed.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Bahraini</th>
<th>Non-Bahraini</th>
</tr>
</thead>
<tbody>
<tr>
<td>1959</td>
<td>46 500</td>
<td>63.1%</td>
<td>36.9%</td>
</tr>
<tr>
<td>1965</td>
<td>53 000</td>
<td>58.6%</td>
<td>41.4%</td>
</tr>
<tr>
<td>1971</td>
<td>60 000</td>
<td>62.9%</td>
<td>37.1%</td>
</tr>
<tr>
<td>1974*</td>
<td>67 000</td>
<td>62.0%</td>
<td>38.0%</td>
</tr>
</tbody>
</table>

* Estimated.

Source: Ministry of Labour and Social Affairs.
Employees of the private sector (1974)

<table>
<thead>
<tr>
<th>Total number of employees</th>
<th>Bahraini</th>
<th>Non-Bahraini</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 555</td>
<td>63.9%</td>
<td>36.1%</td>
</tr>
</tbody>
</table>

Source: Ministry of Labour and Social Affairs.

Economically active population by nationality (1971)

<table>
<thead>
<tr>
<th>Field of activity</th>
<th>Labour force (in round figures)</th>
<th>Bahraini</th>
<th>Non-Bahraini</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture and fishing</td>
<td>4 000</td>
<td>75.1%</td>
<td>24.9%</td>
</tr>
<tr>
<td>Mining and manufacturing</td>
<td>8 500</td>
<td>66.3%</td>
<td>33.7%</td>
</tr>
<tr>
<td>Electricity, gas and water</td>
<td>1 800</td>
<td>84.1%</td>
<td>15.9%</td>
</tr>
<tr>
<td>Construction</td>
<td>10 000</td>
<td>54.2%</td>
<td>45.8%</td>
</tr>
<tr>
<td>Wholesale, hotel and restaurants</td>
<td>6 000</td>
<td>63.0%</td>
<td>37.0%</td>
</tr>
<tr>
<td>Transport, storage and communication</td>
<td>6 000</td>
<td>65.4%</td>
<td>34.6%</td>
</tr>
<tr>
<td>Finance, insurance and real estate</td>
<td>1 200</td>
<td>68.8%</td>
<td>31.2%</td>
</tr>
<tr>
<td>Community, social and personal services</td>
<td>18 500</td>
<td>59.2%</td>
<td>40.8%</td>
</tr>
<tr>
<td>Other activities</td>
<td>1 000</td>
<td>77.0%</td>
<td>23.0%</td>
</tr>
</tbody>
</table>

Source: Ministry of Finance and National Economy.

Distribution of employees by size of establishment (1974): Private sector

<table>
<thead>
<tr>
<th>Establishment Size</th>
<th>Establishment No.</th>
<th>Employees</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bahraini</td>
<td>Non-Bahraini</td>
<td>Total</td>
</tr>
<tr>
<td>1-19</td>
<td>14</td>
<td>111</td>
<td>172</td>
</tr>
<tr>
<td>20-30</td>
<td>13</td>
<td>136</td>
<td>160</td>
</tr>
<tr>
<td>21-40</td>
<td>8</td>
<td>177</td>
<td>298</td>
</tr>
<tr>
<td>41-50</td>
<td>7</td>
<td>263</td>
<td>258</td>
</tr>
<tr>
<td>51-100</td>
<td>14</td>
<td>592</td>
<td>569</td>
</tr>
<tr>
<td>101-200</td>
<td>11</td>
<td>909</td>
<td>681</td>
</tr>
<tr>
<td>201-300</td>
<td>6</td>
<td>928</td>
<td>676</td>
</tr>
<tr>
<td>301-400</td>
<td>3</td>
<td>339</td>
<td>760</td>
</tr>
<tr>
<td>401-500</td>
<td>1</td>
<td>208</td>
<td>291</td>
</tr>
<tr>
<td>501-1 000</td>
<td>4</td>
<td>1 735</td>
<td>1 215</td>
</tr>
<tr>
<td>1 000 +</td>
<td>3</td>
<td>6 550</td>
<td>1 627</td>
</tr>
<tr>
<td>TOTAL</td>
<td>84</td>
<td>11 848</td>
<td>6 707</td>
</tr>
</tbody>
</table>

Source: Ministry of Labour and Social Affairs.
OCCUPATIONAL HEALTH AND SAFETY OF MIGRANT WORKERS IN BAHRAIN

Distribution of employees of private sector (1974)

<table>
<thead>
<tr>
<th>Sectors</th>
<th>Bahrain</th>
<th>%</th>
<th>Non-Bahraini</th>
<th>%</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture and fishing</td>
<td>187</td>
<td>68</td>
<td>88</td>
<td>32</td>
<td>275</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>6 396</td>
<td>77</td>
<td>1 924</td>
<td>23</td>
<td>8 320</td>
</tr>
<tr>
<td>Construction</td>
<td>1 546</td>
<td>53</td>
<td>1 380</td>
<td>47</td>
<td>2 926</td>
</tr>
<tr>
<td>Service</td>
<td>3 719</td>
<td>53</td>
<td>3 315</td>
<td>47</td>
<td>7 034</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>11 848</strong></td>
<td><strong>63</strong></td>
<td><strong>6 707</strong></td>
<td><strong>37</strong></td>
<td><strong>18 555</strong></td>
</tr>
</tbody>
</table>

Source: Ministry of Labour and Social Affairs.

Migrants by nationality (1971)

<table>
<thead>
<tr>
<th>Country</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>6 657</td>
</tr>
<tr>
<td>Pakistan</td>
<td>5 377</td>
</tr>
<tr>
<td>Iran</td>
<td>5 097</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>2 901</td>
</tr>
<tr>
<td>Other European countries</td>
<td>301</td>
</tr>
<tr>
<td>Oman</td>
<td>10 785</td>
</tr>
<tr>
<td>Yemen</td>
<td>1 538</td>
</tr>
<tr>
<td>Jordan and Palestine</td>
<td>1 338</td>
</tr>
<tr>
<td>Egypt</td>
<td>587</td>
</tr>
<tr>
<td>Other Arab countries</td>
<td>2 753</td>
</tr>
<tr>
<td>America</td>
<td>272</td>
</tr>
<tr>
<td>Others</td>
<td>279</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>37 885</strong></td>
</tr>
</tbody>
</table>

Source: Ministry of Finance and National Economy.

Tuberculosis cases admitted to chest diseases hospital (1974)

<table>
<thead>
<tr>
<th>Nationality</th>
<th>No. of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bahraini</td>
<td>83</td>
</tr>
<tr>
<td>Non-Bahraini</td>
<td>81</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>164</strong></td>
</tr>
</tbody>
</table>

Source: Ministry of Health.


<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Imported</th>
<th>Indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>38</td>
<td>24</td>
<td>14</td>
</tr>
<tr>
<td>1971</td>
<td>19</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>1972</td>
<td>12</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>1973</td>
<td>79</td>
<td>77</td>
<td>2</td>
</tr>
<tr>
<td>1974</td>
<td>64</td>
<td>64</td>
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Source: Ministry of Health.